IU HEALTH PAOLI HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1306 Worksheet S Peri od. From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: То 6/29/2020 9:03 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 6/29/2020 Time: 9:03 am Manually prepared cost report use only 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH PAOLI HOSPITAL (15-1306) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. [X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. MI CHAEL CRAIG (Signed) Officer or Administrator of Provider(s) CHIEF FINANCIAL OFFICER Title (Dated when report is electronically signed.) Date

	Title XVIII				
Title V	Part A	Part B	HIT	Title XIX	
1.00	2.00	3.00	4.00	5.00	
0	-43, 046	-126, 461	0	0	1.00
0	0	0		0	2.00
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0	-23, 695	0		0	5.00
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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.

	AL AND HOSPITAL HEALTH CARE COMPLEX I	JENTITICATION DA		Provi der		5-1300	Period: From 01/01. To 12/31.	/2019 /2019	Part I Date/Ti	eet S-2 ime Pre 020 9:0	epare
	1.00	2.	00	3.	00			4.00	0/27/20	JZU 7.L	
_	Hospital and Hospital Health Care Co										
)0)0	Street: 642 WEST HOSPITAL ROAD City: PAOLI	PO Box: State: I	N 7i	p Code:	47454	Count	ty: ORANGE				1.
		Component Na			CBSA	Provi der		Payme	nt Syst	em (P,	2.
				umber N	lumber	Туре	Certified	Т,	0, or	N)	
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	Hospital and Hospital-Based Componen	1.00 t Identification		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
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~		HOSPI TAL									
0 0	Subprovider - IPF Subprovider - IRF										4
0	Subprovi der - (Other)										6
0	Swing Beds - SNF	IUHP SWING BEDS	15	Z306	99915		07/01/2001	N	0	N	7
0	Swing Beds - NF										8
0 00	Hospi tal -Based SNF Hospi tal -Based NF										9
00	Hospi tal -Based OLTC										11
00	Hospital-Based HHA										12
00 00	Separately Certified ASC Hospital-Based Hospice										13
00	Hospital-Based Health Clinic - RHC										14
00	Hospital-Based Health Clinic - FQHC										16
00	Hospital-Based (CMHC) I										17
00 00	Renal Dialysis Other										18
	1	I		I		1	From		Tc		
00	Cost Reporting Period (mm/dd/yyyy)						1.00		2.		20
00	Type of Control (see instructions)						2	019	12/31	/2019	20
	· · · · · · · · · · · · · · · · · · ·										_
	Inpatient PPS Information					1.00	2.00)	3.	00	-
00	Does this facility qualify and is it	currently receiv	/ing paymen	ts for		N	N				22
	disproportionate share hospital adju										
	§412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §	r yes or "N" for 412 106(c)(2)(Pic	no. Is this kle amendmi	S ent							
	hospital?) In column 2, enter "Y" fo			cirt							
01	Did this hospital receive interim un					Ν	N				22
	cost reporting period? Enter in colu the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N				t						
	reporting period occurring on or aft	•									
02	Is this a newly merged hospital that payments to be determined at cost re					Ν	N				22
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob										
	or "N" for no, for the portion of the October 1.	e cost reporting	period on o	or after							
03	Did this hospital receive a geograph					Ν	N		Ν	I	22
	rural as a result of the OMB standar				s						
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportion										
	in column 2, "Y" for yes or "N" for	no for the portio	on of the co	ost							
	reporting period occurring on or after Does this hospital contain at least										
	counted in accordance with 42 CFR 41.										
	yes or "N" for no.										
00	Which method is used to determine Me below? In column 1, enter 1 if date				2		3 N				23
	if date of discharge. Is the method										
	reporting period different from the										
	reporting period? In column 2, ente	r "Y" for yes or	"N" for no. In-State	In-Stat	te 🛛 ∩	ut-of	Out-of !	/edi cai	d O	ther	
			Medi cai d	Medi cai		State		HMO day		di cai d	
			paid days	eligibl			Medi cai d		(days	
				unpai o days	a pai	d days	eligible unpaid				
						3.00	4. 00	5.00		5.00	1
		-	1.00	2.00							
00	If this provider is an IPPS hospital		1.00 0		0	0	0		0		24
00	in-state Medicaid paid days in colum	n 1, in-state				0	0		0		24
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-state umn 2,				0	0		0		24
00	in-state Medicaid paid days in colum	n 1, in-state umn 2, olumn 3, d days in column				0	0		0		24

	Financial Systems IU HEAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	LTH PAOLI H		CN: 15-1306	Peri od:		u of For Workshe	et S-2	
					From 01/0 To 12/3	1/2019 1/2019	Part I Date/Ti 6/29/20		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Meo	ther di cai d days	
. 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.	1.00	2.00	3.00	4.00	5.00	0	5.00	25.
					Urban/R		Date of 2.		-
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural.			he	2			26. 27.
. 00	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	"2" for r cation in	ural. If a _l column 2.	ppl i cabl e,		0			35.
	effect in the cost reporting period.					-	Endi	201	
					Begi nr 1. (Endi 2.		
. 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	er				36.
		the numbe			s	0			37.
	accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	or yes or "	N" for no.	(see					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/		Y/ 2.		-
. 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 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? En [.] requiremen	ter in colum nts in	me N n		N		39.
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for <u>y</u>				Ν	l	40
						V 1.00	XVIII 2.00	XI X 3.00	-
	Prospective Payment System (PPS)-Capital						-	-	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	eption for	extraordi na	ary circumst	ances	N N	N N	N N	45.
. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of			·	5	N	N	N	47.
. 00	Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in					N	N	N	48. 56.
. 00	"N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for	mpacted by no in colu period duri	CR 11642 mn 2. ng which re	(or subseque esidents in	nt CR), MA approved				57
00	is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "\ "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	th of this (", complet , if appli	cost repor [.] e Workshee [.] cable.	ting period? t E-4. If co	Enter "Y" lumn 2 is				58
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	complete W	kst. D-5.		່ວີບວ	N			58
				NAHE 413.8 Y/N	35 Worksh Line	e #	Pass-T Qualifi Criteri	cation	
. 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 adjustement? Enter "Y" for yes or "N" for no in colu	85? (see umn 1. If CR) NAHE MA	column 1	1.00 N	2. (00	3.	00	60.

ealth Financial Systems IU HEAL OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA [®]	ГА	Provider CC	Fi	eriod: rom 01/01/2019	Date/Time Pre	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see 	Ν			0. 00	0.00	61. 00
1.02 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						61.02
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						61.03
 O4 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.04
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.03). (see instructions)						61.05
 O6 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) 						61.00
	Pro	ogram Name	Program Code		Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
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.						61. 10
Image: The second sec						
your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	tions) Teachi <u>ram. (s</u>	ng Health Cent see instruction	ter (THC) into			62.00
3.00 Has your facility trained residents in nonprovider se	ttings	during this co	ost reporting p 57. (see instru	period? Enter uctions)	N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital		
Soction EEOA of the ACA Base Very FTF Desideral ' N	pprovi	dor Setting				
4.00 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	<u>e June</u> y trair -primar all nor	30, 2010. ned residents ry care nprovider	-	-		64.00

			Fr	om 01/01/2019	Part I	
			To	12/31/2019	Date/Time Pre	pared 3 am
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				позрітаі	4))	
	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.
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	Unweighted	Ratio (col. 1/	,
			FTEs	FTEs in	(col. 1 + col.	
				Hospi tal	2))	
				2 00	3.00	-
Section 5504 of the ACA Current	/ear FTE Residents i	n Nonprovider Settin				
00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonpunweighted non-prima al. Enter in column a column 2)). (see ins	rovider settings. ry care resident 3 the ratio of structions)				
	Program Name	Program Code	Unweighted	Unwei ahted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	FTĔs Nonprovider	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)	1.00	To 12/31/2019 Date/Time Preparation (Col. 37) rogram Name Program Code Unweighted Nonprovider Unweighted Site Unweighted Hospital Col. 37 Col. 37 1.00 2.00 3.00 4.00 5.00 0.000 65.0 1.00 2.00 3.00 4.00 5.00 0.00000 65.0 1.00 2.00 3.00 4.00 5.00 0.000000 65.0 1.00 2.00 3.00 0.00 0.00 0.000000 65.0 1.00 2.00 3.00 0.00 0.00 0.00000 65.0 1.00 2.00 3.00 1.00 2.00 3.00 1.00 TE Residents in Nonprovider SettingsEffective for cost reporting periods 0.000000 66.0 0.000000 66.0 1.00 2.00 3.00 0.00 0.000000 67.0 1.00 2.00 3.00 0.00 0.000000 67.0 1.00 2.00 3.00 0.00 0.000000				
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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)	25	2.00	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0 0.000000 0 0.000000 0 2.00 3.00	- 67.
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)	≫S ∕chiatric Facility (2.00 IPF), or does it con	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00 0.00 1.0 rovider?	(col . 3 + col . 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	70. (
<pre>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)</pre>	PS /chiatric Facility (the facility have an fore November 15, 21 umn 2: Did this faci ≷ 412.424 (d)(1)(iii) ate which program ye	2.00 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 tain an IPF subp ing 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 0.0000000 0.000000	70. (
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Health Financial Systems IU HEALTH PAOLI HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1306	In Lie Period: From 01/01/2019 To 12/31/2019	u of Form CMS Worksheet S- Part I Date/Time Pr 6/29/2020 9:	2 repared:
		1.00	_
Long Term Care Hospital PPS80.00Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.81.00Is this a LTCH co-located within another hospital for part or all of the cost reporti "Y" for yes and "N" for no.	ng period? Enter	N N	80.00 81.00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for ye86.00Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sect §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital classified under sectio 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	n	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		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	N	N	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	i v	N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicable column.	NI		
93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "V" for yes or "N" for no in the applicable column.		N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00If line 94 is "Y", enter the reduction percentage in the applicable column.96.00Does 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 f 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. I, 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 Wks C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for 		Y	98. 01
<pre>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</pre>	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		Ν	98. 03
<pre>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, an in column 2 for title VIV</pre>	d N	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 o Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and column 2 for title XIX. 		Y	98. 05
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.	N	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 payme for outpatient services? (see instructions)	nt N		106.00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&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 I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?	N		107.00
Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 4	2 Y		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupation		Respi ratory	
1.00 2.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. N	3. 00 N	4.00 N	109.00
		1.00	_
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 thr applicable.	lf yes,	N	110.00

201 th Financial Systems IU HEALTH PAOLI DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	N: 15-1306	Peri od:	eu of Form CMS Worksheet S-	
			From 01/01/2019 To 12/31/2019		epared 03 am
			1.00	2.00	_
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	eriod? 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 e	N			112. (
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	Ν			116. (
7.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.		Ν	1		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 occurrence			1		118.
8.01 List amounts of malpractice premiums and paid losses:		1. 00 41, 2	2.00	3.00	0118.
			1.00	2.00	_
8.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 9.00 D0 NOT USE THIS LINE			N		118.
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 Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" lifies for th	for yes or Ne Outpatient		N	120.
1. OODid this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	table devices	charged to	Y		121.
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 and "N"	for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2.	er the certif	ication date			126.
7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			127.
8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			128.
		ation date i	n		129.
		ification			130.
column 1 and termination date, if applicable, in column 2. 0.00 f this is a Medicare certified pancreas transplant center, e					131.
column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, educed to the column 1 and termination date, if applicable, in column 1.00 If this is a Medicare certified intestinal transplant center,	mn 2. enter the ce	ertification			
 column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, edate in column 1 and termination date, if applicable, in colum. 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum. 2.00 If this is a Medicare certified islet transplant center, edate in column 1 and termination date, if applicable, in colum. 	mn 2. enter the ce mn 2. r the certifi				132.
0.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu 1.00 If this is a Medicare certified intestinal transplant center,	mn 2. enter the ce mn 2. er the certifi	cation date			132. 133. 134.

Health Financial Systems	IU HEAL	IU HEALTH PAOLI HOSPITAL				In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DAT	A	Provider CC	N: 15-1306		d: 01/01/2019 12/31/2019		epared:
1.00		2.00				3.00	6/29/2020 9:0	
If this facility is part of a chain		er on lir			name ar		of the	
home office and enter the home offic					-+ N		.4	1.41.00
141.00 Name: INDIANA UNIVERSITY HEALTH	Contractor's Na	ame: WISCO SERV		AN Contra	CTOP'S N	umber: 0810		141.00
142.00 Street: 340 WEST TENTH STREET	PO Box:	JERV	ICES					142.00
143.00 City: INDIANAPOLIS	State:	IN		Zip Co	de:	4620	4	143.00
							1.00	-
144.00 Are provider based physicians' costs	included in Works	sheet A?					1.00 Y	144.00
						1.00	2.00	1
 145.00 If costs for renal services are clai inpatient services only? Enter "Y" f no, does the dialysis facility incluperiod? Enter "Y" for yes or "N" fo 146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in c 	or yes or "N" for de Medicare utiliz r no in column 2. changed from the p olumn 1. (See CMS	no in co zation fo previousl Pub. 15-	olumn 1. If co or this cost i y filed cost	olumn 1 is reporting report?		Ν		145. 00 146. 00
yes, enter the approval date (mm/dd/	yyyy) in corunn 2.							
							1.00	
147.00 Was there a change in the statistica							N	147.00
148.00 Was there a change in the order of a 149.00 Was there a change to the simplified					or no		N N	148.00 149.00
149. Oojwas there a change to the shipithed			Part A	Part B		Title V	Title XIX	149.00
			1.00	2.00		3.00	4.00	1
Does this facility contain a provide or charges? Enter "Y" for yes or "N"	r that qualifies f for no for each d	for an ex component	t for Part A	and Part B	cation d . (See 4	42 CFR §413	. 13)	
155.00Hospi tal 156.00Subprovi der – TPF			N N	N N		N N	N N	155.00 156.00
157. 00 Subprovider – TRF			N	N		N	N	157.00
158. 00 SUBPROVI DER								158.00
159. 00 SNF			N	Ν		Ν	N	159.00
160.00HOME HEALTH AGENCY 161.00CMHC			N	N		N	N	160.00
			I	N		N	N	101.00
							1.00	1
Multicampus 165.00 ls this hospital part of a Multicamp	us hospital that h	nas one c	or more campus	ses in dif	ferent C	BSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name		County	State	Zip Code	CBSA	FTE/Campus	
	0		1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0. 00	166. 00
							1.00	
Heal th Information Technology (HIT)	incentive in the	American	Recovery and	Reinvestm	ent Act		1.00	
167.00 Is this provider a meaningful user u					EIIL ACL		Y	167.00
168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HIT	is "Y") and is a m	neani ngfu	ul user (line		"), ente	er the		168.00
168.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? E	nter "Y" for yes o	or "N" fo	or no. (see ii	nstruction	s)		N	168. 01
169.00 If this provider is a meaningful use transition factor. (see instructions) and is	s not a CAH (I	ine 105 i	s "N"),	enter the	0.00	169.00
	/				B	egi nni ng	Endi ng	
						1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and er	nding dat	e for the re	porting				170.00
		· ··	d aluar t			1.00	2.00	174 00
171.00 f line 167 is "Y", does this provid section 1876 Medicare cost plans rep "Y" for yes and "N" for no in column 1876 Medicare days in column 2. (see	orted on Wkst. S-3 1. If column 1 is	3, Pt. I,	line 2, col	6? Enter		Y		171.00

OSPI T.	Financial Systems IU HEALTH PAC	Provider C		Period: From 01/01/2019 To 12/31/2019 Y/N	u of Form CMS- Worksheet S-2 Part II Date/Time Pro 6/29/2020 9:0 Date	2 epared
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	for all NO re	sponses. Ente			
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	e beginning of column 2. (see	instructions)	N		1. (
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare F	program2 lf	1.00 N	2.00	3.00	2. (
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or 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 ler or its of the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A	03/20/2020	4.0
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
				1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf voc ic th	o providor is	N		6.
. 00	the legal operator of the program?	TT yes, is th	le provider is	IN		0.
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		l during the	N N		7. 8.
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	0	al education	Ν		9.
0. 00	Was an approved Intern and Resident GME program initiated c		he current	Ν		10.
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.
					Y/N	
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			st reporting	Y N	12. 13.
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructions.	N	14.
5.00	Did total beds available change from the prior cost reporti	<u>v</u> 1	yes, see inst t A		N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16.
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/01/2020	Y	04/01/2020	17.
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

Health Financial Systems

IU HEALTH PAOLI HOSPITAL

In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1306	Peri od:	Worksheet S	
105111			SN. 15 1500	From 01/01/2019 To 12/31/2019	Part II	repared:
		Descri	pti on	Y/N	Y/N	
)	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
~~ ~~	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense		als made duri	ng the cost	N N	22.00 23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost rep	oorting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lf yes, see	N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost reporti	ng period? If	fyes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th copy.	e cost reportin	g period? If	yes, submit	N	27.00
28.00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	ntered into dur	ing the cost	reporting	N	28.00
	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		0		N	29.00
	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	ructions		,	N	30.00
	instructions.	5	5			
31.00	Has debt been recalled before scheduled maturity without i instructions. Purchased Services	ssuance or new	debt? IT yes,	see	N	31.00
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr	rvi ces furni she	d through cor	ntractual	N	32.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	plied pertainin	g to competit	ive bidding? If		33.00
34 00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	nrovi der-bas	ed physicians?	Y	34.00
	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	0		1 5	Y	35.00
55.00	physicians during the cost reporting period? If yes, see i					35.00
				Y/N 1.00	Date 2.00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y		36.00 37.00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	. ,		N.		38.00
	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth	d of the home o	ffi ce.			39.00
	see instructions. If line 36 is yes, did the provider render services to the		5	N		40.00
	instructions.					
		1.	00	2.	00	
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	RHONDA		UTTER		41.00
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
	Enter the employer/company name of the cost report preparer.	I NDI ANA UNI VER	SITY HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@I UHEALT	H. ORG	43.00

Heal th	Financial Systems IU HEALTH	I PAOL	I HOSPITAL	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-	eriod: rom 01/01/2019	Worksheet S-2	
					Part II Date/Time Pre 6/29/2020 9:0	pared: 3 am
				-		
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	0	DI RECTOR			41.00
	held by the cost report preparer in columns 1, 2, and 3	3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the cos	st				43.00
	report preparer in columns 1 and 2, respectively.					

HUSPI I			Durati 1 CC	NI 1E 100/	Davel and	Walaka I C C	
	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-1306	Period: From 01/01/2019	Worksheet S-3 Part I	
					To 12/31/2019	Date/Time Pre	
						6/29/2020 9:03	3 am
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
1 00		1.00	2.00	3.00	4.00	5.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	24	8, 7	60 16, 656. 00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		24	8, 7	60 16, 656. 00	0	7.00
0 00	beds) (see instructions)	21.00			0 0 00	0	0.00
8.00 9.00	INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.00
9.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		24	8, 7	60 16, 656. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER – I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	101 00				0	21.00
22.00 23.00	HOME HEALTH AGENCY	101.00				0	22.00 23.00
23.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23.00
24.10	HOSPICE (non-distinct part)	30.00					24.00
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		_				31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32. 01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33.00

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/29/2020 9:0	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	223	20 314	69	4		1. 00 2. 00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	0	314				3.00
I. 00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	116	0	11	6		5.00
o. 00	Hospital Adults & Peds. Swing Bed NF		0	15			6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	339	20	96	2		7.00
3.00	INTENSIVE CARE UNIT	0	0		C		8.00
9.00	CORONARY CARE UNIT						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGICAL INTENSIVE CARE UNIT						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)				_		12.00
3.00	NURSERY	200	29	21		40/ 45	13.00
4.00	Total (see instructions)	339	49	1, 17		126.45	
5.00 6.00	CAH visits SUBPROVIDER - IPF	U	0		D		15.0
7.00	SUBPROVIDER - IPF						16.0 17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY	0	0		0.00	0.00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPI CE						24.0
24.10	HOSPICE (non-distinct part)			1	6		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0		0.00	0.00	26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00		
27.00	Total (sum of lines 14-26)				0.00	126.45	
28.00	Observation Bed Days		15	66	5		28.0
29.00	Ambul ance Trips	0					29.0
30.00	Employee discount days (see instruction)				D D		30.0
31.00	Employee discount days - IRF				C		31.0
32.00	Labor & delivery days (see instructions)	0	0		2		32.0
32. 01	Total ancillary labor & delivery room				C		32.0
2 00	outpatient days (see instructions)	0					33.00
33.00	LTCH non-covered days LTCH site neutral days and discharges	0					33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/29/2020 9:0	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 16.00 17.00 22.00 23.00 24.00 24.00 24.00 24.00 25.00 26.02 27.00 28.00 29.00 30.00 24.00	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 HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0.00	0		11.00 38 9 26 125 0 0 38 9	261	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 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 26.00 27.00 28.00 29.00 30.00 21.0
32. 00 32. 01 33. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		32. 00 32. 01 33. 00 33. 01

Heal th	Financial Systems IU HEALTH PAOLI H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
		Provider CC		Period:	Worksheet S-1	
				From 01/01/2019	Data /Tima Dra	narad.
				To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
			· · · · · ·			
					1.00	
	Uncompensated and indigent care cost computation			2)	0.0/0007	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by lin	ne 202 column	8)	0. 360007	1.00
2.00	Medicaid (see instructions for each line) Net revenue from Medicaid				3, 229, 311	2.00
2.00 3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal payments	from Medica	id?	Ý	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr				0	5.00
6.00	Medi cai d charges		16, 545, 536	6.00		
7.00	Medicaid cost (line 1 times line 6)				5, 956, 509	
8.00	Difference between net revenue and costs for Medicaid program ((line 7 minu	ıs sum of lin	es 2 and 5; if	2, 727, 198	8.00
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions fo</pre>	r oach ling	.)			
9.00	Net revenue from stand-al one CHIP		.)		0	9.00
10.00	Stand-al one CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP ((line 11 min	nus line 9; i	f < zero then	0	12.00
	enter zero)					
12.00	Other state or local government indigent care program (see inst			<u>`````````````````````````````````````</u>	071	12.00
13.00 14.00	Net revenue from state or local indigent care program (Not incl Charges for patients covered under state or local indigent care				1, 257	13.00 14.00
14.00	10)	e program (n		III IIIles o oi	1,207	14.00
15.00	State or local indigent care program cost (line 1 times line 14	1)			453	15.00
16.00	Difference between net revenue and costs for state or local ind	digent care	program (lin	e 15 minus line	182	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indig	ent care program	ns (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fu	Indi na chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of h				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local			(sum of lines	2, 727, 380	
	8, 12 and 16)			_		
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	0.00	
20.00	Charity care charges and uninsured discounts for the entire fac	cility	1, 887, 07	4 88, 686	1, 975, 760	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured discou instructions)	unts (see	679, 36	0 88, 686	768, 046	21.00
22.00	Payments received from patients for amounts previously written	off as	3, 57	o o	3, 570	22.00
	chari ty care		-,	-		
23.00	Cost of charity care (line 21 minus line 22)		675, 79	0 88, 686	764, 476	23.00
24.00	Does the amount on line 20 column 2, include charges for patien	t dave bave	nd a longth	of ctoy limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or other indigent care		nu a rengtri	JI Stay ITMIT	IN	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond th		care program	s length of	0	25.00
	stay limit	C		0		
26.00	Total bad debt expense for the entire hospital complex (see ins				3, 633, 369	1
27.00	Medicare reimbursable bad debts for the entire hospital complex		,		874, 654	1
27.01	Medicare allowable bad debts for the entire hospital complex (s	see instruct	ions)		1, 345, 622	
28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp		2, 287, 747 1, 294, 573			
29.00 30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	130 (SEC 1	nati ucti UnS)		2, 059, 049	
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 786, 429	
					•	•

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	IU HEALTH PAOL F EXPENSES	I HOSPITAL Provider CO	CN: 15-1306 P	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
			FI To	rom 01/01/2019 0 12/31/2019	Date/Time Pre 6/29/2020 9:03	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS				E 47 EE 7		1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	-	547, 557 1, 123, 585	547, 557 1, 123, 585	1.00 2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	54, 381	187, 412	241, 793	1, 367, 329	1, 609, 122	4.00
5.00 00500 ADMI NI STRATI VE & GENERAL	437, 647	6, 326, 161	6, 763, 808	-288, 871	6, 474, 937	5.00
7.00 00700 OPERATION OF PLANT	414, 165	1, 352, 811		-711, 237	1, 055, 739	7.00
7.01 00701 UTILITIES 8.00 00800 LAUNDRY & LINEN SERVICE	0	0 63, 499	0 63, 499	359, 967 0	359, 967 63, 499	7.01 8.00
9. 00 00900 HOUSEKEEPING	192, 149	138, 329		-82, 213	248, 265	9.00
10. 00 01000 DI ETARY	188, 888	145, 403		-243, 192	91, 099	10.00
11. 00 01100 CAFETERI A	0	0	-	174, 166	174, 166	11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	589, 990	839, 138		-176, 855	1, 252, 273	13.00
13. 01 01301 HOUSE SUPERVI SORS 14. 00 01400 CENTRAL SERVI CES & SUPPLY	382, 577 0	91,079		-62, 650	411,006	13.01
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	228, 481	36, 213 1, 860, 151		362, 148 -1, 585, 062	398, 361 503, 570	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	12, 486		-3, 838	8, 648	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	341, 058	68, 393	409, 451	-37, 066	372, 385	19.00
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	1,009,626	1, 073, 332	2, 082, 958	-382, 061	1, 700, 897	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1,009,020	1, 073, 332	2,002,950	-362,001	1, 700, 897	30.00
43. 00 04300 NURSERY	90, 640	17, 893	108, 533	-46, 858	61, 675	43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	441, 478	407, 932		-333, 754	515, 656	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	57, 483 843, 723	0 1, 152, 890		32, 031 -735, 258	89, 514 1, 261, 355	52.00 54.00
60. 00 06000 LABORATORY	340	1, 656, 130		-1, 568	1, 654, 902	60.00
64.00 06400 I NTRAVENOUS THERAPY	63, 892	37, 098		-24, 247	76, 743	64.00
65. 00 06500 RESPI RATORY THERAPY	329, 533	164, 208	493, 741	-110, 627	383, 114	65.00
66. 00 06600 PHYSI CAL THERAPY	494, 979	293, 211	788, 190	-396, 190	392, 000	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	89, 271 58, 845	89, 271 58, 845	67.00 68.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25, 900	25, 900	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	20, 169	20, 169	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 509, 068	1, 509, 068	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART) 76. 97 07697 CARDI AC REHABI LI TATI ON	537	3, 837	4, 374	-4, 374	0	75.00 76.97
OUTPATIENT SERVICE COST CENTERS		0,007	1,071	1,071	0	/0. //
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC 90.01 09001 VISITING SPECIALTY CLINIC	42, 809 191, 071	27, 956 71, 680		-1, 729 -34, 907	69, 036 227, 844	90. 00 90. 01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	1,000	1	-1	0	90.02
91. 00 09100 EMERGENCY	1, 230, 083	1, 763, 707	2, 993, 790	-398, 939	2, 594, 851	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES		0		0	0	05 00
101.00 10100 HOME HEALTH AGENCY	0	0		0		95.00 101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>				0	101.00
113.00 11300 INTEREST EXPENSE		0		0	-	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 625, 530	17, 790, 950	25, 416, 480	8, 539	25, 425, 019	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190. 01 19001 VI SI TI NG SPECIALTY CLI NI C	0	0	0	0		190.00
190. 02 19002 OUTREACH	0	1, 230	1, 230	-1, 000		190. 02
190. 03 19003 FOUNDATI ON	0	0	0	0		190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	O	0	0	0		190.04
190. 05 19005 PAOLI FAMILY PRACTICE 190. 06 19006 OTHER PROPERTY	0	5, 215		-1, 621		190. 05 190. 06
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH	0	5, 948 0	5, 948 0	-5, 918 0		190.06 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	0	0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	7, 625, 530	17, 803, 343	25, 428, 873	0	25, 428, 873	200. 00

	Financial Systems FICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IU HEALTH PAOL F EXPENSES	Provider CCN: 15-1306	Peri od:	u of Form CMS-2552 Worksheet A
				From 01/01/2019 To 12/31/2019	Date/Time Prepare
	Cost Center Description	Adjustments	Net Expenses		6/29/2020 9:03 am
			For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS	2 400	EAE 167		1
	DO100 CAP REL COSTS-BLDG & FIXT	-2, 400	545, 157		1.
	DO200 CAP REL COSTS-MVBLE EQUIP DO300 OTHER CAP REL COSTS	0	1, 123, 585		2.
	00400 EMPLOYEE BENEFITS DEPARTMENT	262, 883	1, 872, 005		3.
	00500 ADMINISTRATIVE & GENERAL	-206, 212	6, 268, 725		4.
	DO700 OPERATION OF PLANT	-24, 191	1, 031, 548		7.
	DO701 UTI LI TI ES	0	359, 967		7.
	DOBOOLAUNDRY & LINEN SERVICE	Ő	63, 499		8.
	DO900 HOUSEKEEPI NG	0	248, 265		9.
0.00	D1000 DI ETARY	0	91, 099		10.
1.00	D1100 CAFETERI A	-81, 018	93, 148		11.
3.00	01300 NURSING ADMINISTRATION	-655, 451	596, 822		13.
	D1301 HOUSE SUPERVI SORS	0	411, 006		13.
	01400 CENTRAL SERVICES & SUPPLY	0	398, 361		14.
	D1500 PHARMACY	-47,437	456, 133		15.
	01600 MEDICAL RECORDS & LIBRARY	-4, 327	4, 321		16.
	D1700 SOCIAL SERVICE	0	0		17.
	01900 NONPHYSI CI AN ANESTHETI STS	-88, 503	283, 882		
	INPATIENT ROUTINE SERVICE COST CENTERS	470.015	1 000 000		
	D3000 ADULTS & PEDIATRICS	-472, 015	1, 228, 882		30.
		0	0		31.
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	U	61, 675		43.
	D5000 OPERATING ROOM	-2,000	513, 656		50.
	D5200 DELIVERY ROOM & LABOR ROOM	-2,000	89, 514		52.
	05400 RADI OLOGY-DI AGNOSTI C	-730	1, 260, 625		54.
	D6000 LABORATORY	0	1, 654, 902		60.
	D6400 I NTRAVENOUS THERAPY	Ő	76, 743		64.
	06500 RESPI RATORY THERAPY	0	383, 114		65.
	06600 PHYSI CAL THERAPY	138, 720	530, 720		66.
7.00	06700 OCCUPATIONAL THERAPY	0	89, 271		67.
8.00	D6800 SPEECH PATHOLOGY	0	58, 845		68.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25, 900		71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	20, 169		72.
	07300 DRUGS CHARGED TO PATIENTS	774	1, 509, 842		73.
	07301 DRUGS CHARGED TO PATIENTS	0	0		73.
	07400 RENAL DI ALYSI S	0	0		74.
	07500 ASC (NON-DI STI NCT PART)	0	0		75.
	07697 CARDI AC REHABI LI TATI ON	0	0		
	DUTPATIENT SERVICE COST CENTERS	ol	0		
	08800 RURAL HEALTH CLINIC	0	0		88.
	D8900 FEDERALLY QUALIFIED HEALTH CENTER	0 18, 501			89. 90.
	09000 CLINIC 09001 VISITING SPECIALTY CLINIC	-213	87, 537 227, 631		90.
	09002 PAOLI PRIMARY CARE CLINIC	-213	227,031		90.
	D9100 EMERGENCY	-332, 325	2, 262, 526		91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART	552, 525	2, 202, 320		92.
	OTHER REIMBURSABLE COST CENTERS	II	I		721
	09500 AMBULANCE SERVI CES	0	0		95.
	10100 HOME HEALTH AGENCY	0	o		101.
	SPECIAL PURPOSE COST CENTERS	· · · ·			
13.00	11300 INTEREST EXPENSE	0	0		113.
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 495, 944	23, 929, 075		118.
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.
	19001 VISITING SPECIALTY CLINIC	0	0		190.
	19002 OUTREACH	0	230		190.
	19003 FOUNDATI ON	0	0		190.
	19004 SPRING VALLEY FAMILY PRACTICE	0	0		190.
	19005 PAOLI FAMILY PRACTICE	0	3, 594		190.
	19006 OTHER PROPERTY	0	30		190.
	19100 RESEARCH	0	0		191.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.
93.00 ° 00.00	19300 NONPALD WORKERS	0	0		193.
	TOTAL (SUM OF LINES 118 through 199)	-1, 495, 944	23, 932, 929		200.

	Financial Systems		IU HEALTH PAC	DLI HOSPITAL Provider CCN: 15-130	In Lieu of Form CMS D6 Period: Worksheet A-	
					From 01/01/2019 To 12/31/2019 Date/Time Pr	epared:
		Increases			6/29/2020 9:	03 am
	Cost Center	Line #	Salary	Other		
	2.00 A - EMPLOYEE BENEFITS	3.00	4.00	5.00		-
1.00 2.00 3.00 4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00 0.00 0.00	0 0 0 0	1, 368, 132 0 0 0		1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00		0.00 0.00 0.00 0.00	0 0 0	0 0 0		5.00 6.00 7.00 8.00
9.00 10.00 11.00 12.00		0.00 0.00 0.00 0.00	0 0 0	0 0 0		9.00 10.00 11.00 12.00
13. 00 14. 00 15. 00 16. 00		0.00 0.00 0.00 0.00 0.00	0 0 0			13.00 14.00 15.00 16.00
17.00 18.00 19.00 20.00		0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0			17.00 18.00 19.00 20.00
20.00	O	0.00	0	1, 368, 132		
1.00 2.00 3.00	DRUGS CHARGED TO PATIENTS	73.00 0.00 0.00	0 0 0	1, 509, 068 0 0		1.00 2.00 3.00
4.00 5.00		0.00		0 0 1,509,068		4. 00 5. 00
1 00	C - BILLABLE SUPPLIES		- 1			
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	25, 900		1.00
2.00 3.00 4.00		0.00 0.00 0.00	0 0 0	0 0 0		2.00 3.00 4.00
5.00 6.00 7.00		0.00 0.00 0.00	0 0 0	0 0 0		5.00 6.00 7.00
8.00	0 D - IMPLANT SUPPLIES	0.00	0	0		8.00
1.00	IMPL. DEV. CHARGED TO	72.00	0	20, 169		1.00
2.00	PATI ENTS	0.00	0	0 20, 169		2.00
1.00	E - NON-BILLABLE DRUGS PHARMACY	15.00	0	15, 828		1.00
2.00 3.00		0.00 0.00	0 0	0 0		2.00 3.00
4.00 5.00		0.00 0.00	0 0	0 0		4.00 5.00
6.00 7.00 8.00		0.00 0.00 0.00	0 0 0	0 0 0		6.00 7.00 8.00
0.00	O F - NON-BILLABLE MED SUPPLIES		0	15, 828		
1.00 2.00	CENTRAL SERVICES & SUPPLY CARDIAC REHABILITATION	14. 00 76. 97	0	364, 858 12		1.00 2.00
3.00 4.00		0.00 0.00	0	0 0		3.00 4.00
5.00 6.00		0.00 0.00	0	0 0		5.00 6.00
7.00 8.00		0.00 0.00	0	0 0		7.00 8.00
9. 00 10. 00		0.00 0.00	0 0	0 0		9.00 10.00
11.00 12.00		0.00 0.00	0 0	0		11.00 12.00
13.00 14.00		0.00	0	0 0		13.00 14.00
15. 00 16. 00 17. 00		0.00 0.00 0.00	0 0 0	0 0 0		15.00 16.00 17.00
18.00		0.00	0	0		18.00

Heal th	Financial Systems		IU HEALTH PAOL	LI HOSPITAL	In Lieu	of Form CMS-2552-10
RECLAS	SIFICATIONS			Provider CCN: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet A-6 Date/Time Prepared:
						6/29/2020 9:03 am
	Cost Center	Increases Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	0		0	364, 870		
	G - CAPITAL RELATED COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	377, 978		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 123, 585		2.00
3.00 4.00		0.00 0.00	0	0		3.00 4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	Ö		6.00
7.00		0.00	о	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0.00 0.00	0	0		11.00
12.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19. 00 20. 00		0.00 0.00	0	0		19.00 20.00
20.00		0.00	0	0		20.00
22.00		0.00	0	o		21.00
23.00		0.00	0	0		23.00
24.00	L	0.00	0	O		24.00
	0		0	1, 501, 563		
1 00	H - LEASE EXPENSE	1.00		1/0 570		1.00
1.00	CAP REL_COSTS-BLDG & FIXT		<u>0</u>	<u>169, 579</u> 169, 579		1.00
	I - COO/CNO		U	107, 577		
1.00	ADMI NI STRATI VE & GENERAL	5.00	103, 164	0		1.00
	0		103, 164	ō		
	J - UTILITIES	I I		Г		
1.00	UTI_LI_TI_ES		<u>0</u>	359,967		1.00
	U L - OBSTETRICS		U	359, 967		
1.00	ADULTS & PEDIATRICS	30.00	12, 831	0		1.00
2.00	NURSERY	43.00	0	6, 076		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	22, 619	9, 412		3.00
	0		35, 450	15, 488		
	M - CAFETERIA					
1.00	CAFETERI A		124,019	50, 147		1.00
	O N - OT AND ST		124, 019	50, 147		
1.00	OCCUPATIONAL THERAPY	67.00	81, 367	7, 325		1.00
2.00	SPEECH PATHOLOGY	68.00	53, 985	4, 860		2.00
	0		135, 352	12, 185		
	0 – CARDI AC REHAB					
1.00	OCCUPATI ONAL THERAPY	<u>67.</u> 00	537	42		1.00
F00 00	TOTALS		537	42		F00.00
500.00	Grand Total: Increases	I I	398, 522	5, 412, 938		500.00

IU HEALTH PAOLI HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1306

 Period:
 Worksheet A-6

 From 01/01/2019
 Date/Time Prepared:

 To
 12/31/2019
 Date/Time Prepared:

2.00 DEPERTION OF PLANT 7.00 0 4.370 0 2.00 2.00 DEPERTION OF PLANT 7.00 0 7.778 0 3.00 4.00 DITAGY 13.00 0 6.7.78 0 4.00 4.00 DITAGY 13.00 0 6.7.79 0 4.00 4.00 DITAGY 13.00 0 6.7.89 0 4.00 7.00 PMAMARY CAA ARSTHETSTS 15.00 0 2.2.2.2.2.2.0 0 0.00 0.00 OPERATING ROATING 54.00 0 12.2.2.2.2.2.0 0 11.00 10.00 OPERATING ROATING 54.00 0 12.2.2.2.0 0 11.00 12.00 LARDRATORY 66.00 0 12.2.2.2.0 0 11.00 12.00 LARDRATORY 66.00 0 12.2.2.2.0 0 12.00 12.00 LARDRATORY 66.00 0 1.7.22.2.0 0 12.00 12.0							6/29/2020 9:	
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4 00 00 DETRAY 00 0.00 0.01733 0.00 0.01733 0.00 0.01733 0.00 0.01733 0.00 0.00 4.00 0.00 0.00 0.00 0.00 0.00 0.00	2.00	OPERATION OF PLANT	7.00	0	64, 376	0		2.00
0.00 MIRST NG AXMEN STARTION 13.00 0 7.3.26 0 8.00 8.00 9.00						0		3.00
0.00 INLES SUPERVISIONES 13.01 0 6.00 7.00 0.00 MARARY 15.00 0 57.66 0 7.00 0.00 MARARY 15.00 0 57.66 0 7.00 0.00 MARARY 15.00 0 25.59 0 10.00 0.00 MARARY 50.00 0 7.523 0 10.00 0.00 MARARY 64.00 0 12.238 0 11.00 1.00 MARARYNDS THERAWY 64.00 0 14.317 0 13.00 1.00 MARARYNDS THERAWY 64.00 0 14.317 0 13.00 1.00 MARARYNDS THERAWY 64.00 0 12.20 17.00 13.00 13.00 13.00 13.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.0						0		4.00
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14 00 RSPERINTORY THERAPY 66.00 0 46.317 0 14.00 16.00 PRISCAL THERAPY 66.00 0 88.370 0 15.00 16.00 CARDIAC EFMALLTATION 76.97 0 22 0 16.00 17.00 CLIARC EFGALTY CLIN C 00.00 0 1.220 0 17.00 17.00 CLIARC EFGALTY CLIN C 00.00 0 22.01 0 17.00 17.00 DEFTARY 0 0 22.31.564 0 12.00 17.00 DEFTARY 10.00 31 0 1.00 1.30.01 1.00 17.00 DEFTARY 10.00 1.50.72 0 3.00 2.00 17.00 DEFTARY 10.00 1.50.90.00 0 1.50.90.00 1.00					-	0		
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B Bill ARLE DRUGS	20.00	EMERGENCY						20.00
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2 00 PHARMACY 15.00 1.482.440 0 2.00 3.00	1 00		10.00		31	0		1 00
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C - BILLABLE SUPPLIES 100 CENTRAL SERVICES & SUPPLY 14.00 0 200 0 2.00 PHARMACY 15.00 0 28.0 0 2.00 PHARMACY 55.00 0 28.0 0 3.00 0 0.015.8 PEDIATRICS 30.00 0 27.0 0.00 PERATING ROOM 50.00 0 18.10 0 6.00 0.00 PERATING ROOM 50.00 0 1.676 0 7.00 0.01 0 1.676 0 25.990 0 7.00 1.00 0.00 PERATING ROOM 50.00 19.946 0 2.00 0 1.00 DERATING ROOM 50.00 19.946 0 2.00 0 2.00 0 2.0169 0 2.00 0 2.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 2.0169 1.00 2.00 0 2.0170 0 <t< td=""><td>5.00</td><td>VISITING SPECIALTY CLINIC</td><td><u> </u></td><td></td><td></td><td></td><td></td><td>5.00</td></t<>	5.00	VISITING SPECIALTY CLINIC	<u> </u>					5.00
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4.00 OPERATING ROOM 50.00 0 2,357 0 4.00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 0 2,912 0 5.00 6.00 INTRAVENOUS THERAPY 64.00 0 7.03 0 6.00 7.00 PHYSI CAL THERAPY 66.00 0 3.7 0 7.00 8.00 EMERGENCY 0 6.716 0 0 7.00 9 0 0 5.626 0 7.00 7.00 8.00 O 0 5.626 0 1.00 0 15.828 1.00 9 0 0 5.56 0 1.00 0 3.00 HOUSEKEEPING 2.00 2.00 2.00 3.00 HOUSEKEEPING 9.00 0 10.335 0 3.00 4.00 5.00 3.00 4.00 DI ETARY 10.00 0 2.276 0 5.00 0.00 5.00 0.00 5.00 0.00 0.00 7.00 9.00 0.00 0.00 0.00 0.00						-		
5.00 RADIOLOGY-DIAGNOSTIC 54.00 0 2,912 0 5.00 6.00 INTRAVENOUS THERAPY 64.00 0 703 0 6.00 7.00 PHYSICAL THERAPY 66.00 0 37 0 7.00 8.00 EMERGENCY 91.00 0 6,716 0 0 0 0 15,828 0 8.00 8.00 F NON-BILLABLE MED SUPPLIES 5.00 0 556 0 1.00 1.00 ADMINI STRATI VE & GENERAL 5.00 0 556 0 1.00 2.00 OPERATION OF PLANT 7.00 0 1,292 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 10,335 0 4.00 5.00 NURSING ADMINISTRATI ON 13.00 0 2 0 5.00 6.00 PHARMACY 15.00 0 1 0 7.00 8.00 NONPHYSICIAN ANESTHETISTS 19.00 0 2,276 0 9.00 9.00 ADULTS & PEDIATRICS								
6.00 INTRAVENOUS THERAPY 64.00 0 703 0 60.00 703 0 7.00 8.00 EMERGENCY 91.00 0 6,716 0 7.00 8.00 F NON-BILLABLE MED SUPPLIES 0 15,828 0 100 2.00 0 1,292 0 2.00 0 2.00 0 3.00 10.00 3.00 1.00 0 3.00 10.035 0 1.00 0 3.00 1.00 0 3.00 1.00 0 3.00 1.00 0 3.00 1.00 0 3.00 4.00 0 1.000 0 3.60 0 3.00 4.00 5.00 0 2.00 5.00 3.00 4.00 5.00 0 2.00 5.00 0 5.00 0 4.00 5.00 0 2.00 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.				-	_,			5.00
8.00 EMERGENCY								6.00
O Image: Colored State Image: Colored State	7.00	PHYSI CAL THERAPY	66.00	0	37	0		7.00
F NON-BI LLABLE MED SUPPLIES 1.00 ADMI NI STRATI VE & GENERAL 5.00 0 556 0 1.00 2.00 OPERATI ON OF PLANT 7.00 0 1,292 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 10,335 0 4.00 4.00 DI ETARY 10.00 0 360 0 4.00 5.00 NURSI NG ADMI NI STRATI ON 13.00 0 2 0 5.00 6.00 PHARMACY 15.00 0 28,583 0 6.00 7.00 MEDI CAL RECORDS & LI BRARY 16.00 1 0 7.00 8.00 NONPHYSI CI AN ANESTHETI STS 19.00 2.276 0 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 44,722 0 9.00 11.00 OPERATI NG ROOM 50.00 0 37,057 0 11.00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 37,057 <td< td=""><td>8.00</td><td></td><td><u>91.</u>00</td><td></td><td></td><td></td><td></td><td>8.00</td></td<>	8.00		<u>91.</u> 00					8.00
1.00 ADMI NI STRATI VE & GENERAL 5.00 0 556 0 1.00 2.00 OPERATI ON OF PLANT 7.00 0 1,292 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 10,335 0 3.00 4.00 DI ETARY 10.00 0 360 0 4.00 5.00 NURSI NG ADMI NI STRATI ON 13.00 0 2 0 5.00 6.00 PHARMACY 15.00 0 28,583 0 6.00 7.00 MEDI CAL RECORDS & LI BRARY 16.00 0 1 0 7.00 8.00 NONPHYSI CI AN ANESTHETI STS 19.00 0 2,276 0 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 44,722 0 10.00 10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATI NG ROOM 50.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 <tr< td=""><td></td><td></td><td></td><td>0</td><td>15, 828</td><td></td><td></td><td>-</td></tr<>				0	15, 828			-
2.00 OPERATION OF PLANT 7.00 0 1,292 0 2.00 3.00 HOUSEKEEPING 9.00 0 10,335 0 3.00 4.00 DIETARY 10.00 0 360 4.00 5.00 NURSING ADMINISTRATION 13.00 0 2 0 5.00 6.00 PHARMACY 15.00 0 28,583 0 6.00 7.00 MEDICAL RECORDS & LI BRARY 16.00 0 1 0 7.00 8.00 NONPHYSI CI AN ANESTHETI STS 19.00 0 2,276 0 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 14,722 0 9.00 10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATI NG ROOM 50.00 0 37,057 0 12.00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 39,242 0 14.00 13.00 INTRAVENOUS THERAPY 65.00 0 8,219 0 14.00 14.00	1 00			0	FEL			1 00
3.00 HOUSEKEEPING 9.00 0 10,335 0 3.00 4.00 DI ETARY 10.00 0 360 0 4.00 5.00 NURSI NG ADMI NI STRATI ON 13.00 0 2 0 5.00 6.00 PHARMACY 15.00 0 28,583 0 6.00 7.00 MEDI CAL RECORDS & LI BRARY 16.00 0 1 0 7.00 8.00 NONPHYSI CI AN ANESTHETI STS 19.00 0 2,276 0 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 44,722 0 9.00 10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATI NG ROOM 50.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 14.00 RESPI RATORY THERAPY 66.00 0 8,219 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 16.00 17.00						-		
4.00 DI ETARY 10.00 0 360 0 4.00 5.00 NURSI NG ADMI NI STRATI ON 13.00 0 2 0 5.00 6.00 PHARMACY 15.00 0 28,583 0 6.00 7.00 MEDI CAL RECORDS & LI BRARY 16.00 0 1 0 7.00 8.00 NONPHYSI CI AN ANESTHETI STS 19.00 0 2,276 0 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 44,722 0 9.00 10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATI NG ROOM 50.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 14.00 RESPI RATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 15.00 16.00 VI SI TI NG SPECI ALTY CLI NI C 90.01 0 4,099 0 17.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
5.00 NURSI NG ADMI NI STRATI ON 13.00 0 2 0 5.00 6.00 PHARMACY 15.00 0 28,583 0 6.00 7.00 MEDI CAL RECORDS & LI BRARY 16.00 0 1 0 7.00 8.00 NONPHYSI CI AN ANESTHETI STS 19.00 0 2,276 0 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 44,722 0 9.00 10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATI NG ROOM 50.00 0 37,057 0 11.00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 39,242 0 13.00 14.00 RESPI RATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 15.00 16.00 VI SI TI NG SPECI ALTY CLI NI C 90.01 0 4,099 0 16.00 17.00 18.00 OUTREACH 190.02 0 769 <						-		4.00
7.00 MEDI CAL RECORDS & LI BRARY 16.00 0 1 0 7.00 8.00 NONPHYSI CI AN ANESTHETI STS 19.00 0 2,276 0 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 44,722 0 9.00 10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATI NG ROM 50.00 0 37,057 0 11.00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 14.00 RESPI RATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 15.00 16.00 VI SI TI NG SPECI ALTY CLI NI C 90.01 0 4,099 0 17.00 17.00 OITREACH 190.02 0 769 0 18.00 18.00								5.00
8.00 NONPHYSI CI AN ANESTHETI STS 19.00 0 2,276 0 8.00 9.00 ADULTS & PEDI ATRI CS 30.00 0 44,722 0 9.00 10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATI NG ROOM 50.00 0 53,567 0 11.00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 14.00 RESPI RATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 16.00 15.00 16.00 VI SI TI NG SPECI ALTY CLI NI C 90.01 0 4,099 0 16.00 17.00 17.00 18.00 OUTREACH 190.02 0 769 0 18.00				0	28, 583	0		6.00
9.00 ADULTS & PEDIATRICS 30.00 0 44,722 0 9.00 10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATING ROOM 50.00 0 53,567 0 11.00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 13.00 14.00 RESPI RATORY THERAPY 65.00 0 39,242 0 14.00 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 16.00 16.00 17.00 EMERGENCY 91.00 0 110,098 0 17.00 18.00	7.00	MEDICAL RECORDS & LIBRARY		0	1	0		7.00
10.00 NURSERY 43.00 0 15,458 0 10.00 11.00 OPERATING ROOM 50.00 0 53,567 0 11.00 12.00 RADI OLOGY-DI AGNOSTIC 54.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 14.00 RESPI RATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 15.00 16.00 VI SI TING SPECIALTY CLINIC 90.01 0 4,099 0 16.00 17.00 18.00 OUTREACH 190.02 0 769 0 18.00				-	_,			8.00
11.00 OPERATING ROOM 50.00 0 53,567 0 11.00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 14.00 RESPI RATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 15.00 16.00 VI SI TI NG SPECI ALTY CLINIC 90.01 0 4,099 0 16.00 17.00 EMERGENCY 91.00 0 110,098 0 17.00 18.00						-		9.00
12.00 RADI OLOGY-DI AGNOSTI C 54.00 0 37,057 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 14.00 RESPI RATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 15.00 16.00 VI SI TI NG SPECI ALTY CLINIC 90.01 0 4,099 0 17.00 17.00 EMERGENCY 91.00 0 110,098 0 17.00 18.00 18.00 18.00				-		0		
13.00 INTRAVENOUS THERAPY 64.00 0 8,234 0 13.00 14.00 RESPIRATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 15.00 16.00 VI SI TI NG SPECI ALTY CLI NI C 90.01 0 4,099 0 16.00 17.00 EMERGENCY 91.00 0 110,098 0 17.00 18.00 OUTREACH 190.02 0 769 0 18.00						0		
14.00 RESPIRATORY THERAPY 65.00 0 39,242 0 14.00 15.00 PHYSI CAL THERAPY 66.00 0 8,219 0 15.00 16.00 VI SI TI NG SPECI ALTY CLINIC 90.01 0 4,099 0 16.00 17.00 EMERGENCY 91.00 0 110,098 0 17.00 18.00 OUTREACH 190.02 0 769 0 18.00						-		
15.00 PHYSICAL THERAPY 66.00 0 8,219 0 15.00 16.00 VISITING SPECIALTY CLINIC 90.01 0 4,099 0 16.00 17.00 EMERGENCY 91.00 0 110,098 0 17.00 18.00 OUTREACH 190.02 0 769 0 18.00				-				14.00
16.00 VI SI TI NG SPECI ALTY CLINIC 90.01 0 4,099 0 16.00 17.00 EMERGENCY 91.00 0 110,098 0 17.00 18.00 OUTREACH 190.02 0 769 0 18.00				-				15.00
18.00 OUTREACH 190.02 0 769 0 18.00	16.00			0				16.00
								17.00
U U 364, 870	18.00		190.02					18.00
		ln		0	364,870			I

IU HEALTH PAOLI HOSPITAL

Heal th	Financial Systems		IU HEALTH PAOL	HOSPI TAL		In Lie	u of Form CMS	S-2552-10
	SIFICATIONS				CCN: 15-1306	Peri od:	Worksheet A	
						From 01/01/2019		
						To 12/31/2019	Date/Time P 6/29/2020 9	repared: ·03 am
		Decreases				L	0/2//2020 /	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	G - CAPITAL RELATED COSTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	803		9		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	177, 361		9		2.00
3.00	OPERATION OF PLANT	7.00	0	285, 602		0		3.00
4.00	HOUSEKEEPI NG	9.00	0	160		0		4.00
5.00	DI ETARY	10.00	0	6, 682		0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	427		0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 406		0		7.00
8.00	PHARMACY	15.00	0	32, 070		0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	3, 837		0		9.00
10.00	NONPHYSI CI AN ANESTHETI STS	19.00	0	9, 481		0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	56, 037		0		11.00
12.00	NURSERY	43.00	0	1, 897		0		12.00
13.00	OPERATING ROOM	50.00	0	142, 254		0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	547, 193		0		14.00
15.00	LABORATORY	60.00	0	1, 563		0		15.00
16.00	INTRAVENOUS THERAPY	64.00	0	993		0		16.00
17.00	RESPI RATORY THERAPY	65.00	0	25, 068		0		17.00
18.00	PHYSI CAL THERAPY	66.00	0	151, 735		0		18.00
19.00	CARDI AC REHABI LI TATI ON	76.97	0	3, 785		0		19.00
20.00	VISITING SPECIALTY CLINIC	90.01	0	2, 304		0		20.00
21.00	EMERGENCY	91.00	0	42, 135		0		21.00
22.00	OUTREACH	190.02	0	231		0		22.00
23.00	PAOLI FAMILY PRACTICE	190.05	0	1, 621		0		23.00
24.00	OTHER PROPERTY	190.06	0	5, 918		0		24.00
	0			1, 501, 563		7		
	H - LEASE EXPENSE							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	169, 579	1	0		1.00
	0			169, 579		1		
	I - COO/CNO							
1.00	NURSING ADMINISTRATION	13.00	103, 164	0		0		1.00
	0		103, 164	0		7		1
	J - UTILITIES	· ·						
1.00	OPERATION OF PLANT	7.00	0	359, 967		0		1.00
	0		0	359, 967		7		
	L - OBSTETRI CS							
1.00	ADULTS & PEDIATRICS	30.00	0	15, 488		0		1.00
2.00	NURSERY	43.00	35, 450	0		0		2.00
3.00		0.00	0	0		0		3.00
	0		35, 450	15, 488		7		
	M – CAFETERIA							
1.00	DI ETARY	10.00	124, 019	50, 147		0		1.00
	0		124, 019	50, 147		7		
	N - OT AND ST							
1.00	PHYSI CAL THERAPY	66.00	135, 352	12, 185		0		1.00
2.00		0.00	0	0		0		2.00
	lo		135, 352	12, 185				
	O – CARDIAC REHAB							
1.00	O – CARDIAC REHAB CARDIAC REHABILITATION	76.97	537	42		0		1.00
		<u> </u>	<u>537</u> 537 398, 522	42 42 5, 412, 938		0		1.00

Hoal th	Financial Systems	IU HEALTH PAO				Inlio	u of Form CMS-2	0550 10
	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1306	Peri From To		Worksheet A-7 Part I	
				Acqui si ti on:	s			
		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 2.00	Land Land Improvements	148,000 438,464	0		0	0	0	1.00 2.00
3.00	Buildings and Fixtures	4, 741, 722	0		0	0	0	3.00
4.00	Building Improvements	1, 786, 121	153, 618		0	153, 618	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	9, 877, 540	1, 992, 160		0	1, 992, 160	535, 046	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16, 991, 847	2, 145, 778		0	2, 145, 778	535, 046	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	16, 991, 847	2, 145, 778		0	2, 145, 778	535, 046	10.00
		Endi ng Bal ance	Fully					
		-	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	148,000	0					1.00
2.00	Land Improvements	438, 464	0					2.00
3.00	Buildings and Fixtures	4, 741, 722	0					3.00
4.00	Building Improvements	1, 939, 739	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	11, 334, 654	0					6.00
7.00	HIT designated Assets	10 (02 570	0					7.00
8.00	Subtotal (sum of lines 1-7)	18, 602, 579	0					8.00
9.00 10.00	Reconciling Items Total (line 8 minus line 9)	19 402 570	0					9.00 10.00
10.00	Total (THE & MINUS TINE 9)	18, 602, 579	0	1				10.00

Heal th	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CCN: 15-1306	Peri od:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019		narad
					10 12/31/2019	6/29/2020 9:0	3 am
			S	UMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
					^	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	(0	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	(0	0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	(0	0 0	0	3.00
		SUMMARY O	F CAPITAL				
			T + + (4) (_			
	Cost Center Description		Total (1) (sur	n			
		Capital - Relate					
		d Costs (see instructions)	through 14)				
		14.00	15.00	-			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			and 2			
1.00	CAP REL COSTS-BLDG & FIXT		(1.00
2.00	CAP REL COSTS - MVBLE EQUIP	0	(2.00
3.00	Total (sum of lines 1-2)	0	(3.00
0.00		۱ V	· · · · · · · · · · · · · · · · · · ·				0.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part III Date/Time Prep 6/29/2020 9:03	
	COM	PUTATION OF RAT	[10S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	7, 267, 926				0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	11, 334, 653				0	2.00
3.00 Total (sum of lines 1-2)	18, 602, 579		18, 602, 57		0	3.00
	ALLOCA	FION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		0			400 700	4 00
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0 675, 860		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 123, 585		2.00
3.00 Total (sum of lines 1-2)	0	U	I JMMARY OF CAPI	0 1, 799, 445	-130, 703	3.00
		50	JIMIMARY OF CAPT			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	12.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	11.00	12.00	13.00	14.00	15.00	
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	545, 157	1.00
2.00 CAP REL COSTS-DEDU & TTXT	0	-		0 0	1, 123, 585	2.00
3.00 Total (sum of lines 1-2)	0	-		0 0	1, 668, 742	3.00
			I	-1 0	., 555, 712	0.00

	Financial Systems MENTS TO EXPENSES		IU HEALTH PAC	Provider CCN: 15-1306	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	
				Expense Classification o	Worksheet A	6/29/2020 9:0	3 am
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	<u> </u>	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)		0	CAR REE COSTS MUDEL EQUIT			
3.00	Investment income - other (chapter 2)		U		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		O		0.00	0	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter		C C		0.00	0	
8.00	21) Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
	Provider-based physician	A-8-2	-2, 371, 522			0	1
11.00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	3, 810, 952	,		0	12.00
	transactions (chapter 10)				0.00		
	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0 0	
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than		C		0.00	0	16.00
	patients						
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
	Vending machines Income from imposition of		0		0. 00 0. 00	0	
21.00	interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	O	RESPI RATORY THERAPY	65.00		23.00
	limitation (chapter 14)						
24.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
20.00	physicians' compensation		Ū		111.00		20.00
26.00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	COSTS-MVBLE EQUIP					0	
	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19.00 0.00	0	28.00 29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
20.00	limitation (chapter 14)		~				20.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
22 00	limitation (chapter 14)	Δ	151 000		2.00	9	32.00
	CAH HIT Adjustment for Depreciation and Interest	A		CAP REL COSTS-MVBLE EQUIP	2.00		
33.00	MI SCELLANEOUS I NCOME	В	4, 511	ADMINISTRATIVE & GENERAL	5.00	0	33.00

Health Financial Systems	IU HEALTH PAC	DLI HOSPITAL	In Lie	u of Form CMS-2	2552-10	
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				rom 01/01/2019		
				Fo 12/31/2019	Date/Time Pre 6/29/2020 9:03	
· · · · · · · · · · · · · · · · · · ·			Expense Classification on	Workshoot A	0/29/2020 9.0.	
			To/From Which the Amount is			
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33. 01 MI SCELLANEOUS I NCOME	В	-1, 303	OPERATION OF PLANT	7.00	0	33.01
33. 02 MI SCELLANEOUS I NCOME	В	-81, 018	CAFETERI A	11.00	0	33.02
33. 03 MI SCELLANEOUS I NCOME	В	1, 000	NURSING ADMINISTRATION	13.00	0	33.03
33. 04 MI SCELLANEOUS I NCOME	В		MEDICAL RECORDS & LIBRARY	16.00		33.04
33. 05 MI SCELLANEOUS I NCOME	В		OPERATING ROOM	50.00	0	33.05
33. 06 MI SCELLANEOUS I NCOME	В		PHYSICAL THERAPY	66.00	0	33.06
33.07 MISCELLANEOUS INCOME	В	774	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08 MI SCELLANEOUS I NCOME	В		VISITING SPECIALTY CLINIC	90.01	0	33.08
33. 09 HAF	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.09
33.10 ACCRUED PTO	A		EMPLOYEE BENEFITS DEPARTMENT		0	33.10
33. 11 BENEFI TS	A		EMPLOYEE BENEFITS DEPARTMENT			33. 11
33. 12 CRNA	A		NONPHYSI CI AN ANESTHETI STS	19.00	0	33. 12
33.13 MARKETING	A		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 13
50.00 TOTAL (sum of lines 1 thru 49)		-1, 495, 944				50.00
(Transfer to Worksheet A,						
column 6. line 200.)	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.

Heal th	Financial Systems	IU HEALTH PA	OLI HOSPITAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1
OFFI CE	COSTS			From 01/01/2019 To 12/31/2019		nared
				10 12/31/2017	6/29/2020 9:0	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	0.00	2.00	4.00	5	
			3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
1.00		CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	297, 882	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	151, 803	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1, 730, 366	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4, 107, 938	3, 814, 017	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	205, 353	0	3. 02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	85, 801	127, 279	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1, 189, 924	878, 620	3.04
3.05			RELATED PARTY	0	22, 888	3.05
3.06	13.00	NURSING ADMINISTRATION	RELATED PARTY	45, 627	702, 078	3.06
3.07			RELATED PARTY	162, 311	209, 748	3.07
3.09			RELATED PARTY	150, 981	0	3.09
3.10			RELATED PARTY	41, 430		3.10
3.11			SIP ER ALLOCATION	2, 653, 571	1, 234, 476	3. 11
3.12			SHARED EMPLOYEES	574	574	3.12
3.13			SHARED EMPLOYEES	161, 068		3.13
3.14			SHARED EMPLOYEES	44, 140		
3.15			SHARED EMPLOYEES	1, 581, 220	1, 581, 220	3.15
3.16			SHARED EMPLOYEES	19, 078		3. 16
4.00		VISITING SPECIALTY CLINIC	SHARED EMPLOYEES	62, 791	62, 791	4.00
5.00	TOTALS (sum of lines 1-4).			12, 691, 858	8, 880, 906	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.			1		

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

nas not	been posted to worksheet A,	corumns r anu/or z, the amour	it allowable sh	ouru be murcateu mi corumn 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownership		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

Termbur	Sement under titte Aviii.		
6.00	В	0.00 U HEALTH BLOOM 0.00	6.00
7.00	В	0.00 1U HEALTH 100.00	7.00
8.00	С	0.00 I UH SI P 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 organi zati on.

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

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED	ORGANIZATIONS AND HOME	Provider CCN: 15-1306	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2019 To 12/31/2019	Date/Time Prepared:

						6/29/2020 9:0	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
			ENTS REQUIRED AS A RESULT OF TRAN	NSACTIONS WITH RELATED OF	RGANIZATIONS OR CI	LAI MED	
	HOME OFFICE CO						
1.00	297, 882						1.00
2.00	151, 803						2.00
3.00	1, 730, 366	0					3.00
3.01	293, 921	0					3. 01
3.02	205, 353						3. 02
3.03	-41, 478						3.03
3.04	311, 304						3.04
3.05	-22, 888	0					3.05
3.06	-656, 451	0					3.06
3.07	-47, 437	0					3.07
3.09	150, 981	0					3.09
3.10	18, 501	0					3.10
3.11	1, 419, 095	0					3. 11
3.12	0	0					3. 12
3.13	0	0					3.13
3.14	0	0					3.14
3.15	0	0					3. 15
3.16	0	0					3.16
4.00	0	0					4.00
5.00	3, 810, 952						5.00
* The	amounts on line	es 1-4 (and subs	scripts as appropriate) are trans	ferred in detail to Work	sheet A column 6	lines as	

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

nas noi	been posted to worksheet A,	cordinars r and/or 2, the amount arrowable should be mulcated in cordinar 4 or this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

1 01 110 01			
6.00	HOSPI TAL	6	6.00
7.00	HOME OFFICE	7	7.00
8.00	PHYSICIAN GROUP	8	8.00
9. 00 10. 00		9	9.00
10.00		10	D. 00
100.00		100	0. 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.

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

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

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

Heal th	Financial Syste	ems	IU HEALTH PA	OLI HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C	CCN: 15-1306	Period: From 01/01/2019	Worksheet A-8	3-2
						To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMINISTRATIVE & GENERAL	148, 087	148, 087		0 0	0	
2.00		ADULTS & PEDIATRICS	569, 513	472, 015	97, 49		0	
3.00		EMERGENCY	2, 468, 633		717, 21		0	
4.00	0.00		0	0		0 0	0	
5.00	0.00		0	-		0 0	0	
6.00	0.00		0	-		0 0	0	
7.00	0.00		0	0		0 0	0	
8.00	0.00		0	-		0 0	0	
9.00	0.00		0	0		0 0	0	9.00
10.00	0.00		0	0		0 0	0	
200.00			3, 186, 233		814, 71		0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			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		ADMINISTRATIVE & GENERAL	0			0 0	0	
2.00		ADULTS & PEDIATRICS	0			0 0	0	
3.00		EMERGENCY	0			0 0	0	
4.00	0.00		0	°		0 0	0	
5.00	0.00		0			0 0	0	
6.00	0.00		0	°		0 0	0	
7.00	0.00		0	0		0 0	0	
8.00	0.00		0	, i i i i i i i i i i i i i i i i i i i		0 0	0	
9.00	0.00		0	-		0 0	0	
10.00	0.00		0	0		0 0	0	
200.00			0	0		0 0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	1/ 00	17.00	10.00		
1 00	1.00			16.00	17.00	18.00		1.00
1.00		ADMI NI STRATI VE & GENERAL	0	-		148,087		1.00
2.00		ADULTS & PEDIATRICS	0	-		472,015		2.00
3.00		EMERGENCY	0	-		1, 751, 420		3.00
4.00	0.00		0			0 0		4.00
5.00	0.00		0	-		0 0		5.00
6.00	0.00		0	°		0 0		6.00
7.00	0.00		0	-		0 0		7.00
8.00	0.00		0	-		0 0		8.00
9.00	0.00		0			0 0		9.00
10.00	0.00		0	-		0 0		10.00
200.00			0	0		2, 371, 522		200.00

Tron 0100000000000000000000000000000000000	Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	IU HEALTH PAO	LI HOSPITAL Provider CO	°N· 15-1306 ₽	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
Description Ref Pyromesis (from mist A Ref Pyromesis (from mist A MARE Fluttion Differences (from mist A MARE Fluttion Differences (from mist A Subtotal 1.00 Gen 20.1 Control (from mist A) 1.00 2.00 4.00				F	rom 01/01/2019	Part I Date/Time Pre	pared:
Prof. Dost (1) (0) (0) (0) (0) (0) (0) (0) (0) (0) (0			CAPI TAL REL	ATED COSTS		0/29/2020 9:0	
OCHEMAL SERVICE COST CENTER 0 1.00 2.00 4.00 4.4 1.00 00000 CAP REL COST SELUC & FITTP 1.72, 588 1.72, 578 1.72, 578 1.72, 578 1.72, 578 1.72, 578 1.72, 578 1.72, 578 1.72, 578 1.72, 578 1.72, 578 <td< td=""><td>Cost Center Description</td><td>for Cost Allocation (from Wkst A</td><td>BLDG & FIXT</td><td>MVBLE EQUIP</td><td>BENEFI TS</td><td>Subtotal</td><td></td></td<>	Cost Center Description	for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	BENEFI TS	Subtotal	
1.00 DOTIDIO CAP NIL COSTS MURG & LIXT 1.945, 157 1.12, 286 1.12, 286 1.12, 286 1.12, 286 1.12, 206 2.00<			1.00	2.00	4.00	4A	
2.00 00200 CAP FEL COSTS-MVBLE EDUIP 1, 123, 685 1, 123, 685 2, 20 1, 123, 685 2, 20 0, 2000 CAP FEL COSTS-MVBLE EDUIP 4, 20 3, 399 77, 944 1, 85, 731 6, 511, 049 5, 00 00000 Anm NISTATIVE & CIMPEAL 6, 201, 20 5, 00 77, 944 1, 85, 731 6, 511, 049 5, 00 70 10 00000 LAMENT FE HAR 6, 201, 09 7, 944 1, 85, 731 6, 511, 049 5, 00 70 20, 900 70 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 11, 123, 685 20, 000 10, 200 10, 000		E 4 E 1 E 7					1 00
4.00 DARDI MER OVER ENVERTIS DEPARTEMENT 1, 872, 003 9, 722 21, 249 1, 902, 976 4.00 0.00 DSG MAN INSTRATI VE & COVERAL 1, 031, 548 41, 099 91, 800 104, 900 6, 511, 900 6, 511, 900 6, 511, 900 7, 900 370, 900 13, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 7, 900 937, 900 937, 900 937, 900 931, 172 154, 637 11, 900 933, 190 940, 123, 243, 120 71, 124, 134, 134, 134, 134, 134, 134, 134, 13			545, 157				
5.00 00000 AMM INSTRATIVE & GENERAL 6.268, 725 33, 399 72, 994 135, 931 6, 511, 049 5.00 7.01 00701 UTLLTTES 339, 497 0 0 0 399, 497 7.01 7.01 00701 UTLLTTES 339, 497 0 0 0 0 399, 497 7.01 7.01 00701 UTLLTTES 441, 494 441, 994 441, 441, 792 441, 441, 794 16, 613 441, 741 172, 546, 620 6.00 0 0 0 000 0000 UES ADERNOVSES 441, 1000 0 0 0 0 66, 150, 164, 144 13, 001 131, 001 130, 000 URSING AUMINISTRATION 596, 622, 153, 031 110, 002 444, 441, 144, 130 130, 01 0 0 0 66, 154, 144 141, 1006 0 0 66, 154, 144 141, 1006 0 0 164, 441, 144, 144 130, 01 130, 01000 144, 144, 144, 144 144, 144 144, 101 144, 144, 144, 144 144, 144, 144, 144, 144, 144, 144, 144,			9, 722				
7.01 DOTOL UT LLTES 399, 907 0 0 0 399, 907 7.01 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 0 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 7.07 10 10.07						6, 511, 049	
B.00 OBSOD LAUNDER X LINEN SERVICE 63,499 2,460 6,507 0 72,566 8,00 00 10.00 DICTA ALL		1, 031, 548	41, 995	91, 780	104, 099	1, 269, 422	7.00
9. 00 00000 H002ENCERPINO 248,205 8,975 19,614 48,226 325,959 10.00 0000 11.00 01100 CALE_LENIA 93,149 9,514 20,799 31,172 124,427 11.00 11.00 01100 CALE_LENIA 93,149 9,514 20,799 13,172 144,424 13.00 14.00 01400 CENTRAL <services &="" supply<="" td=""> 398,301 19,805 42,186 61,150 516,000 160,00 14,00 54,146 14.00 15.00 01600 HERIDAL RECORDS & LIBRARY 4,321 7,129 15,579 7,48 54,848 16.00 17,00 17,00 19,00 MAPERING LENE RECORD ESCONCECONCENTRES 0 0 0 10,00 10,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 17,00 13,00 31,00 31,00 31,00 31,00 31,00 31,00 <td< td=""><td></td><td></td><td>8</td><td>s s</td><td>Ű</td><td></td><td></td></td<></services>			8	s s	Ű		
10.00 010000 010000 010000 010000 010000 00000 00000 00000							
11.00 0100 CAHETERIA 93,148 9,514 20,793 31,172 194,627 11.00 13.01 01301 MUSEN SAMINISTRATION 956,822 13.203 28,987 12.233 27,716 13.01 13.01 01301 MUSEN SAMINISTRATION 956,822 13.203 28,987 12.2362 75.144 13.01 15.00 01500 PHARMACY 436,133 11.067 24,186 57,428 546,814 15.00 15.00 01500 PHARMACY 432,028 73.371 100.370 256,990 17.702 15.00 19.00 01900 KNEPKSIC LAN ARESTHETISTS 283,882 73.371 100.370 256,990 1.719,417 30.00 30.00 03000 ARULTS & FEDI ATRICS 1.288,882 73.371 100.370 256,990 1.719,417 30.00 43.00 DEX000 CPERATIRE ROW 512,665 57.057 124,698 10.064 80.05,375 0.00 44.00 DEX000 ARESPRATORY 1.64,900 1.673,937 226,930 1.57,62,83 1.50,640 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00<							
13.00 01300 MMRSING AMMIN STRATION 996,622 13,203 28,907 122,362 761,494 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 398,301 19,805 42,182 0 461,449 14.00 15.00 01500 MARAMACY 42,337 71,20 15,577 0 27,029 16.00 16.00 MENDIA MESTINC TANKINCT 233,882 0 0 300,00 179,00 1990 01900 1990							
14.00 01400 CENTRAL SERVICES & UBPRAY 398, 361 19, 805 42, 323 0 401, 449 14.00 15.00 15.00 01500 MEDICAL RECORDS & LIBRARY 45, 132 1, 129 15.79 0 27, 029 16.00 14.00 01700 MEDICAL RECORDS & LIBRARY 43, 321 7, 129 15.79 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
15. 00 01500 [PARMARY 456, 133 11. 067 24. 186 57, 428 548, 814 15. 00 16. 00 01700 [SOCI AL SERVICE 0 <td>13. 01 01301 HOUSE SUPERVI SORS</td> <td>411, 006</td> <td>0</td> <td>0</td> <td>96, 159</td> <td>507, 165</td> <td>13.01</td>	13. 01 01301 HOUSE SUPERVI SORS	411, 006	0	0	96, 159	507, 165	13.01
16. 00 010COL MEDICAL, RECORDS & LIBRARY 4. 321 7. 129 15. 57 0 27. 029 16. 00 0 07. 00 07. 00 07. 00 07. 00 07. 00 07. 00 07. 00 07. 00 07. 00 07. 00 07. 00 07. 00 0. 0							
17. 00 01700 SOCIAL SERVICE 0 1 0 0 0 0 1 0							
19.00 01900 NONPHYSICIAN AMESTICITSTS 283,882 0 0 65,724 369,600 19.00 00.00 03000 ADULTS & PEDIATRICSS 1,226,882 73,375 160,370 256,990 1,719,617 30.00 01.00 0100 CINERSIVE CASE CENTERS 512,656 57,057 124,698 110,964 830,084 43.00 00.00 05000 DELWERY ROUM & LABOR ROUM 513,656 57,057 124,698 110,964 806,375 50.00 00.00 06000 DELWERY ROUM & LABOR ROUM 99,514 2,002 4,572 20,133 116,311 52,00 50.00							
INPATI ENT ROUTINE SERVICE COST CENTERS Instruction 0.00 000000000001178 & PEDDI ARICS 0		0	-				
11.00 03100 INTERSIVE CARE UNIT 0							
43. 00 0 04300 NURSERV 61,675 2,367 5,172 13,872 83.066 43.00 50. 00 0 5500 0FEAT ING. RODM 513,656 57,057 124,698 110,964 806,375 50.00 52. 00 0 5200 0FEAT ING. RODM 8,9514 2,092 4,572 20,133 116,311 52.00 65.00 66.00 66.00 1,466,605 54.00 64.00 0,4000 INTRAVENUS THERAPY 7,6,743 4,200 9,310 16,059 100,372 64.00 66.00 66.00 06000 CUPATI OWA THERAPY 530,720 38,464 84.063 90,391 743,638 66.00 67.00 67.00 0700 CUPATI OWA THERAPY 58,775 12,621 13,559 90,517 68.00 0 0 22,007 71,00 710,00 710,00 72,00 0000 DURS CHARGED TO PATI ENTS 2,0169 0 0 0 20,073,01 73,01 73,01 73,01 73,01 73,01 73,01 73,01 73,01 73,01 74,00 0 0 0			73, 375	160, 370		1, 719, 617	
ANCL LLARY SERVICE COST CENTERS 0.00 05200 OPERATINK NOOM 513, 656 57, 057 124, 698 110, 964 806, 375 50, 00 52 00 05200 DELI VERY ROOM & LABOR ROOM B9, 514 2, 092 14, 572 20, 133 116, 311 52, 00 64 00 6400 (MIRIO LOR) CHARONSTIC 1, 266, 025 54, 595 119, 319 212, 066 1, 646, 605 54, 00 64 00 6400 (INTRAVENUS THERAPY 76, 743 4, 260 9, 310 16, 053 26, 40 65 00 06500 [PHSI CLA THERAPY 383, 114 2, 864 68, 40, 63 90, 917 743, 638 66, 00 66 00 06600 [PHSI CLA THERAPY 89, 271 8, 700 19, 014 20, 586 137, 571 67, 00 71 00 07100 [PHCI CLA, SUPPLI ES, CHARGED TO PATI ENTS 20, 169 0 0 22, 900 71, 00 73 01 07300 [PHCI CLA, SUPPLI ES, CHARGED TO PATI ENTS 0 0 0 0 73, 01 73 01 07300 [PHCI CLA, SUPPLI ES, CHARGED TO PATI ENTS 0 0 0		0	0	0	0	0	
50.00 050000 (DFLATEN ROM & LABOR ROM 513, 656 57, 057 124, 698 110, 944 806, 375 50.00 52.00 05200 (DFLIVERY ROM & LABOR ROM 89, 514 2, 092 4, 572 20.133 116, 311 52.00 54.00 05400 (ADD LAGVE-DIAGNOSTIC 1, 260, 625 54, 592 119, 319 212, 066 1.646, 605 54.00 64.00 06400 (INTRAVENOUS THERAPY 1, 654, 902 16, 103 35, 193 85 1.706, 283 60.00 65.00 06500 (PESPI RATOR THERAPY 38, 114 2, 689 5, 876 82, 827 743, 508 65.00 66.00 06000 (OCLIPATIONAL THERAPY 89, 271 8, 700 19, 014 20, 586 137, 571 67.00 670.00 0 22, 900 10.00 710.00		61,675	2,367	5, 172	13, 872	83, 086	43.00
52.00 OS200 [ELI VERY ROUM & LABOR ROUM 89, 514 2, 00, 24 4, 572 20, 133 116, 311 52.00 64.00 OGOD (ADD IGLOV-DIAGNOSTI C 1, 260, 625 54, 595 119, 319 212.066 1, 646, 605 54, 00 64.00 OGOD (INTRAVENUS THERAPY 76, 743 4, 260 9, 310 10, 059 106, 372 64, 00 65.00 OGOD (PHS) CLA THERAPY 383, 114 2, 684 84, 603 99, 91 734, 548 66, 00 66.00 OGOD (PHS) CLA THERAPY 59, 770 12, 621 13, 569 99, 810 68, 00 71.00 OTOO MED LOL, CHARGED TO PATI ENTS 20, 169 0 0 22, 907 71, 00 73.01 OTOO MED LOL, CHARGED TO PATI ENTS 1, 509, 842 0 <td></td> <td>513 656</td> <td>57 057</td> <td>124 698</td> <td>110 964</td> <td>806 375</td> <td>50 00</td>		513 656	57 057	124 698	110 964	806 375	50 00
60.000 060000 LABORATORY 1, 654, 902 16, 103 35, 193 B5 1, 706, 283 60.00 64.00 064000 INTRAVENOUS THERAPY 76, 743 4, 260 9, 310 16, 059 106, 372 44, 450 65, 00 06500 PESPIRATORY THERAPY 530, 720 38, 464 84, 063 90, 391 743, 638 66, 00 66, 00 66, 00 66, 00 66, 00 66, 00 66, 00 97, 00 97, 014 20, 586 137, 571 67, 00 90, 810 68, 00 72, 00 90, 810 68, 00 25, 900 0 0 25, 900 71, 00 25, 900 71, 00 25, 900 0 0 0 26, 00 71, 00 73, 01 73, 00 74, 00 0 0 0 0							
64.00 0c400 NTRAVENOUS THERAPY 76, 743 4, 2c0 9, 310 16, 059 106, 372 44, 00 65.00 0c6000 RESPE ATORY THERAPY 383, 114 2, 689 5.876 82, 327 744, 506 65.00 66.00 0c6000 RESPE ATORNAL THERAPY 89, 221 8, 700 19, 014 20, 586 137, 571 67.00 67.00 0c6000 SPEECH PATHOLOGY 89, 221 8, 700 19, 014 20, 586 137, 571 67.00 0 0100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 20, 1699 0 0 0 21, 69 90, 810 68.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 509, 842 0 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 0 0 0 0 75.00 76.97 76.0757 CARDI AC REHABILITATION 0 <td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>1, 260, 625</td> <td>54, 595</td> <td>119, 319</td> <td>212, 066</td> <td>1, 646, 605</td> <td>54.00</td>	54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 260, 625	54, 595	119, 319	212, 066	1, 646, 605	54.00
65.00 0c500 PESPI RATORY THERAPY 383, 114 2, 689 5, 876 82, 827 747, 506 65.00 66.00 0c600 PHYSI CAL THERAPY 89, 271 87, 700 19, 014 20, 586 137, 571 67.00 66.00 0c600 SECEH PATHOLOCY 58, 845 5, 775 12, 621 13, 569 90, 810 68.00 680, 00 71.00 07100 NDICAL SUPPLIES CHARGED TO PATIENTS 25, 900 0 0 20, 169 72, 00 73, 01 73, 00 0 0 0 0 0 0 73, 01 74, 00 0 0 0 0 0 0 0 0 0 0 0 0 0							
66.00 06000 PHYSICAL THERAPY 530,720 38,464 84,063 90,391 743,638 66.00 67.00 06700 0CPUPATIONAL THERAPY 99,271 8,700 19,014 20,586 137,571 67.00 71.00 0700 MEDICAL SUPPLIES CHARCED TO PATIENTS 25,900 0 0 0 25,900 71.00 72.00 07200 IAPL. DEV. CHARCED TO PATIENTS 20,169 0 0 0 20,169 72.00 73.00 07300 DRUGS CHARCED TO PATIENTS 1,509,842 0 0 0 0 0 73.01 73.01 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 74.00 75.00 75.00 76.97 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 0 76.97 88.00 080800 RURAL HEALTH CLINIC 27.7537 35.00 756 10.756 99,443 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00							
67:00 OCJUPATI DNAL THERAPY 89,271 8,700 19,014 20,586 137,571 67.00 06:00 OBGOS SPECCH PATHOLOGY 58,845 5,775 12,621 13,569 90,810 68.00 71:00 D7100 MEDI CAL SUPPLIES CHARCED TO PATIENTS 20,169 0 0 25,900 0 0 20,169 72.00 73.01 73.00 73.00 73.00 73.00 73.00 0 0 0 0 0 0 0 0 73.00 73.00 73.00 0							
68:00 06800 SPECH PATHOLOGY 58:845 5,775 12,621 13,569 90,810 68:00 71:00 07100 MIDO MEDICAL SUPPLIES CHARCED TO PATIENTS 25,900 0 0 22,900 71:00 72:00 07200 INPL. DEV. CHARGED TO PATIENTS 20,169 0 0 0 20,169 72:00 72:00 0 0 0 0 0 0 0 73:01 73:01 73:01 73:01 73:01 73:01 0 0 0 0 0 0 74:00 74:00 0							
12.00 07200 IMPL DEV. CHARGED TO PATIENTS 20, 169 0 0 20, 169 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 509, 842 0 0 0 0 73.01 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
73.00 OP300 PRUGS CHARGED TO PATIENTS 1,509,842 0 0 1,509,842 73.00 73.01 O7400 RENAL DI ALYSI S 0 0 0 0 73.01 74.00 O7400 RENAL DI ALYSI S 0 0 0 0 0 74.00 76.07 O7407 REHAL DI ALYSI S 0 0 0 0 0 75.00 76.77 O797 CARPIA CRHABIL LITATION 0 0 0 0 0 76.97 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 89.00 90.00 08900 FEDERALLY QUALIFIE D HEALTH CENTER 87.537 360 78.6 10.76 99.443 90.01 90.01 09001 VISITING SPECIALTY CLINIC 22.62.526 38.606 84.373 309.173 2.694.678 91.00 91.00 09100 EMERGENCY 0 0 0 0 0 0 <td< td=""><td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td><td>25, 900</td><td>0</td><td>0</td><td>0</td><td>25, 900</td><td>71.00</td></td<>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 900	0	0	0	25, 900	71.00
73.01 OT301 DRUGS CHARGED TO PATLENTS 0 0 0 0 73.01 74.00 OT400 RENAL DIALYSIS 0 0 0 0 0 74.00 75.00 O7500 ASC (NON-DISTINCT PART) 0 <td< td=""><td></td><td></td><td>-</td><td>0</td><td>0</td><td></td><td></td></td<>			-	0	0		
74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0			8	0	0		
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 0 75.00 76.97 076.97 CARDIAC REHABILITATION 0 0 0 0 0 0 0 0 0 0 0 76.97 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 90.00 09000 CLINIC 87.537 360 77.67 88.00 99.00 99.0443 90.00 90.01 190001 VISITING SPECIALTY CLINIC 227.631 35.501 77.587 48.025 38.744 90.00 90.02 90.00 90.02 90.00 90.02		0	-		0		
76. 97 07697 [CARDI AC REHABI LI TATI ON OUTPATI ENT SERVICE COST CENTERS 76. 97 0017PATI ENT SERVICE COST CENTERS 0<		0	-	0	0	-	•
88.00 0800 RURAL HEALTH CLINIC 0 </td <td>76. 97 07697 CARDI AC REHABI LI TATI ON</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>76.97</td>	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0		_	_	-			
90.00 09000 CLINIC 87,537 360 786 10,760 99,443 90.00 90.01 09001 VISITING SPECIALTY CLINIC 227,631 35,501 77,587 48,025 388,744 90.01 90.02 09002 PALI PRIMARY CARE CLINIC 0		0	0	0	0		
90.01 09001 VI SI TI NG SPECIALTY CLINIC 227,631 35,501 77,587 48,025 388,744 90.01 90.02 PAOLI PRI MARY CARE CLINIC 0		, o	360	786	10 760		
90.02 09002 PAOLI PRI MARY CARE CLI NI C 0 <							
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 92.00 0THER REIMBURSABLE COST CENTERS 0 <	90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90. 02
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 <td< td=""><td></td><td>2, 262, 526</td><td>38, 606</td><td>84, 373</td><td>309, 173</td><td></td><td></td></td<>		2, 262, 526	38, 606	84, 373	309, 173		
95.00 09500 AMBULANCE SERVICES 0 113.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>92.00</td>						0	92.00
101.00 10100 HOME HEALTH AGENCY 0<		0	0	0	0	0	95.00
113.00 11300 INTEREST EXPENSE 113.00 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 23,929,075 514,106 1,123,585 1,902,976 23,898,024 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 190.01 19000 VI SI TI NG SPECI ALTY CLI NI C 0 0 0 0 190.01 190.02 19002 OUTREACH 230 4,241 0 0 4,471 190.03 190.04 19004 SPRI NG VALLEY FAMI LY PRACTICE 0 0 0 190.03 190.05 19005 PAOLI FAMI LY PRACTICE 0 0 0 0 190.04 190.06 19006 OTHER PROPERTY 30 26,810 0 0 190.06 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00			0				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 23,929,075 514,106 1,123,585 1,902,976 23,898,024 118.00 NONREI MBURSABLE COST CENTERS							
NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 190.01 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0		00.000.075	544.404	4 400 505	1 000 07/	00.000.004	
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 190.01 19001 VISITING SPECIALTY CLINIC 0 0 0 0 190.01 190.02 19002 OUTREACH 230 4,241 0 0 4,471 190.02 190.03 FOUNDATI ON 0 0 0 0 0 190.03 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 190.03 190.05 PAOLI FAMILY PRACTICE 3,594 0 0 0 3,594 190.05 190.06 19006 OTHER PROPERTY 30 26,810 0 0 26,840 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRIVATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 <t< td=""><td></td><td>23, 929, 075</td><td>514, 106</td><td>1, 123, 585</td><td>1, 902, 976</td><td>23, 898, 024</td><td>118.00</td></t<>		23, 929, 075	514, 106	1, 123, 585	1, 902, 976	23, 898, 024	118.00
190.01 19001 VI SI TI NG SPECI ALTY CLINIC 0 0 0 190.01 190.02 19002 OUTREACH 230 4, 241 0 0 4, 471 190.02 190.03 19003 FOUNDATI ON 0 0 0 0 190.03 190.04 19004 SPRI NG VALLEY FAMILY PRACTICE 0 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 190.05 190.06 19006 OTHER PROPERTY 30 26,810 0 0 26,840 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 0 201.00 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>190.00</td>		0	0	0	0	0	190.00
190.03 FOUNDATION 0 0 0 190.03 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 3,594 0 0 3,594 190.05 190.06 19006 OTHER PROPERTY 30 26,810 0 0 26,840 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 192.00 200.00 Cross Foot Adj ustments		0	0	0	0		
190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 3,594 0 0 3,594 190.05 190.06 19006 OTHER PROPERTY 30 26,810 0 0 26,840 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adj ustments 0 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 0 201.00		230	4, 241	0	0		
190.05 19005 PAOLI FAMILY PRACTICE 3,594 0 0 3,594 190.05 190.06 19006 OTHER PROPERTY 30 26,810 0 0 26,840 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 192.00 192.00 192.00 192.00 192.00 192.00 0 0 0 192.00 192.00 192.00 192.00 192.00 0 0 0 192.00 192.00 192.00 192.00 192.00 0 192.00 192.00 0 0 192.00 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
190.06 19006 OTHER PROPERTY 30 26,810 0 26,840 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 193.00 193.00 193.00 0 193.00 0 0 193.00 193.00 193.00 193.00 0 193.00 193.00 0 193.00 193.00 193.00 193.00 193.00 193.00 0 193.00		0 2 504	0	0	0		
191.00 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			26 810		0		
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		0	20,010	0	0		
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00		0	0	0	0	0	192.00
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	193.00 19300 NONPALD WORKERS	0	0	0	0		•
				_			•
202.00 [1017] (300] 1.702,710 [23,732,727] 343,137] 1.123,303 1.702,710 23,732,727[202.00	8	23 022 020	0 515 157	0 1 122 505	0 1 000 1 1		
		20, 702, 727	5-5, 157	1 1, 120, 000	1, 702, 770	20, 102, 727	1-02.00

Heal th Finar	ncial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2019 o 12/31/2019	Worksheet B Part I Date/Time Pre 6/29/2020 9:0	pared:
	Cost Center Description		OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPING	
		& GENERAL 5.00	PLANT 7.00	7.01	LINEN SERVICE 8.00	9.00	
GENER	AL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2.00 4.00
	ADMINISTRATIVE & GENERAL	6, 511, 049					4.00 5.00
	OPERATION OF PLANT	474, 419	1, 743, 841				7.00
	UTI LI TI ES	134, 530	0	494, 497			7.01
	LAUNDRY & LINEN SERVICE	27, 112	13, 104	3, 081			8.00
) HOUSEKEEPI NG DI ETARY	121, 518	41, 409	9, 736 17, 850		497, 813	9.00 10.00
	CAFETERIA	59, 728 57, 788	75, 916 43, 899	10, 322		20, 972 12, 127	11.00
	NURSING ADMINISTRATION	284, 569	61, 196	14, 389		16, 906	13.00
13.01 01301	HOUSE SUPERVI SORS	189, 542	0	0	0	0	13.01
	CENTRAL SERVICES & SUPPLY	172, 456	91, 379	21, 486		0	14.00
) PHARMACY MEDICAL RECORDS & LIBRARY	205, 107 10, 101	51, 062 32, 891	12, 006 7, 734		0 9, 086	15.00 16.00
	SOCIAL SERVICE	0	52, 891	0		9, 080 0	17.00
	NONPHYSICIAN ANESTHETISTS	138, 132	0	0		0	19.00
	IENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	642, 669	338, 565	79, 608		93, 532	30.00
	INTENSIVE CARE UNIT	0 31, 052	0 10, 920	0 2, 568		0 3, 017	31.00 43.00
	LARY SERVICE COST CENTERS	31,032	10, 920	2, 500	0	3,017	43.00
	OPERATING ROOM	301, 365	263, 260	61, 901	8, 388	72, 728	50.00
	DELIVERY ROOM & LABOR ROOM	43, 469	9, 653	2, 270	1, 833	2, 667	52.00
	RADI OLOGY-DI AGNOSTI C	615, 382	251, 903	59, 230		69, 591	54.00
	LABORATORY I NTRAVENOUS_THERAPY	637, 686 39, 754	74, 300 19, 656	17, 470 4, 622		20, 526 5, 430	60.00 64.00
	RESPIRATORY THERAPY	177, 336	19,000	2, 917		3, 430	65.00
	PHYSI CAL THERAPY	277, 918	6, 334	41, 729		49, 028	
	OCCUPATIONAL THERAPY	51, 414	1, 441	9, 439		11, 090	67.00
	SPEECH PATHOLOGY	33, 938	961	6, 265		7, 361	68.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 680 7, 538	0	0	0	0	71.00 72.00
	DRUGS CHARGED TO PATIENTS	564, 270	0	0	0	0	73.00
	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
	RENAL DIALYSIS	0	0	0	0	0	74.00
	ASC (NON-DI STI NCT PART)	0	0	0		0	75.00
	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
		37, 165	1, 660	390		459	
	VISITING SPECIALTY CLINIC PAOLI PRIMARY CARE CLINIC	145, 285	163, 800	38, 515 0		45, 251 0	90. 01 90. 02
91.00 09100		1,007,081	178, 127	41, 883	-		91.00
	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	REIMBURSABLE COST CENTERS		-				
	AMBULANCE SERVICES HOME HEALTH AGENCY	0	0	0 0			95.00
	AL PURPOSE COST CENTERS	0	0	0	0	0	101.00
	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	6, 498, 004	1, 743, 841	465, 411	115, 843	492, 407	118.00
	I MBURSABLE COST CENTERS						1.00.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190. 00 190. 01
190. 01 19001		1,671	0	0	0		190.01
190. 03 19003		0	0	0	0		190.03
	SPRING VALLEY FAMILY PRACTICE	0	О	0	0		190. 04
	PAOLI FAMILY PRACTICE	1, 343	0	0	0		190.05
190.0619006	OTHER PROPERTY	10, 031	0	29, 086	0		190. 06 191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		191.00
	NONPAID WORKERS	0	0	0	0		193.00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	1 742 041	0	115 043		201.00
202.00	TOTAL (sum lines 118 through 201)	6, 511, 049	1, 743, 841	494, 497	115, 843	497, 813	202.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2019 p 12/31/2019	Worksheet B Part I Date/Time Pre 6/29/2020 9:0	pared:
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	HOUSE SUPERVI SORS	CENTRAL SERVI CES & SUPPLY	
	10.00	11.00	13.00	13.01	14.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 UTI LI TI ES 8.00 00800 LAUNDRY & LI NEN 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 13.01 HOUSE SUPERVI SORS 14.00 01400 CENTRAL SERVI CES	334, 282 0 0 0	278, 763 16, 439 12, 816	1, 154, 933 0	709, 523 0	746, 770	1.00 2.00 4.00 5.00 7.00 7.01 8.00 9.00 10.00 11.00 13.01 14.00
15. 00 01500 PHARMACY	0	10, 657		261	53, 726	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	10, 00, C		0	2	16.00
17.00 01700 SOCIAL SERVICE	0	C	0 0	0	0	17.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	5, 432	2 0	0	4, 148	19.00
30. 00 03000 ADULTS & PEDIATRICS	334, 282	46, 790	461, 434	283, 479	82, 532	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	40, 770	0	203, 477	02, 332	31.00
43. 00 04300 NURSERY	0	1, 985	20, 870	12, 821	29, 306	43.00
ANCI LLARY SERVI CE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	0	15, 887		85, 094	114, 167	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0	2, 881 33, 146		18, 604 9, 129	0 68, 148	52.00 54.00
60. 00 06000 LABORATORY	0	33, 000		253	00, 140	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	2, 180		14, 077	15, 028	64.00
65. 00 06500 RESPI RATORY THERAPY	0	14, 167		0	70, 621	65.00
66. 00 06600 PHYSI CAL THERAPY	0	14, 565		0	11, 185	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	3, 322 2, 186		0	2, 530 1, 679	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 100		0	46, 209	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0 0	0	35, 982	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	C		0	0	73.01
75. 00 07500 ASC (NON-DI STINCT PART)	0		-	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C	-	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C		0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	C 888		0	0	89.00 90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	8, 983		30, 455	7, 468	
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	C	0	0	0	90.02
91. 00 09100 EMERGENCY	0	53, 439	415, 649	255, 350	202, 613	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0	C	0	0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	C		0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE				700 500	715 011	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	334, 282	278, 763	1, 154, 933	709, 523	745, 344	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190.00
190. 01 19001 VI SI TI NG SPECIALTY CLINIC	0	C		0		190.01
190. 02 19002 OUTREACH	0	C	0 0	0		190. 02
190. 03 19003 FOUNDATI ON	0	C	0	0		190.03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	C	0	0		190. 04 190. 05
190. 05 19005 PAOLI FAMILY PRACTICE 190. 06 19006 OTHER PROPERTY	0	ſ		0		190.05
191. 00 19100 RESEARCH	0	C	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C	0	0	0	192.00
193. 00 19300 NONPAI D WORKERS	0	C	0	0	0	193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers		r.		_	0	200. 00 201. 00
201.00 TOTAL (sum lines 118 through 201)	334, 282	278, 763	1, 154, 933	709, 523		
	00.,202	2.0,.00	.,,	,		

Heal th	Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 6/29/2020 9:0	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI	CE NONPHYSI CI AN ANESTHETI STS	Subtotal	
		15.00	16.00	17.00	19.00	24.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1.00
2.00 4.00 5.00 7.00	00200 CAP REL COSTS-SUBJE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						2.00 4.00 5.00 7.00
7.01 8.00 9.00	00701 UTI LI TI ES 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						7.01 8.00 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
13.01	01301 HOUSE SUPERVI SORS						13.01
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	882, 058					14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	002,030	86, 843				16.00
17.00	01700 SOCIAL SERVICE	0	0		0		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0 517, 318		19.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 673 0	8, 006 0		0 0 0 0	4, 123, 090	30.00
43.00	04300 NURSERY	62	412		0 0	196, 099	1
101 00	ANCI LLARY SERVI CE COST CENTERS	02		<u>.</u>		170,077	101.00
50.00	05000 OPERATI NG ROOM	1, 363	7, 139		0 517, 318	2, 393, 498	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 423		0 0	229, 393	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 685	16, 035		0 0	2, 806, 292	
60.00 64.00		0 407	7,782		0 0	2, 497, 712 232, 694	
65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	407	2, 254 1, 690		0 0	757, 069	1
66.00	06600 PHYSI CAL THERAPY	16	2,016		0 0	1, 149, 950	1
67.00	06700 OCCUPATI ONAL THERAPY	3	455		0 0	218, 062	1
68.00	06800 SPEECH PATHOLOGY	2	265		0 0	143, 995	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	201		0 0	81, 990	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	123		0 0	63, 812	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 DRUGS CHARGED TO PATIENTS	872, 962	11, 004 0		0 0	2, 958, 078 0	1
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	1
75.00	07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	1
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	1
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	1
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90.00 90.01	09000 CLINIC 09001 VISITING SPECIALTY CLINIC	0	84 865		0 0	140, 089 880, 400	
90.02	09002 PAOLI PRIMARY CARE CLINIC	0	000		0 0	000, 400	1
91.00	09100 EMERGENCY	3, 885	27, 089		0 0	4, 976, 838	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						1 05 00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	0 0		0 0 0 0	0	95.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0	<u> </u>	0 0	0	
113.00	11300 I NTEREST EXPENSE						113.00
118.00		882, 058	86, 843		0 517, 318	23, 849, 061	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	19001 VISITING SPECIALTY CLINIC	0	0		0 0		190. 01
		0	0		0 0		190.02
	19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE	0	0		0 0		190. 03 190. 04
	19004 SPRING VALLEY FAMILY PRACTICE	0	0		0 0		190.04
	19006 OTHER PROPERTY	o	0		0 0		190.06
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	О	0		0 0		192.00
	19300 NONPAI D WORKERS	0	0		0 0		193.00
200.00	5		0		0		200.00
201.00 202.00	Ũ	0 882, 058	0 86, 843		0 0 0 517, 318		201.00
202.00		002,000	50, 045	I	SI 517, 510	20, 102, 727	1-02.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL	In Lieu of Form CMS	-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1306	Period: Worksheet B From 01/01/2019 Part I	
			To 12/31/2019 Date/Time Pr 6/29/2020 9:	
Cost Center Description	Intern &	Total	0/24/2020 4.	
	Residents Cost & Post			
	Stepdown			
	Adjustments	24.00		
GENERAL SERVICE COST CENTERS	25.00	26.00		
1. 00 00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL				4.00 5.00
7.00 00700 OPERATION OF PLANT				7.00
7. 01 00701 UTI LI TI ES				7.01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				9.00 10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
13. 01 01301 HOUSE SUPERVI SORS 14. 00 01400 CENTRAL SERVI CES & SUPPLY				13.01 14.00
15. 00 01500 PHARMACY				15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY				16.00
17.00 01700 SOCIAL SERVICE				17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS				19.00
30. 00 03000 ADULTS & PEDIATRICS	0	4, 123, 090		30.00
31.00 03100 I NTENSI VE CARE UNI T	0	0		31.00
43. 00 04300 NURSERY	0	196, 099		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	2, 393, 498		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	229, 393		52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 806, 292		54.00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0	2, 497, 712 232, 694		60.00 64.00
65. 00 06500 RESPIRATORY THERAPY	0	757, 069		65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 149, 950		66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	218, 062		67.00
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	143, 995 81, 990		68.00 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	63, 812		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 958, 078		73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	0		73.01 74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		76.97
	0	0		
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		88.00 89.00
90. 00 09000 CLINIC	0	140, 089		90.00
90. 01 09001 VI SI TI NG SPECIALTY CLI NI C	0	880, 400		90. 01
90. 02 09002 PAOLI PRIMARY CARE CLINIC 91. 00 09100 EMERGENCY	0	0 4, 976, 838		90.02 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 970, 030		91.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		101.00
113. 00 11300 I NTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	23, 849, 061		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 VISITING SPECIALTY CLINIC	0	0		190.00
190. 02 19002 OUTREACH	0	12, 974		190. 02
190. 03 19003 FOUNDATI ON	0	0		190.03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 05 19005 PAOLI FAMILY PRACTICE	0	0 4, 937		190. 04 190. 05
190. 06 19006 OTHER PROPERTY	0	65, 957		190.05
191. 00 19100 RESEARCH	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	0		192.00 193.00
200.00 Cross Foot Adjustments	0	0		200.00
201.00 Negative Cost Centers	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	23, 932, 929		202.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: ^om 01/01/2019	Worksheet B Part II	
			Т	0 12/31/2019	Date/Time Pre 6/29/2020 9:0	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Related Costs 0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	9, 722	21, 249	30, 971	30, 971	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT	205, 353 0	33, 399 41, 995	72, 994 91, 780	311, 746 133, 775	2, 212 1, 694	5.00 7.00
7. 01 00701 UTI LI TI ES	0	0	0	0	0	7.01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	2, 840 8, 975	6, 207 19, 614	9, 047 28, 589	0 786	8.00 9.00
10. 00 01000 DI ETARY	0	16, 453	35, 959	52, 412	265	10.00
11.00 01100 CAFETERIA	0	9, 514	20, 793	30, 307	507	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 13. 01 01301 HOUSE SUPERVI SORS	0	13, 263 0	28, 987 0	42, 250 0	1, 992 1, 565	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	19, 805	43, 283	63, 088	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	11, 067 7, 129	24, 186 15, 579	35, 253 22, 708	935 0	15.00 16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	1, 395	19.00
30. 00 03000 ADULTS & PEDIATRICS	0	73, 375	160, 370	233, 745	4, 183	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	2, 367	5, 172	7, 539	226	43.00
50. 00 05000 OPERATI NG ROOM	0	57, 057	124, 698	181, 755	1, 806	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	0	2, 092 54, 595	4, 572 119, 319	6, 664 173, 914	328 3, 452	
60. 00 06000 LABORATORY	0	16, 103	35, 193	51, 296	1	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	4, 260 2, 689	9, 310 5, 876	13, 570 8, 565	261 1, 348	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	38, 464	84, 063	122, 527	1, 348	66. 00
67.00 06700 OCCUPATI ONAL THERAPY	0	8, 700	19, 014	27, 714	335	67.00
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 775 0	12, 621 0	18, 396 0	221 0	68.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 01 07301 DRUGS CHARGED TO PATI ENTS	0	0	0	0	0	73.00 73.01
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 97
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC	0	0 360	0 786	0 1, 146	0 175	89.00 90.00
90. 01 09001 VI SI TI NG SPECIALTY CLI NI C	0	35, 501	77, 587	113, 088	782	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC 91.00 09100 EMERGENCY	0	0 38, 606	0 84, 373	0 122, 979	0 5, 031	90.02 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	30, 000	04, 373	0	5,051	92.00
	0	0	0	ol	0	
95. 00 09500 AMBULANCE SERVI CES 101. 00 10100 HOME HEALTH AGENCY	0	0	0	0		95.00 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	205, 353	514, 106	1, 123, 585	1, 843, 044	30, 971	113.00 118.00
NONREI MBURSABLE COST CENTERS	2007000	011/100	., .20, 000	., 0.0, 0.1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 00 190. 01
190. 02 19002 OUTREACH	0	4, 241	0	4, 241		190.01
190. 03 19003 FOUNDATI ON	0	0	0	0		190.03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 05 19005 PAOLI FAMILY PRACTICE	0	0	0	0		190. 04 190. 05
190.06 19006 OTHER PROPERTY	0	26, 810	0	26, 810	0	190. 06
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191. 00 192. 00
192. OO 19200 PHYSICIANS PRIVATE OFFICES 193. OO 19300 NONPAID WORKERS	0	0	0	0		192.00 193.00
200.00 Cross Foot Adjustments				0		200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	205, 353	0 545, 157	0 1, 123, 585	0 1, 874, 095	0 30, 971	201. 00 202. 00

Heal th	Financial Systems	IU HEALTH PAOL	I HOSPITAL		Inlie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		eriod:	Worksheet B	2002 10
				F T	rom 01/01/2019 o 12/31/2019	Part II Date/Time Pre	pared
						6/29/2020 9:0	
	Cost Center Description	ADMI NI STRATI VE		UTILITIES	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	PLANT 7.00	7.01	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS	0.00	1100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0100	7100	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	313, 958					4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	22, 876	158, 345				5.00 7.00
7.00	00701 UTI LI TI ES	6, 487	130, 349				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 307	1, 190				8.00
9.00	00900 HOUSEKEEPI NG	5, 860	3, 760			39, 123	9.00
10.00	01000 DI ETARY	2,880	6, 893			1, 648	
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	2, 787 13, 722	3, 986 5, 557	135 189		953 1, 329	11.00 13.00
13.00	01301 HOUSE SUPERVI SORS	9, 140	5, 557			1, 329	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 316	8, 297	282	0	0	14.00
15.00	01500 PHARMACY	9, 890	4, 637		0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	487	2, 987		0	714	16.00
17.00 19.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0		-	0	17.00 19.00
19.00	INPATIENT ROUTINE SERVICE COST CENTERS	6, 661	0	0	0	0	19.00
30.00	03000 ADULTS & PEDIATRICS	30, 989	30, 742	1, 045	3, 090	7, 351	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		-	0	31.00
43.00		1, 497	992	34	0	237	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	14, 532	23, 905	812	839	5, 716	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,096	23, 903			210	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	29, 673	22, 873		2, 058	5, 469	54.00
60.00	06000 LABORATORY	30, 749	6, 747	229	0	1, 613	60.00
64.00	06400 I NTRAVENOUS THERAPY	1, 917	1, 785		0	427	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	8, 551 13, 401	1, 126 575		0 352	269 3, 853	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	2, 479	131			872	67.00
68.00	06800 SPEECH PATHOLOGY	1,636	87			578	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467	0		-	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	363	0		-	0	72.00
73.00 73.01	07300 DRUGS CHARGED TO PATIENTS 07301 DRUGS CHARGED TO PATIENTS	27, 209	0	0	0	0	73.00 73.01
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	75.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
00 00	OUTPATIENT SERVICE COST CENTERS	o	0	0	0	0	
88.00 89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	88.00 89.00
90.00	09000 CLI NI C	1, 792	151	5		36	
	09001 VISITING SPECIALTY CLINIC	7,006	14, 873			3, 556	90. 01
	09002 PAOLI PRIMARY CARE CLINIC	0	0	-	-	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	48, 558	16, 174	549	4, 783	3, 867	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS	l I					72.00
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	313, 328	158, 345	6, 105	11, 584	38, 698	113.00
110.00	NONREI MBURSABLE COST CENTERS	515, 520	130, 343	0,103	11, 304	30,070	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 01
		81	0	0	0		190.02
	19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	-		190. 03 190. 04
	19004 SPRING VALLET TAMPET PRACTICE	65	0	0	-		190.04
190.06	19006 OTHER PROPERTY	484	0	382		0	190. 06
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193.00 200.00	19300 NONPAID WORKERS Cross Foot Adjustments	0	0	0	0	0	193.00 200.00
200.00		о	0	о	0	0	200.00
202.00		313, 958	158, 345	6, 487	11, 584		

Health Financial Systems	IU HEALTH PAOI	I HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS				eri od:	Worksheet B	
			T	rom 01/01/2019 o 12/31/2019	Part II Date/Time Pre	pared:
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	HOUSE	6/29/2020 9:0 CENTRAL	3 am
Cost Center Description	DIEIMA	GALETERIA	ADMI NI STRATI ON		SERVICES &	
	10.00	11.00	13.00	13.01	SUPPLY 14.00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	13.01	14.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00 00700 OPERATION OF PLANT						7.00
7. 01 00701 UTI LI TI ES						7.01
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	64, 332					9.00 10.00
11. 00 01100 CAFETERIA	04, 332	38, 675	5			11.00
13.00 01300 NURSING ADMINISTRATION	0	2, 281				13.00
13. 01 01301 HOUSE SUPERVI SORS	0	1, 778		12, 483		13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	1 470	-	0	79, 983 5, 754	14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1, 479 C		5	5,754 0	
17. 00 01700 SOCI AL SERVICE	0	C		0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	754	0	0	444	19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(4.222)	(402	24.004	4.00/	0.040	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	64, 332 0	6, 492	2 26, 896	4, 986	8, 840 0	30.00 31.00
43. 00 04300 NURSERY	0	275	1, 216	226	3, 139	•
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	2, 204		1, 497	12, 228	•
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	400		327	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	4, 599 4, 578		161 4	7, 299 0	54.00 60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	302		248	1, 610	
65. 00 06500 RESPI RATORY THERAPY	0	1, 965		0	7, 564	
66. 00 06600 PHYSI CAL THERAPY	0	2, 021		0	1, 198	1
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	461 303		0	271 180	67.00 68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	303 C		0	4, 949	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0	0	3, 854	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0 0	0	0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	•
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0	C		0	0	74.00 75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0	0	•
OUTPATIENT SERVICE COST CENTERS			I			
88.00 08800 RURAL HEALTH CLINIC	0	C		0	0	•
89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 90. 00 09000 CLINIC	0	C 123		0	0 0	
90. 01 09001 VISITING SPECIALTY CLINIC	0	1, 246		536	800	•
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	C	0	0	0	•
91. 00 09100 EMERGENCY	0	7, 414	24, 228	4, 493	21, 700	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0	C	0 0	0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	C				101.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 I NTEREST EXPENSE	(4, 222)	00 (75	(7.000	10, 100	70,000	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	64, 332	38, 675	67, 320	12, 483	/9, 830	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190.00
190. 01 19001 VISITING SPECIALTY CLINIC	0	C		0		190.01
190. 02 19002 OUTREACH	0	C	0 0	0		190. 02
190. 03 19003 FOUNDATI ON	0	C	0	0		190.03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 05 19005 PAOLI FAMILY PRACTICE	0	C		0		190. 04 190. 05
190. 06 19006 OTHER PROPERTY	0	C		0		190.05
191. 00 19100 RESEARCH	0	C	o o	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C	0	0		192.00
193. 00 19300 NONPAID WORKERS	0	C	0	0	0	193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	ſ		Ω	Ω	200. 00 201. 00
202.00 TOTAL (sum Lines 118 through 201)	64, 332	38, 675	67, 320	12, 483		201.00
						-

ALICATION OF CAPITAL RELATE COSTS Provide: C0: 15-130 Provide: C0:		Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Contor Description PHARMACY INCOMES Provided Stress Solutional Income Stress Solutional Income Income Stress Solutional Income Income Stress Solutional Income Income Stress Solutional Income Income Stress Solutional Income Inc	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1306	From 01/01/2019	Part II Date/Time Pre	
DEREMAL SERVICE COST CENTRES 1.00 00 00000 (DM FEL COST-SERVICE SET IN TOTAL SECTION OF TOTAL SECTIO		Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVIO			
1.00 DOTOG CAP FRI_COSTS MIRE & FLYT 1.00 0.00 DOTOG CAP FRI_COSTS MIRE & FLYTS 2.00 0.00 DOTOG CAP FRI_COSTS MIRE & FLYTS 0.00 0.00 DOTOG CAP FRI_COSTS MIRE & FLYTS 1.00 0.00 DOTOG CAP FRI_COSTS MIRE & FLYTS 1.00 0.00 DOTOG CAP FRI_COSTS MIRE & FLYTS 0.00			15.00	16.00	17.00	19.00	24.00	
2.00 00200 CAP, REL. COSTS-WISE. EQUIP. 2.00 5.00 00200 ARMINISTRATIVE & CLEARDAL. 5.00 5.00 00200 ARMINISTRATIVE & CLEARDAL. 5.00 5.00 00200 ARMINISTRATIVE & CLEARDAL. 5.00 5.00 00200 LAURENT & LINER SERVICE 9.00 6.00 00200 LAURENT & LINER SERVICE 9.00 7.00 007001 UNISSENTET IN NO. 11.00 10.00 10100 DISTANCE SERVICE 11.00 10.00 10100 DISTANCE SERVICE SE SIGNAL 11.00 10.00 10100 DISTANCOMANAL 11.00 11.00 <td>1 00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1 1 00</td>	1 00							1 1 00
17.00 01700 SOLAL SERVICE 0 0 9, 254 17.00 0000PHYSICIAL MARSTHETISTS 0 0 9, 254 18.00 03000NHYSICIAL MARSTHETISTS 0 0 9, 254 0.00 03000NHYSICIAL MARSTHETISTS 0 0 0, 2300 142, 52, 923 30, 00 0.00 03100 MARSTHERT ROUTINE SERVICE COST CENTERS 4 120 31, 00 33, 00 31, 00 31, 00 30, 00 31, 00 33, 00 31, 00 33, 00 33, 00 33, 00 33, 00 31, 00 35, 600 50, 00 31, 00 35, 200 52, 00 52, 00 52, 640 0 23, 52, 00 52, 640 60, 00 24, 52, 24, 54, 00 60, 00 60, 00 60, 00 60, 00 60, 00 60, 00 60, 00 60, 00 22, 54, 64, 00 64, 00 22, 54, 64, 00 64, 00 22, 54, 64, 00 64, 00 22, 54, 64, 00 64, 00 66, 00 66, 00 66, 00 66, 00 66, 00 66, 00 66, 00 66, 00 66, 00 66, 00 67, 00 78, 78, 73, 73, 73, 73, 73, 73, 73, 73, 73, 73	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 01\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00701 UTI LI TI ES 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01301 HOUSE SUPERVI SORS 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						2.00 4.00 5.00 7.01 8.00 9.00 10.00 11.00 13.01 14.00 15.00
19:00 01900/NOPENPSICIAN AMESTRETISTS 0 0 9.254 19.00 INPATE TRA NOTINE SERVICE COST CENTERS 110 2.492 0 455.293 30.00 01:00 03000/ADULTS & PEDIATRICS 110 0.200 0						0		1
31.00 03100 NITENSIVE CARE UNIT 0		01900 NONPHYSI CI AN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-	•		-		1
43.00 04300 NURSERY 4 128 0 15.513 43.00 ANCILLARY SERVICE COST CENTERS								1
50:00 50:00 50:00 50:00 25:60 25:60 50:00 25:60 50:00 25:60 50:00 25:60 50:00 25:60 50:00 25:60 50:00 25:60 50:00 25:60 50:00 25:60 25:60 25:60 25:60 25:60 22:24:50 61:00 66:00		04300 NURSERY		0			-	
52:00 05:20:00 DELL'REY, ROOM & LABOR ROOM 0 4.4.3 0 13:323 52:00 64:00 64:00 ARDUIOCO-LIARONGSTIC 111 4,990 0 25:6:242 54:00 64:00 64:00 ARDUIOCO-LIARONGSTIC 111 4,990 0 22:6:242 54:00 64:00 64:00 ARDUIOCO-LIARONGSTIC 111 4,990 0 22:05 64:00 66:00 06:000 RESPIRATORY 162:7 0 146:573 66:00 06:00 06:000 OCUPATIONAL THERAPY 0 142 0 32:00 67:00 07:00 07:000 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 21:618 66:00 07:00 07:000 DRUGS CHARGED TO PATIENTS 57:537 3,425 0 88:0717 73:0 07:00 07:000 DRUGS CHARGED TO PATIENTS 57:537 3,425 0 0 0 74:00 73:01 DRUGS CHARGED TO PATIENTS 57:537 32	50 00		90	2 222		0	255 680	50 00
60.00 66000 LABORATORY 0 2,22 0 97,663 60.00 6600 77,663 60.00 22,245 65.00 22,245 65.00 22,245 65.00 6600 79,952 65.00 65.00 6600 70.00 71.00 71.00 72.245 66.00 66.00 6600 70.00 71.00 72.00 73.01 73.00 73.01 73.00 73.01 73.00 73.01 73.00 73.01 74.00								1
64.00 06400 INTRAVENUUS THERAPY 27 701 0 22.245 64.00 65.00 06500 PESPIRATORY THERAPY 0 526 0 146.573 66.00 66.00 00000 PHYSICAL THERAPY 1 677 0 146.573 66.00 67.00 06700 0000 CULPATI IONAL THEERAPY 0 142 0 32.609 67.00 07.00 0000 CULPATI IONAL THERAPY 0 82 0 21.618 66.00 07.00 0000 UMPL. DEV. CHARGED TO PATIENTS 0 62 0 4.255 72.00 07.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.01 74.00 07400 REMAL PIALYSIS 0 0 0 0 74.00 0 0 75.00 07507 CARDIAC REHABILITATION 0 0 0 0 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.90 76.97 76.97	54.00	05400 RADI OLOGY-DI AGNOSTI C	111	4, 990		0	256, 242	54.00
65:00 06500 PESPIRATORY THERAPY 0 526 0 29,952 65.00 66:00 06500 PHSICAL THERAPY 1 627 0 146.573 66.00 06:00 0500 OCUPATI ONLI THERAPY 0 142 0 32.699 67.00 07100 NEDICAL SUPPLIES CHARGED TO PATIENTS 0 62 0 27.01 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 57.537 3,425 0 88.17 73.01 73.01 07300 RENUS CHARGED TO PATIENTS 0 0 0 0 74.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 75.00 75.00 0 0 0 0 75.00 75.00 76.97	60.00	06000 LABORATORY	-	2, 422		0	97, 663	60.00
66.00 06600 PHYSICAL THERAPY 1 627 0 146.573 66.00 70.00 67.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0 0 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.97 70.01 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td>						-		
67.00 06700 0CCUPATI ONAL THERAPY 0 142 0 32.609 67.00 67.00 68.00 680.00 680.00 680.00 67.00 71.00			0			-		
68. 00 068.00 SPEECH PATHOLOCY 0 82 0 21, 618 68. 00 71. 00 7100 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 62 0 5, 478 71. 00 72. 00 07300 MRUS CHARGED TO PATIENTS 0 38 0 4, 255 72. 00 73. 00 07400 RENAGE TO PATIENTS 57, 537 3, 425 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 74. 00 74. 00 0 0 0 0 74. 00 74. 00 0 0 0 0 74. 00 0 0 0 0 74. 00 0 0 0 74. 00 0 0 0 75. 00 76. 97 07.697 CARDI ALYSIS 0 0 0 0 0 89. 00 89. 00 89. 00 89. 00 89. 00 90. 01 90. 01 90. 01 90. 02 90. 00 90. 00 90. 02			1			-		1
71.00 VID0 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 62 0 5,478 71.00 72.00 07200 IVPL, CHARGED TO PATIENTS 0 38 0 4,255 72.00 73.01 07300 IRUGS CHARGED TO PATIENTS 57,537 3,425 0 0 0 73.00 073.01 IVUSS CHARGED TO PATIENTS 0 0 0 0 73.00 0 0 0 0 0 0 73.00 0 0 0 0 0 0 73.00 <			0			-		1
72.00 072.00 IVPL. DEV. CHARGED TO PATIENTS 0 38 0 4.255 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 57,537 3,425 0 00 0			0					
73.00 OR300 DRUGS CHARGED TO PATIENTS 57,537 3,425 0 88,171 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0 73.01 74.00 07400 RENAL DIALYSIS 0 0 0 0 73.01 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 70.77 77.77 CARDIA CREHABL LITATION 0 0 0 0 75.00 0017PATLENT SERVICE COST CENTERS 0 0 0 0 0 89.00 89.00 89.00 89.00 89.00 90.00 90.00 145.677 90.01 89.00 89.00 90.00 90.00 145.677 90.01 89.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.01			0			-		
73.01 ORGS CHARGED TO PATIENTS 0 0 0 73.01 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 07500 RENAL DIALYSIS 0 0 0 0 0 74.00 75.00 07500 RSC (NON-DISTINCT PART) 0 0 0 0 75.00 00TPATLENT SERVICE COST CENTERS			Ŭ			0		
74.00 Or400 EVAL DI ALYSIS 0 0 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0			07,007			0		
75.00 OSC (NON-DISTINCT PART) O O O O 75.00 SC (NON-DISTINCT PART) O O O O 75.00 SC (NON-DISTINCT PART) O			o	-		0	-	
OUTPATIENT SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>-</td><td>1</td></t<>			0	0		0	-	1
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 90.00 09000 CLINIC 0 26 0 3,454 90.00 90.	76.97	07697 CARDI AC REHABILI TATI ON	0	0		0	0	76.97
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0								
90.00 90000 CLINIC 0 26 0 3,454 90.00 90.01 99001 VISITING SPECIALTY CLINIC 0 269 0 145,677 90.01 90.02 99002 PAOLI PRIMARY CARE CLINIC 0	88.00		0				0	88.00
90.01 09001 VISITING SPECIALTY CLINIC 0 269 0 145,697 90.01 90.02 09002 PADLI PRIMARY CARE CLINIC 0 0 0 0 90.02 91.00 09100 EMERGENCY 256 8,402 0 268,434 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 268,434 91.00 92.00 07HER <reimbursable centers<="" cost="" td=""> 0 0 0 95.00 075.00 INBURSABLE COST CENTERS 0 0 0 101.00 113.00 INTERES TEXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 58,136 26,997 0 0 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 58,136 26,997 0 0 190.01 190.01 190.01 190.02 118.00 118.00 118.00 118.00 190.02 190.02 190.02 00 0 0 0 0 0 190.02 190.02 190.02 190.02</reimbursable>			0					
90.02 09002 PAOLI PRIMARY CARE CLINIC 0 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td>0</td><td></td><td></td></t<>			0			0		
91.00 09100 EMERGENCY 256 8,402 0 268,434 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART 0 0 92.00 92.00 0 92.00 0 92.00 0 92.00 0 0 0 92.00 0 0 0 0 92.00 0			0	269		0		
92.00 OP200 OBSERVATI ON BEDS (NON-DI STINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 95.00 10 0 10 0 10 0 10 0 10 0 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 0 10 0 0 10 0 0 10 0 10 0 0 0 10 0 0 0 0 10 0 0 0 0 0 0 0 0 0 </td <td></td> <td></td> <td>-</td> <td>8 402</td> <td></td> <td>0</td> <td></td> <td></td>			-	8 402		0		
OTHER REIMBURSABLE COST CENTERS 95.00 OPSCO AMBULANCE SERVICES O <th< td=""><td></td><td></td><td>230</td><td>0,402</td><td></td><td>0</td><td>200, 434</td><td></td></th<>			230	0,402		0	200, 434	
95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 0 0 0 101.00 100.01 100.01 100.01 100.01 100.01 100.01 100.01 100.01 100.01 100.01 100.01 100.02 100.01 100.02 100.01 100.02 100.01 100.02 100.01 100.02 <th< td=""><td>72.00</td><td></td><td><u> </u></td><td></td><td></td><td></td><td></td><td>72.00</td></th<>	72.00		<u> </u>					72.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 58,136 26,997 0 0 1,832,200 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 58,136 26,997 0 0 1,832,200 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 190.00 0 190.00 0 190.00 0 190.00 190.01 190.01 190.02 0 0 0 0 190.02 190.02 0 0 0 190.02 190.02 0 0 0 0 190.02 190.02 190.02 0 0 0 0 190.02 190.02 190.02 190.02 0 0 0 0 0 190.02 190.02 190.03 190.04 190.04 190.04 190.04 190.04 190.05 190.05 190.05 190.05 190.05 190.05 190.06 190.06 190.05 190.06 <td>95.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>95.00</td>	95.00		0	0		0	0	95.00
113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 58, 136 26, 997 0 0 1, 832, 200 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.01 190.01 19001 VISITING SPECIALTY CLINIC 0 0 0 190.01 190.02 19002 UTREACH 0 0 0 190.02 190.03 19003 FOUNDATION 0 0 0 190.03 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 190.05 190.06 019006 OTHER PROPERTY 0 0 0 27, 676 190.06 191.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 191.00 192.00 19300 NONPAI D WORKERS 0 0 0 193.00	101.00		0	0		0	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 58,136 26,997 0 0 1,832,200 118.00 NORREI MBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.01 19001 VISITING SPECIALTY CLINIC 0 0 0 190.01 190.02 19002 0UTREACH 0 0 0 190.02 19003 FOUNDATION 0 0 0 190.02 190.03 FOUNDATION 0 0 0 190.04 190.04 190.04 190.04 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.06 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 190.05 190.06 191.00 191.00 191.00 191.00 191.00 191.00 192.00 191.00 192.00 192.00 192.00 193.00 193.0								
NORREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.01 19001 VISITING SPECIALTY CLINIC 0 0 0 190.01 190.02 19002 UTREACH 0 0 0 0 190.02 190.03 19003 FOUNDATION 0 0 0 190.02 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 190.05 190.06 19006 OTHER PROPERTY 0 0 0 190.05 190.00 19100 RESEARCH 0 0 0 191.00 191.00 19100 RESEARCH 0 0 0 192.00 193.00 19300 NOPAID WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 9, 254 9, 254 200.0								
190.01 190.01 VISITING SPECIALTY CLINIC 0 0 0 190.01 190.02 20UTREACH 0 0 0 4,900 190.02 190.03 FOUNDATION 0 0 0 0 190.03 190.04 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 190.04 190.06 19005 PAOLI FAMILY PRACTICE 0 0 0 65 190.06 190.06 19006 OTHER PROPERTY 0 0 0 27,676 190.06 191.00 19100 RESEARCH 0 0 0 191.00 191.00 192.00 19300 NONPAI D WORKERS 0 0 0 192.00 200.00 Cross Foot Adjustments 9, 254 9, 254 20.00 190.00 0 192.00 0 0 192.00 0 0 <td></td> <td>NONREI MBURSABLE COST CENTERS</td> <td>58, 136</td> <td>26, 997</td> <td></td> <td>0 0</td> <td>1, 832, 200</td> <td>118.00</td>		NONREI MBURSABLE COST CENTERS	58, 136	26, 997		0 0	1, 832, 200	118.00
190.02 19002 0UTREACH 0 0 4,900 190.02 190.03 19003 FOUNDATION 0 0 0 190.03 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 190.05 190.06 19006 OTHER PROPERTY 0 0 0 27,676 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 193.00 193.00 200.00 Cross Foot Adj ustments 9,254 9,254 20.00 201.00 0 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>			-					
190.03 19003 FOUNDATION 0 0 190.03 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 190.04 190.06 19006 OTHER PROPERTY 0 0 0 27,676 190.06 191.00 19200 OTHER PROPERTY 0 0 0 191.00 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 9,254 9,254 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	0		-		
190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 65 190.05 190.06 19006 OTHER PROPERTY 0 0 0 27,676 190.06 191.00 19100 RESEARCH 0 0 0 191.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 193.02 9,254 9,254 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	0		-		
190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 65 190.05 190.06 19006 OTHER PROPERTY 0 0 0 27,676 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 9,254 9,254 20.00 0 0 0 0 201.00 0 0 0 0 0 201.00 0 0 0 0 0 201.00 0 0 0 0 0 0 201.00 0 0 0 1201.00 0 0 1201.00 0 0 1201.00 0 1201.00 0 0 1201.00 0 1201.00 0 1201.00 1201.00 1201.00 1201.00 1201.00 1201.00 1201.00 1201.00 1201.00			0	0				
190.06 190.06 0THER PROPERTY 0 0 27,676 190.06 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 192.00 0 0 192.00 200.00 Cross Foot Adj ustments 9,254 9,254 200.00 0				0		0		
191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 9,254 9,254 200.00 201.00 0 0 0 0 201.00			0	0		õ		
192.00 19200 PHYSICLANS' PRIVATE OFFICES 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 9,254 9,254 200.00 201.00 0 0 0 0 0 201.00			0	0		0		
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 9,254 9,254 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0			Ő	0		0		
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	0		0		
201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 58,136 26,997 0 9,254 1,874,095 202.00						9, 254		
202.00 101AL (sum lines 118 through 201) 58, 136 26, 997 0 9, 254 1, 874, 095 202.00			0	0				
	202.00	UTAL (sum Fines 118 through 201)	58, 136	26, 997	I	U 9, 254	1, 874, 095	202.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lieu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1306	Period: Worksheet B From 01/01/2019 Part II	
			To 12/31/2019 Date/Time Pre	epared:
Cost Center Description	Intern &	Total	6/29/2020 9:0	
	Residents Cost & Post			
	Stepdown			
	Adjustments	0(00		
GENERAL SERVICE COST CENTERS	25.00	26.00		-
1.00 00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL				4.00 5.00
7.00 00700 OPERATION OF PLANT				7.00
7. 01 00701 UTI LI TI ES				7.01
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				9.00 10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSI NG ADMI NI STRATI ON				13.00
13. 01 01301 HOUSE SUPERVI SORS				13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY				14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
17. 00 01700 SOCI AL SERVI CE				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS				19.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	425, 293		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		31.00
43. 00 04300 NURSERY	0	15, 513		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	255, 680		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	13, 323		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	256, 242		54.00
60. 00 06000 LABORATORY	0	97, 663		60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	22, 245 29, 952		64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	146, 573		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	32, 609		67.00
68. 00 06800 SPEECH PATHOLOGY	0	21, 618		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 478 4, 255		71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	88, 171		73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		73.01
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0		74.00 75.00
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		76.97
OUTPATIENT SERVICE COST CENTERS		-		
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0 3, 454		89.00 90.00
90. 01 09001 VISITING SPECIALTY CLINIC	0	145, 697		90.00
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	0		90. 02
91.00 09100 EMERGENCY	0	268, 434		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	0			92.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 832, 200		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190. 01 19001 VI SI TI NG SPECIALTY CLI NI C 190. 02 19002 OUTREACH	0	0 4, 900		190. 01 190. 02
190. 03 19003 FOUNDATI ON	0	4, 700		190. 02
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	0	65		190.05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH	0	27, 676 0		190.06 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0		193.00
200.00 Cross Foot Adjustments	0	9, 254		200. 00 201. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	0 1, 874, 095		201.00

	Financial Systems LOCATION - STATISTICAL BASIS	IU HEALTH PAO	LI HOSPITAL Provider CO		eri od:	eu of Form CMS-: Worksheet B-1	
					rom 01/01/2019 o 12/31/2019	Date/Time Pre	
		CAPI TAL REL	ATED COSTS			6/29/2020 9:0	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4. 00	5A	5.00	
	GENERAL SERVICE COST CENTERS	57.50/					1 00
2.00 4.00 5.00 7.00 7.01	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL D0700 OPERATION OF PLANT D0701 UTILITIES	57, 586 1, 027 3, 528 4, 436 0	54, 306 1, 027 3, 528 4, 436 0	7, 571, 149 540, 811 414, 165 C	-6, 511, 049 0	1, 269, 422	7.00
9.00 10.00 11.00 13.00 13.01	D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1301 HOUSE SUPERVISORS D1400 CENTRAL SERVICES & SUPPLY	300 948 1, 738 1, 005 1, 401 0	300 948 1, 738 1, 005 1, 401 0 2, 002	0 192, 149 64, 869 124, 019 486, 826 382, 577		325, 150 159, 816 154, 627 761, 434 507, 165	9.00 10.00 11.00 13.00 13.01
15. 00 16. 00 17. 00 19. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS NPATIENT ROUTINE SERVICE COST CENTERS	2, 092 1, 169 753 0	2, 092 1, 169 753 0 0	C 228, 481 C C 341, 058	000000000000000000000000000000000000000	548, 814 27, 029 0	15. 00 16. 00 17. 00
31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	7, 751 0 250	7, 751 0 250	1, 022, 457 C 55, 190	0	0	31.00
52.00 54.00 60.00 64.00 65.00 66.00 67.00 68.00 71.00 72.00	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM D5400 RADIOLOGY-DIAGNOSTIC D6000 LABORATORY D6400 INTRAVENOUS THERAPY D6500 RESPIRATORY THERAPY D6600 PHYSICAL THERAPY D6700 OCCUPATIONAL THERAPY D6800 SPEECH PATHOLOGY D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS D7200 IMPL. DEV. CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS	6, 027 221 5, 767 1, 701 450 284 4, 063 919 610 0 0	6, 027 221 5, 767 1, 701 450 284 4, 063 919 610 0 0	441, 478 80, 102 843, 723 340 63, 892 329, 533 359, 627 81, 904 53, 985 0 0 0 0		116, 311 1, 646, 605 1, 706, 283 106, 372 474, 506 743, 638 137, 571 90, 810 25, 900 20, 169	52.00 54.00 60.00 64.00 65.00 66.00 67.00 68.00 71.00 72.00
73. 01 74. 00 75. 00 76. 97	07301 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 07697 CARDI AC REHABI LI TATI ON DUTPATI ENT SERVI CE COST CENTERS	0 0 0 0	0 0 0 0	0 0 0 0	0		73. 01 74. 00 75. 00
89.00 90.00 90.01 90.02 91.00 92.00	D8800 RURAL HEALTH CLINIC D8900 FEDERALLY QUALIFIED HEALTH CENTER D9000 CLINIC D9001 VISITING SPECIALTY CLINIC D9002 PAOLI PRIMARY CARE CLINIC D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART DTHER REIMBURSABLE COST CENTERS	0 0 38 3, 750 0 4, 078	0 0 38 3, 750 0 4, 078	C C 42, 809 191, 071 C 1, 230, 083		388, 744	89.00 90.00 90.01 90.02
95.00	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	0	C			95.00 101.00
113.00 118.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	54, 306	54, 306	7, 571, 149	-6, 511, 049	17, 386, 975	113. 00 118. 00
190.00 190.01 190.02 190.03 190.04 190.05 190.06 191.00 192.00 193.00 200.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC 19002 OUTREACH 19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE 19005 PAOLI FAMILY PRACTICE 19006 OTHER PROPERTY 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS Cross Foot Adjustments	0 0 448 0 0 0 2,832 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0	0 4,471 0 3,594 26,840 0 0	190.00 190.01 190.02 190.03 190.04 190.05 190.06 191.00 192.00 193.00 200.00
201.00 202.00 203.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	545, 157 9. 466832				6, 511, 049 0. 373728	

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2019	Worksheet B-1	
				Γο 12/31/2019	Date/Time Pre 6/29/2020 9:0	
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS	Reconciliation	ADMI NI STRATI VE & GENERAL	
			DEPARTMENT (GROSS		(ACCUM. COST)	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
204.00 Cost to be allocated (per Wkst. B, Part II)			30, 97	1	313, 958	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0.00409	1	0. 018021	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH PAC	LI HOSPITAL	CN: 15-1306 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-10
			F	rom 01/01/2019 o 12/31/2019	Date/Time Pre 6/29/2020 9:03	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY	
	7.00	7.01	LAUNDRY) 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 UTILITIES	39, 923 0	48, 147				1.00 2.00 4.00 5.00 7.00 7.01
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	300 948	300	11, 186	41, 254		8.00 9.00
10. 00 01000 DI ETARY	1, 738			1, 738	4, 971	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	1,005	1, 005 1, 401		1, 005 1, 401	0	11.00 13.00
13. 01 01301 HOUSE SUPERVI SORS	0	0		0	0	13.01
14.00 01400 CENTRAL SERVICES & SUPPLY	2, 092	2, 092		0	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL_RECORDS & LI BRARY	1, 169	1, 169 753		0 753	0	15.00 16.00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	17.00 19.00
INPATIENT ROUTINE SERVICE COST CENTERS					0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	7, 751	7, 751	2, 984 0	7, 751 0	4, 971 0	30. 00 31. 00
43. 00 04300 NURSERY	250	250		250	0	43.00
ANCI LLARY SERVICE COST CENTERS	(027	(027	010	(027		F0 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 027 221	6, 027 221		6, 027 221	0	50.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 767	5, 767		5, 767	0	54.00
60. 00 06000 LABORATORY	1, 701	1, 701		1, 701	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	450	450		450	0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	284	284 4, 063		284 4, 063	0	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	33	919		919	0	67.00
68.00 06800 SPEECH PATHOLOGY	22	610	51	610	0	68.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	72.00 73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.97
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90. 00 09000 CLINIC	38	38		38	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC 90.02 09002 PAOLI PRIMARY CARE CLINIC	3, 750	3, 750	141	3, 750	0	90. 01 90. 02
91. 00 09100 EMERGENCY	4,078	4, 078	4, 619	4, 078	0	90.02 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					-	92.00
OTHER REI MBURSABLE COST CENTERS						05 00
95. 00 09500 AMBULANCE SERVICES 101. 00 10100 HOME HEALTH AGENCY	0	0				95.00 101.00
SPECIAL PURPOSE COST CENTERS		0	0	0	0	101.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	39, 923	45, 315	11, 186	40, 806	4, 971	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190. 01 19001 VI SI TI NG SPECIALTY CLINIC	0	0	0	-		190.01
190. 02 19002 OUTREACH	0	0	0	448		190. 02
190. 03 19003 FOUNDATI ON	0	0	0	0		190.03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 05 19005 PAOLI FAMILY PRACTICE	0		0	0		190. 04 190. 05
190. 06 19006 OTHER PROPERTY	0	2, 832	0	0		190.05
191. 00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193.0019300 NONPALD WORKERS 200.00 Cross Foot Adjustments	0	0	0	0	0	193. 00 200. 00
201.00 Negative Cost Centers	1					200.00
202.00 Cost to be allocated (per Wkst. B,	1, 743, 841	494, 497	115, 843	497, 813	334, 282	
203.00 Part I) Unit cost multiplier (Wkst. B, Part I)	43. 680109	10. 270567	10. 356070	12.067024	67.246429	203. 00
204.00 Cost to be allocated (per Wkst. B,	158, 345				64, 332	
Part II)	I	l	I	I		

Heal th F	nancial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 15-1306		Period: From 01/01/2019	Worksheet B-1	
					To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
	Cost Center Description	OPERATION OF	UTI LI TI ES	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT	(SQUARE FEET)	LINEN SERVICI	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)		(POUNDS OF			
				LAUNDRY)			
		7.00	7.01	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	3. 966260	0. 134733	1. 03558	0 0. 948344	12. 941460	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH PAG	DLI HOSPITAL Provider C		Period:	u of Form CMS- Worksheet B-1	
				rom 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
Cost Center Description	CAFETERI A (MAN HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	(DIRECT NRSING	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	
	11.00	13.00	13.01	14.00	15.00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FIXT 2.00 O0200 CAP REL COSTS-MUBLE EQUIP 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL 7.00 O0700 OPERATION OF PLANT 7.01 O0701 UTILITIES BROND O0800 LAUNDRY & LINEN SERVICE 9.00 O0900 HOUSEKEEPING 10.000 D10000 DI ETARY						1.00 2.00 4.00 5.00 7.00 7.01 8.00 9.00 10.00
11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 13.01 01301 HOUSE SUPERVI SORS 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 19.00 INPATI ENT ROUTI NE SERVI CE COST CENTERS	213, 556 12, 594 9, 818 6 8, 164 6 6 6 7 4, 161	4 84, 173 3 0 0 0 4 31 0 0 0 0	84, 173 (31 (0 418, 562 1 30, 113 0 1 0 0	1, 524, 791 0 0 0	11.00 13.00 13.01 14.00 15.00 16.00 17.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	35, 845				2, 892	
31. 00 03100 NTENSI VE CARE UNI T 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 521			-	0 107	
52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 60.00 06000 LABORATORY 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 73.01 07301 DRUGS CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 75.00 07500 ASC (NON-DI STI NCT PART) 76.97 07697 CARDI AC REHABILITATI ON	2, 207 25, 393 25, 281 1, 670 10, 853 11, 158 2, 544 1, 675 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3 1,083 30 30 0 1,670 3 0 5 0 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		3 38, 197 0 8, 423 39, 583 39, 583 0 6, 269 0 1, 418 0 25, 900 0 20, 168 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 2, 912 0 703 0 27 6 4 0 0 1, 509, 067 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 54.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 01\\ 74.\ 00\\ 75.\ 00\\ \end{array}$
OUTPATIENT SERVICE COST CENTERS		,			0	/0. //
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.01 09000 CLINIC 90.01 09001 VISITING SPECIALTY CLINIC 90.02 09002 PAOLI PRIMARY CARE CLINIC 91.00 09100 EMERGENCY 92.00 09SERVATION BEDS (NON-DISTINCT PART	680 6,882 6,938	2 3, 613 0 0	3, 613	0 0	0 0 0 0 6, 716	90.00 90.01 90.02
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 101.00 10100 HOME HEALTH AGENCY					0	95.00 101.00
SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	213, 556	84, 173	84, 173	417, 763	1, 524, 791	113. 00 118. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 VI SI TI NG SPECI ALTY CLI NI C 190. 02 19002 OUTREACH 190. 03 19003 FOUNDATI ON				0 0 0 0 0 799 0 0	0	190. 00 190. 01 190. 02 190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE 190.05 19005 PAOLI FAMILY PRACTICE 190.06 19006 OTHER PROPERTY 191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS 200.00 Cross Foot Adjustments					0 0 0 0 0 0	190. 04 190. 05 190. 06 191. 00 192. 00 193. 00 200. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I)	278, 763	3 1, 154, 933	709, 523	3 746, 770	882, 058	201.00
203.00 204.00 Part II) 204.10 Part II)	1. 305339 38, 675		1		0. 578478 58, 136	203. 00 204. 00

Health Fin	ancial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOC	CATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
	Cost Center Description	CAFETERI A	NURSI NG	HOUSE	CENTRAL	PHARMACY	
		(MAN HOURS)	ADMI NI STRATI ON	SUPERVI SORS	SERVICES &	(COSTED	
				(DIRECT NRSIN	IG SUPPLY	REQUIS.)	
			(DIRECT NRSING	HRS)	(COSTED		
			HRS)		REQUIS.)		
		11.00	13.00	13.01	14.00	15.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 181100	0. 799781	0. 14830	0. 191090	0. 038127	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	IU HEALTH PAO				u of Form CMS	
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2019	Worksheet B-	
				Го 12/31/2019	Date/Time Pr 6/29/2020 9:	
Cost Center Description	MEDI CAL RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS			
	LIBRARY	(TIME SPENT)	(ASSI GNED			
	(GROSS		TIME)			
	CHARGES) 16.00	17.00	19.00	-		
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						5.00 7.00
7. 01 00700 0FERATION OF FEART						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 13. 01 01301 HOUSE SUPERVI SORS						13.00 13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	((0.4(4.05					15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	66, 246, 135 0	0				16.00 17.00
19.00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	100	כ		19.00
30. 00 03000 ADULTS & PEDIATRICS	6, 106, 966	0				30.00
31. 00 03100 I NTENSI VE CARE UNI T	0, 100, 700	0		2		31.00
43. 00 04300 NURSERY	314, 572	0	(43.00
ANCI LLARY SERVICE COST CENTERS	5, 445, 245	0	10			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 085, 196	0		D		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	12, 231, 451 5, 935, 659	0				54.00 60.00
64. 00 06400 I NTRAVENOUS THERAPY	1, 719, 044	0		2		64.00
65. 00 06500 RESPI RATORY THERAPY	1, 289, 470	0				65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	1, 537, 943 346, 999	0				66.00 67.00
68.00 06800 SPEECH PATHOLOGY	201, 996	0	(D		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	152, 990 94, 034	0				71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 393, 884	0	(D D		73.00
73. 01 07301 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S	0	0				73.01 74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0				75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(D		76. 97
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(D D		89.00
90.00 09000 CLINIC 90.01 09001 VISITING SPECIALTY CLINIC	64, 394 660, 046	0				90.00 90.01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	000, 040	0				90.01
91.00 09100 EMERGENCY	20, 666, 246	0	(C		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0		0		95.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(101.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	66, 246, 135	0	10			118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(D		190.00
190. 01 19001 VI SI TI NG SPECIALTY CLINIC	0	0	(D		190.01
190. 02 19002 0UTREACH 190. 03 19003 FOUNDATI ON	0 0	0				190. 02 190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	(190. 04
190. 05 19005 PAOLI FAMILY PRACTICE 190. 06 19006 OTHER PROPERTY	0	0				190. 05 190. 06
191. 00 19100 RESEARCH	0	0		D D		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193.00 19300 NONPALD WORKERS 200.00 Cross Foot Adjustments	0	0				193.00 200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	86, 843	0	517, 31	3		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 001311	0. 000000	5, 173. 18000	D		203.00
204.00 Cost to be allocated (per Wkst. B,	26, 997	0	9, 25	4		204.00
Part II)	1			1		1

Health Financi	ial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATI	ON - STATISTICAL BASIS		Provider CCN: 15-1306		Period: Worksheet From 01/01/2019		
					To 12/31/2019	Date/Time Pre 6/29/2020 9:0	pared: 3 am
C	Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN			
		RECORDS &		ANESTHETI STS			
		LI BRARY	(TIME SPENT)	(ASSI GNED			
		(GROSS		TIME)			
		CHARGES)					
		16.00	17.00	19.00			
	Init cost multiplier (Wkst. B, Part I)	0. 000408	0. 000000	92.54000	0		205.00
	IAHE adjustment amount to be allocated per Wkst. B-2)						206.00
207.00 N	IAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	IU HEALTH PAO	LI 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 9:0	
		Title	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		2.00	0100		0100	
30. 00 03000 ADULTS & PEDI ATRI CS	4, 123, 090		4, 123, 09	0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		17 120707	0 0	0	31.00
43. 00 04300 NURSERY	196, 099		196, 09		0	43.00
ANCI LLARY SERVI CE COST CENTERS			1,0,0,	<u> </u>		101.00
50. 00 05000 OPERATING ROOM	2, 393, 498		2, 393, 49	98 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	229, 393		229, 39		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 806, 292		2, 806, 29		0	54.00
60. 00 06000 LABORATORY	2, 497, 712		2, 497, 71		0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	232, 694		232, 69		0	64.00
65. 00 06500 RESPIRATORY THERAPY	757,069	0			0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 149, 950				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	218, 062		218, 06		0	67.00
68. 00 06800 SPEECH PATHOLOGY	143, 995		143, 99		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			81, 99		0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	63, 812		63, 81		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 958, 078		2, 958, 07		0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	2, 750, 070		2,750,07	0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0			0 0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	0			0 0	0	/0.9/
88.00 08800 RURAL HEALTH CLINIC	0		1	0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 109000 CLINIC	140, 089		140, 08	-	0	90.00
90. 01 09001 VISITING SPECIALTY CLINIC	880, 400		880, 40		0	90.00
90. 02 09002 PAOLI PRIMARY CARE CLINIC	000,400		000,40	0 0	0	90.01
91. 00 09100 EMERGENCY	4, 976, 838		4, 976, 83	-	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 850, 735		1, 850, 73		0	92.00
OTHER REIMBURSABLE COST CENTERS	1,000,733		1,000,73		0	92.00
95. 00 09500 AMBULANCE SERVICES	0	[1	0 0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
SPECIAL PURPOSE COST CENTERS	0	1	1		0	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	25, 699, 796	0	25, 699, 79	06 0	^	200.00
201.00 Less Observation Beds	25, 899, 798		1, 850, 73			200.00
201.00 Total (see instructions)	23, 849, 061					201.00
	23, 047, 001	0	23, 049, 00	U U	0	1202.00

Health Financial System	S	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF	COSTS TO CHARGES				Period: Worksheet C		
					From 01/01/2019	Part I	
					To 12/31/2019	Date/Time Pre	pared:
			Ti +1 o	XVIII	Hospi tal	6/29/2020 9:0	<u>3 am</u>
			Charges	AVIII	ноѕрі таї	Cost	
Cost Contor	Decerintion	Inpatient		Total (col	6 Cost or Other	TEFRA	
COST CENTER	Description	Inpatrent	Outpati ent	+ col. 7)	Ratio	Inpatient	
				+ COL. 7)	Ratio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
	E SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PE		1, 713, 078		1, 713, 07	8		30,00
31. 00 03100 I NTENSI VE 0		1, 710, 070		1, 710, 07	0		31.00
43. 00 04300 NURSERY	ARE ON T	314, 572		314, 57	0		43.00
ANCI LLARY SERVI CE		514, 572	I	514, 57	2		43.00
50. 00 05000 OPERATING R		963, 037	4, 482, 208	5, 445, 24	5 0. 439557	0. 000000	50.00
52. 00 05200 DELIVERY RC		741, 567	343, 629	1, 085, 19		0. 000000	52.00
54. 00 05400 RADI OLOGY-D		177, 313	12,054,138	12, 231, 45		0. 000000	
60. 00 06000 LABORATORY		434, 609	5, 501, 050	5, 935, 65		0. 000000	
64. 00 06400 I NTRAVENOUS	THERAPY	0	1, 719, 044	1, 719, 04		0. 000000	
65. 00 06500 RESPI RATORY		180, 249	1, 109, 221	1, 289, 47		0. 000000	
66.00 06600 PHYSI CAL TH		107, 874	1, 430, 069	1, 537, 94		0. 000000	
67.00 06700 0CCUPATI 0NA		23, 542	323, 457	346, 99		0. 000000	
68.00 06800 SPEECH PATH		2, 918	199, 078	201, 99		0. 000000	
	PLIES CHARGED TO PATIENTS	16, 771	136, 219	152, 99		0. 000000	71.00
	CHARGED TO PATIENTS	0,771	94, 034	94, 03		0. 000000	
73.00 07300 DRUGS CHARG		644, 098	7, 749, 786	8, 393, 88		0. 000000	73.00
73. 01 07301 DRUGS CHARG		011,070	0	0,0,0,00	0 0.000000	0. 000000	73.01
74.00 07400 RENAL DIALY		0	0		0 0.000000	0. 000000	74.00
75.00 07500 ASC (NON-DI		0	0		0 0.000000	0. 000000	75.00
76. 97 07697 CARDI AC REH		0	0		0 0.000000	0. 000000	76.97
OUTPATIENT SERVIC		-1					
88.00 08800 RURAL HEALT		0	0		0		88.00
	UALIFIED HEALTH CENTER	0	0		0		89.00
90.00 09000 CLINIC		0	64, 394	64, 39	2. 175498	0.000000	
90.01 09001 VISITING SF	PECIALTY CLINIC	0	660, 046	660, 04		0.000000	
90.02 09002 PAOLI PRIMA		0	0		0 0.000000	0.000000	
91.00 09100 EMERGENCY		180, 699	20, 485, 547	20, 666, 24		0.000000	91.00
	I BEDS (NON-DISTINCT PART	5, 550	4, 388, 338	4, 393, 88		0. 000000	92.00
OTHER REI MBURSABL	· · · · · · · · · · · · · · · · · · ·	-/	.,,	.,			
95.00 09500 AMBULANCE S		0	0		0 0.000000	0.00000	95.00
101.00 10100 HOME HEALTH		0	0		0		101.00
SPECIAL PURPOSE (-		
113.00 11300 INTEREST EX							113.00
	ee instructions)	5, 505, 877	60, 740, 258	66, 246, 13	5		200.00
201.00 Less Observ							201.00
202.00 Total (see	instructions)	5, 505, 877	60, 740, 258	66, 246, 13	5		202.00
	·						•

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1306	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/29/2020 9:0	epared:)3 am
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
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
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74. 00 07400 RENAL DIALYSIS					74.00
	0.000000				
75. 00 07500 ASC (NON-DI STI NCT PART)	0. 000000				75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000				76.97
OUTPATIENT SERVICE COST CENTERS	1				
88.00 08800 RURAL HEALTH CLINIC					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90. 00 09000 CLINIC	0. 000000				90.00
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000				90.01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000				90.02
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1306	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/29/2020 9:0	pared: 3 am
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 123, 090		4, 123, 09	0 0	4, 123, 090	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	31.00
43.00 04300 NURSERY	196, 099		196, 09	09 0	196, 099	43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 393, 498		2, 393, 49	0 8	2, 393, 498	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	229, 393		229, 39	03 0	229, 393	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 806, 292		2, 806, 29	02 0	2, 806, 292	54.00
60. 00 06000 LABORATORY	2, 497, 712		2, 497, 71	2 0	2, 497, 712	60.00
64.00 06400 I NTRAVENOUS THERAPY	232, 694		232, 69	04 0	232, 694	64.00
65. 00 06500 RESPI RATORY THERAPY	757,069	0	757, 06	9 0	757, 069	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 149, 950	0	1, 149, 95	0 0	1, 149, 950	66.00
67.00 06700 OCCUPATI ONAL THERAPY	218, 062	0	218, 06	02 0	218, 062	67.00
68.00 06800 SPEECH PATHOLOGY	143, 995		143, 99	05 0	143, 995	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	81, 990		81, 99	0 0	81, 990	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	63, 812		63, 81	2 0	63, 812	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 958, 078		2, 958, 07	8 0	2, 958, 078	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0			0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
76. 97 07697 CARDI AC REHABILI TATI ON	0			0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	-	I				
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	140, 089		140, 08	9 0	140, 089	90.00
90.01 09001 VISITING SPECIALTY CLINIC	880, 400		880, 40		880, 400	1
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0			0 0	0	1
91. 00 09100 EMERGENCY	4, 976, 838		4, 976, 83	8 0	4, 976, 838	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 850, 735		1, 850, 73		1, 850, 735	
OTHER REIMBURSABLE COST CENTERS	.,		.,		.,	
95. 00 09500 AMBULANCE SERVICES	0		1	0 0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
SPECIAL PURPOSE COST CENTERS			•	<u> </u>		
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	25, 699, 796	l o	25, 699, 79	6 0	25, 699, 796	
201.00 Less Observation Beds	1, 850, 735		1, 850, 73		1, 850, 735	
202.00 Total (see instructions)	23, 849, 061				23, 849, 061	1

	Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC	Provider CCN: 15-1306		Period: Worksheet C	
					From 01/01/2019	Part I	
					To 12/31/2019	Date/Time Pre 6/29/2020 9:0	epared:
			Ti +1	e XIX	Hospi tal	PPS	
	· · · · · ·		Charges			ГГЗ	
	Cost Center Description	Inpatient		Total (col	6 Cost or Other	TEFRA	
	cost center bescription	Thpatrent	outpatrent	+ col. 7)	Ratio	Inpatient	
				+ cor. 7)	Natio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30, 00	03000 ADULTS & PEDIATRICS	1, 713, 078		1, 713, 07	78		30.00
31.00	03100 I NTENSI VE CARE UNI T	1,710,070		1, 710, 07	0		31.00
43.00	04300 NURSERY	314, 572		314, 57	0		43.00
45.00	ANCI LLARY SERVICE COST CENTERS	514, 572		514, 57			43.00
50.00	05000 OPERATING ROOM	963, 037	4, 482, 208	5, 445, 24	0. 439557	0.00000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	741, 567	4, 482, 208	1, 085, 19		0.000000	
54.00	05400 RADI OLOGY - DI AGNOSTI C		12,054,138	12, 231, 45		0. 000000	
60.00	06000 LABORATORY	177, 313 434, 609	5, 501, 050	5, 935, 65		0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	1, 719, 044	1, 719, 04		0.000000	
65.00		180, 249	1, 109, 221	1, 289, 47		0.000000	
66.00	06600 PHYSI CAL THERAPY	107, 874	1, 430, 069	1, 537, 94		0.000000	•
67.00	06700 OCCUPATIONAL THERAPY	23, 542	323, 457	346, 99		0.000000	
68.00	06800 SPEECH PATHOLOGY	2, 918	199, 078	201, 99		0.000000	•
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	16, 771	136, 219	152, 99		0.00000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	94, 034	94, 03		0.00000	•
73.00	07300 DRUGS CHARGED TO PATIENTS	644, 098	7, 749, 786	8, 393, 88		0.000000	•
73.01	07301 DRUGS CHARGED TO PATIENTS	0	0		0 0.000000	0.000000	
74.00	07400 RENAL DIALYSIS	0	0		0 0.000000	0.000000	
75.00	07500 ASC (NON-DI STI NCT PART)	0	0		0 0.000000	0.000000	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0.00000	0.00000	76.97
	OUTPATIENT SERVICE COST CENTERS	-	-				
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0.00000	0.00000	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0.00000	
90.00	09000 CLI NI C	0	64, 394	64, 39		0.000000	
90.01	09001 VISITING SPECIALTY CLINIC	0	660, 046	660, 04		0.000000	
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0	0		0 0.000000	0. 000000	
91.00	09100 EMERGENCY	180, 699	20, 485, 547	20, 666, 24		0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 550	4, 388, 338	4, 393, 88	0. 421207	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0		0 0. 000000	0. 000000	
101.00	10100 HOME HEALTH AGENCY	0	0		0		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	5, 505, 877	60, 740, 258	66, 246, 13	35		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	5, 505, 877	60, 740, 258	66, 246, 13	35		202.00

31.00 04300 INTENSIVE CARE UNIT 31.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPECATING ROM 0.439557 50.00 50.00 52.00 52.00 52.00 52.00 52.00 052.00 052.00 052.00 052.00 052.00 052.00 065.00 0.43067Y 0.420798 60.00 60.00 66.00 67.00 0.712661 68.00 71.00 71.00 71.00 71.00 71.00 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 <t< th=""><th>Health Financial Systems</th><th>IU HEALTH PAOLI</th><th>HOSPI TAL</th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></t<>	Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-	2552-10
Cost Center Description PPs Inpatient 11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 30.00 03100 INTENSIVE CARE UNIT 30.00 05200 ADULTS & PEDIATRICS 31.00 043000 ADULTS & PEDIATRICS 31.00 043000 PENATINE SERVICE COST CENTERS 50.00 052000 DELVICEY ROOM 52.00 052000 DELVICEY ROOM 64.00 064000 INTRAVENUS THERAPY 0.05500 RESPI RATORY THERAPY 0.135362 66.00 066000 HYSICAL THERAPY 0.6700 0CCUPATIONAL THERAPY 0.5387116 66.00 066000 PHYSICAL THERAPY 0.712861 068.00 71.00 07300 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.7200 01WPL CAL SUPPLIES CHARGED TO PATIENTS 0.532409 73.01 07300 DRUGS CHARGED TO PATIENTS 0.532409 73.00 07300 DRUGS CHARGED TO PATIENTS 0.322409 73.00 07300 DRUGS CHARGED TO PATIENTS 0.322409 73.00 07300 DRUGS CHARGED TO PATIENTS 0.322409 73.00<	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	epared: 03 am
Ratio 11.00 11.00 11.00 0.00 03000 ADULTS & PEDLATRICS 30.00 0.10 03000 INTENSIVE CARE UNIT 31.00 43.00 04300 INTENSIVE CARE UNIT 31.00 0.11.LARY SERVICE COST CENTERS 52.00 50.00 05000 DELIVERY NOM & LABOR ROOM 0.211384 50.00 05400 DELIVERY NOM & LABOR ROOM 0.211384 50.00 05400 DELIVERY NOM & LABOR ROOM 0.229432 50.00 05400 RADIOLGOV-DI AGNOSTIC 0.229432 50.00 6600 DELIVERY NOM & LABOR ROOM 0.317364 50.00 6600 PHYSICAL THERAPY 0.587116 50.00 6600 PHYSICAL THERAPY 0.747720 51.00 05600 PHYSICAL THERAPY 0.74261 51.00 0700 OCLASUPATIONAL THERAPY 0.678606 51.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.355917 51.00 07300 DRUGS CHARGED TO PATIENTS 0.352409 51.00 07300 DRUGS CHARGED TO PATIENTS 0.352409 51.00 07300 DRUGS CHARGED TO PATIENTS 0.352409			Title XIX	Hospi tal	PPS	
11.00 INPATI_ENT_ROUTINE_SERVICE_COST_CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSI VE CARE UNIT 31.00 03000 VINSERY ANCILLARY SERVICE_COST_CENTERS 50.00 05200 OPERATING ROOM 0.211134 52.00 50.00 05000 OPERATING ROOM 0.211384 51.00 05000 OPERATING ROOM 0.211384 52.00 06000 LABORATORY 0.420798 60.00 06600 LABORATORY 0.420798 60.00 06000 PHYSICAL THERAPY 0.135362 61.00 06000 OPHYSICAL THERAPY 0.587116 62.00 06000 PHYSICAL THERAPY 0.587116 63.00 06000 SPECEH PATHOLOGY 0.712861 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.535917 72.00 073.00 07300 DRUGS CHARGED TO PATIENTS 0.535409 73.00 07300 DRUGS CHARGED TO PATIENTS 0.352409 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.352409 73.00 73.00 07300 DRUGS CHARGED TO PA	Cost Center Description	PPS Inpatient				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0000 ONDUCTS & PEDIATRICS 31.00 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NUESSERY 43.00 AMOTLLARY SERVICE COST CENTERS 50.00 50.00 05000 DELIVERY NOOM & LABOR ROOM 0.211384 50.00 05000 DELIVERY NOOM & LABOR ROOM 0.211384 50.00 05000 RESPICATORY 0.420798 60.00 06000 RESPICATORY 0.437720 66.00 06600 RESPICATORY THERAPY 0.353716 66.00 06600 RESPICATORY THERAPY 0.747720 66.00 06600 RESPICATIORY THERAPY 0.747720 67.00 06700 OCCUPATIONAL THERAPY 0.747861 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.585917 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.678423 71.00 07300 RUSC CHARGED TO PATIENTS 0.678423 72.00 7200 T300 RUSC CHARGED TO PATIENTS 0.678423 73.00 07300 RUSC CHARGED TO PATIENTS 0.678423 74.00 07000 RUSC CHARGED TO PATIENTS 0						
30: 0.0 03000 ADULTS & PEDIATRICS 30: 0.0 31: 0.0 03100 INTERSIVE CARE UNIT 31: 0.0 43: 0.0 04300 INTRSERY 43: 0.0 ANCILLARY SERVICE COST CENTERS 50: 0.0 50: 0.0 05200 DELIVERY ROOM & LABOR ROOM 0: 211384 50: 0.0 05000 DERATING ROOM 0: 211384 52: 0.0 60: 0.0 06000 INTRAVENDUS THERAPY 0: 439557 60: 0.0 60: 0.0 06000 INTRAVENDUS THERAPY 0: 420798 64: 0.0 61: 0.0 06000 INTRAVENDUS THERAPY 0: 587116 65: 0.0 66: 0.0 06600 PHYSICAL THERAPY 0: 587116 66: 0.0 61: 0.0 06000 CCUPATIONAL THERAPY 0: 628423 67: 0.0 63: 0.0 06000 SPEECH PATHOLOGY 0: 712861 68. 0.0 71: 0.0 07100 IMEDICAL SUPPLIES CHARGED TO PATIENTS 0: 535917 71: 0.0 72: 0.0 0: 7000 INFL DEV CHARGED TO PATIENTS 0: 535917 71: 0.0 73: 0.0 07300 INESCIAL SURGED TO PATIENTS 0: 352409 73: 0.0 74: 0.0 0: 700000 0: 7000 INTRAVENTER TO PATIENTS 0: 352409 73: 0.0 74: 0.0<		11.00				
31.00 04300 INTENSIVE CARE UNIT 31.00 43.00 04300 NURSERY 43.00 AMOLILLARY SERVICE COST CENTERS 50.00 05000 PERATING ROM 0.43957 50.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 62.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 71.00 71.00 71.00 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00						
43.00 0.4300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 Scool (LARY SERVICE COST CENTERS) 50.00 50.00 05000 OPERATING ROOM 0.211384 52.00 50.00 05000 RADILLARY SERVICE COST CENTERS 50.00 50.00 05000 RADILUSERY 0.4207432 52.00 60.00 C6000 INTRAVENUS THERAPY 0.430532 64.00 64.00 O400 INTRAVENUS THERAPY 0.587116 65.00 65.00 OSCOP RESPERATORY THERAPY 0.587116 65.00 66.00 OAGOD INTRAVENDUS THERAPY 0.587116 65.00 66.00 OSCOP RESPERATORY THERAPY 0.747720 66.00 67.00 GETOD OCCUPATIONAL THERAPY 0.728423 67.00 0.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.352409 71.00 0.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.352409 73.00 0.00 OT400 RENAL DIALYSIS 0.000000 73.00 0.00 OT400 RENAL	30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCL LARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT					31.00
50. 00 05000 0PERATING ROOM 0. 439557 50. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 211384 52. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 211384 52. 00 64. 00 05400 RADI OLGOY-DI AGNOSTIC 0. 229432 60. 00 64. 00 06400 INTRAVENUS THERAPY 0. 135362 64. 00 65. 00 06500 RESPI RATORY THERAPY 0. 587116 65. 00 66. 00 06400 OV INTRAVENUS THERAPY 0. 747720 66. 00 67. 00 000 OV OCUPATIONAL THERAPY 0. 712861 68. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 535917 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 362409 73. 00 73. 01 07301 DRUGS CHARGED TO PATIENTS 0. 000000 74. 00 74. 00 07400 RENAL DIALYSIS 0. 000000 74. 00 75. 00 05600 RURAL HARCED TO PATIENTS 0. 000000 74. 00 76. 97 07697 CARDIA CREGED TO PATIENTS 0. 000000 74. 00 76. 97 07697 CARDIA CREGED TO PATIENTS	43.00 04300 NURSERY					43.00
52.00 05200 DELIVERY POON & LABOR ROOM 0.211384 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.229432 54.00 64.00 06400 LABORATORY 0.420798 60.00 65.00 06500 RESPI RATORY THERAPY 0.135362 64.00 65.00 06600 RESPI RATORY THERAPY 0.581716 65.00 66.00 06600 PKYSICAL THERAPY 0.747720 66.00 67.00 06200 COUPATI ONAL THERAPY 0.747261 68.00 68.00 06800 SPEECH PATHOLOCY 0.712861 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.535917 71.00 72.00 72.00 73.00 73.00 73.00 73.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0.000000 74.00 74.00 70400 RENAL DI ALYSI S 0.000000 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 75.00 70 70767 CARDIA CR HHALTH CLINIC	ANCI LLARY SERVI CE COST CENTERS	· ·				
54.00 0s400 RADIOLOCY-DIAGNOSTIC 0.229432 54.00 60.00 06000 LABORATORY 0.420798 60.00 60.00 06000 INTRAVENUS THERAPY 0.35352 64.00 65.00 06500 PESPIRATORY THERAPY 0.587116 65.00 66.00 06000 PHYSICAL THERAPY 0.712861 65.00 67.00 06700 OCCUPATIONAL THERAPY 0.628423 67.00 68.00 06800 SPEECH PATHOLOGY 0.712861 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.678606 72.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0.050000 73.01 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 73.01 74.00 07400 RENAL DIALYSIS 0.000000 74.00 75.00 7500 ASC (NON-DISTIC PART) 0.000000 75.00 76.97 CARDIAC REHABILITATION 0.000000 89.00 89.00 08900 FUBERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 90.01 0	50. 00 05000 OPERATI NG ROOM	0. 439557				50.00
60.00 ABORATORY 0.420798 60.00 64.00 \overline{ABORATORY 0.135362 64.00 65.00 \overline{ABORATORY 0.587116 65.00 65.00 \overline{ABORATORY 1HERAPY 0.747720 66.00 66.00 \overline{ABORATORY 0.628423 66.00 67.00 67.00 \overline{ABORATORY 0.712661 68.00 68.00 71.00 OT100 NEDIC AL SUPPLIES CHARGED TO PATIENTS 0.535917 71.00 73.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.352409 73.00 73.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.352409 74.00 74.00 74.00 PAOD RENAL DIALYSIS 0.000000 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 75.00 76.00 75.00 76.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 211384				52.00
60.00 ABORATORY 0.420798 60.00 64.00 \overline{ABORATORY 0.135362 64.00 65.00 \overline{ABORATORY 0.587116 65.00 65.00 \overline{ABORATORY 1HERAPY 0.747720 66.00 66.00 \overline{ABORATORY 0.628423 66.00 67.00 67.00 \overline{ABORATORY 0.712661 68.00 68.00 71.00 OT100 NEDIC AL SUPPLIES CHARGED TO PATIENTS 0.535917 71.00 73.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.352409 73.00 73.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.352409 74.00 74.00 74.00 PAOD RENAL DIALYSIS 0.000000 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 75.00 76.00 75.00 76.00						54.00
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90.02 09002 PAOLI PRIMARY CARE CLINIC 0.00000 90.02 91.00 09100 EMERGENCY 0.240820 91.00 92.00 09500 0BSERVATION BEDS (NON-DISTINCT PART 0.421207 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 95.00 95.00 01000 HOME HEALTH AGENCY 0.000000 95.00 95.00 113.00 INTEREST EXPENSE 0.000000 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00						•
91.00 09100 EMERGENCY 0.240820 91.00 91.00 92.00		1. 333846				90.01
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.421207 92.00 0THER REIMBURSABLE COST CENTERS 00.00000 9500 AMBULANCE SERVICES 95.00 <t< td=""><td></td><td>0. 000000</td><td></td><td></td><td></td><td>90.02</td></t<>		0. 000000				90.02
0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 101.00 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 100.00 101.00 100.00 101.00 100.00 101.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00	91. 00 09100 EMERGENCY	0. 240820				91.00
95.00 09500 AMBULANCE SERVICES 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 101.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 200.00 200.00 200.00 200.00 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 421207				92.00
101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	OTHER REIMBURSABLE COST CENTERS	· ·				1
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds	95.00 09500 AMBULANCE SERVICES	0.000000				95.00
113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	101.00 10100 HOME HEALTH AGENCY					101.00
113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00		· ·				
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						113.00
201.00 Less Observation Beds 201.00						
	202.00 Total (see instructions)					201.00

Health Financial Systems	IU HEALTH PAC				u of Form CMS-	2552-1
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provider C	CN: 15-1306	Period: From 01/01/2019	Worksheet C Part II	
REDUCTIONS FOR MEDICAID ONLY				To 12/31/2019	Date/Time Pre	pared:
					6/29/2020 9:0	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part			Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
	1.00	2.00	col . 2)	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	2, 393, 498	255, 680	2, 137, 8	18 0	0	50.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 393, 498				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 806, 292			-	0	
60. 00 06000 LABORATORY	2, 800, 292				0	
64. 00 06400 INTRAVENOUS THERAPY	232, 694				0	
65. 00 06500 RESPIRATORY THERAPY	757,069				0	
66. 00 06600 PHYSI CAL THERAPY	1, 149, 950				0	
67. 00 06700 OCCUPATI ONAL THERAPY	218, 062				0	
68. 00 06800 SPEECH PATHOLOGY	143, 995				0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	81, 990				0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	63, 812				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 958, 078				0	
73.01 07301 DRUGS CHARGED TO PATIENTS	0	C C		0 0	0	73.0
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.0
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.0
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76.9
OUTPATIENT SERVICE COST CENTERS	·					1
88.00 08800 RURAL HEALTH CLINIC	0	0)	0 0	0	88.0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0)	0 0	0	89.0
90. 00 09000 CLINIC	140, 089	3, 454	136, 6	35 0	0	90.0
90.01 09001 VISITING SPECIALTY CLINIC	880, 400	145, 697	734,70	03 0	0	
90.02 09002 PAOLI PRIMARY CARE CLINIC	0			0 0	0	
91. 00 09100 EMERGENCY	4, 976, 838				0	1 / 0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 850, 735	190, 901	1, 659, 8	34 0	0	92.0
OTHER REIMBURSABLE COST CENTERS		1	1			
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	1
101.00 10100 HOME HEALTH AGENCY	0	C		0 0	0	101. 0
SPECIAL PURPOSE COST CENTERS		1	1	1		
113.00 11300 I NTEREST EXPENSE	04.000.007	4 500 005	10 700 0			113.0
200.00 Subtotal (sum of lines 50 thru 199)	21, 380, 607					200.0
201.00 Less Observation Beds	1, 850, 735					201.0
202.00 Total (line 200 minus line 201)	19, 529, 872	1, 391, 394	18, 138, 4	78 0	0	202.0

ealth Financial Systems ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	IU HEALTH PAC	Provider C	CN: 15-1306	Peri od:	Worksheet C
EDUCTIONS FOR MEDICAID ONLY				From 01/01/201	9 Part II
				To 12/31/2019	9 Date/Time Prepar 6/29/2020 9:03 a
		Titl	e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,			
	Operating Cost			6	
	Reducti on	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS	-				
0.00 05000 OPERATING ROOM	2, 393, 498				50
2.00 05200 DELIVERY ROOM & LABOR ROOM	229, 393				52
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 806, 292				54
0. 00 06000 LABORATORY	2, 497, 712				60
4.00 06400 INTRAVENOUS THERAPY	232, 694				64
5. 00 06500 RESPI RATORY THERAPY	757, 069				65
6. 00 06600 PHYSI CAL THERAPY	1, 149, 950	1, 537, 943			66
7.00 06700 OCCUPATI ONAL THERAPY	218, 062	346, 999	0. 6284	23	67
8.00 06800 SPEECH PATHOLOGY	143, 995	201, 996	0. 7128	61	68
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	81, 990	152, 990	0. 5359	17	71
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	63, 812	94, 034	0. 6786	06	72
3.00 07300 DRUGS CHARGED TO PATIENTS	2, 958, 078	8, 393, 884	0. 3524	09	73
3.01 07301 DRUGS CHARGED TO PATIENTS	0	0			73
4.00 07400 RENAL DIALYSIS	0	0	0. 0000	00	74
5.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 0000	00	75
6. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 0000	00	76
OUTPATIENT SERVICE COST CENTERS					
8.00 08800 RURAL HEALTH CLINIC	0	0			88
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 0000	00	89
0. 00 09000 CLINIC	140, 089	64, 394			90
0.01 09001 VISITING SPECIALTY CLINIC	880, 400	660, 046	1. 3338	46	90
0.02 09002 PAOLI PRIMARY CARE CLINIC	0	C	0.0000	00	90
1.00 09100 EMERGENCY	4, 976, 838	20, 666, 246	0. 2408	20	91
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 850, 735	4, 393, 888	0. 4212	07	92
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES	0	0	0.0000	00	95
01.00 10100 HOME HEALTH AGENCY	0	0	0.0000	00	101
SPECIAL PURPOSE COST CENTERS					
13.00 11300 INTEREST EXPENSE					113
00.00 Subtotal (sum of lines 50 thru 199)	21, 380, 607	64, 218, 485	j		200
01.00 Less Observation Beds	1, 850, 735	C			201
02.00 Total (line 200 minus line 201)	19, 529, 872	64, 218, 485			202

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 6/29/2020 9:0	pared: 3 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	255, 680				267	
52.00 05200 DELIVERY ROOM & LABOR ROOM	13, 323				-	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	256, 242	12, 231, 451	0. 02094	50, 818	1, 065	54.00
60. 00 06000 LABORATORY	97,663	5, 935, 659	0. 01645	69, 597	1, 145	60.00
64.00 06400 INTRAVENOUS THERAPY	22, 245	1, 719, 044	0. 01294	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	29, 952	1, 289, 470	0. 02322	28 72, 102	1, 675	65.00
66. 00 06600 PHYSI CAL THERAPY	146, 573	1, 537, 943	0. 09530	18, 634	1, 776	66.00
67.00 06700 OCCUPATI ONAL THERAPY	32, 609	346, 999	0. 09397	4 1, 841	173	67.00
68.00 06800 SPEECH PATHOLOGY	21, 618	201, 996	0. 10702	2, 067	221	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 478	152, 990	0. 03580	06 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 255	94, 034	0. 04525	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	88, 171	8, 393, 884	0. 01050	121, 697	1, 278	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.0000	0 0	0	73.01
74.00 07400 RENAL DI ALYSI S	0	0	0, 00000	0 0	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0	0.0000	0 0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.0000		0	76.97
OUTPATIENT SERVICE COST CENTERS				- <u>-</u>		
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000		0	89,00
90. 00 09000 CLINIC	3, 454	64, 394			0	90.00
90. 01 09001 VISITING SPECIALTY CLINIC	145, 697	660, 046			0	90, 01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	0	0.0000		0	90.02
91. 00 09100 EMERGENCY	268, 434	20, 666, 246			68	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	190, 901	4, 393, 888				92.00
OTHER REIMBURSABLE COST CENTERS		., ,		.,	10	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	1, 582, 295	64, 218, 485		348, 706	7, 714	200.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2019 To 12/31/2019		
			e XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health	Allied Health	
	Anesthetist	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	517, 318	C)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	C		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATI ENT SERVICE COST CENTERS	-			-	-	1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0	89.00
90. 00 09000 CLINIC	0	C		0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0 0	0	90.01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	0		0 0	0	90.02
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0	0	
OTHER REIMBURSABLE COST CENTERS	-		1	-	-	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	517, 318	C		0 0	0	200.00
	1 2, 0.10		I			1

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider CO		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019 To 12/31/2019		norod.
				10 12/31/2019	6/29/2020 9:0	
		Title	XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
		5.00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	0	E17 010		0 5 445 245	0. 095004	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	517, 318		0 5, 445, 245 0 1, 085, 196		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 1, 085, 196 0 12, 231, 451		
60. 00 06000 LABORATORY	0	0		0 12, 231, 451		
64. 00 06400 INTRAVENOUS THERAPY	0	0		0 5, 935, 659		
65. 00 06500 RESPIRATORY THERAPY	0	0		0 1, 289, 470		1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 537, 943		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 537, 943		1
68. 00 06800 SPEECH PATHOLOGY	0	0		0 201, 996		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 152, 990		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 94,034		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 8, 393, 884		1
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0		0 0, 0, 0, 001	0.000000	1
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0. 000000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0, 000000	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0. 000000	
OUTPATIENT SERVICE COST CENTERS				· .		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.00000	88.00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0		0 0	0.000000	89.00
90. 00 09000 CLINIC	0	0		0 64, 394	0. 000000	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0 660, 046	0. 000000	90.01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0		0 0	0. 000000	90.02
91.00 09100 EMERGENCY	0	0		0 20, 666, 246	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 4, 393, 888	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	517, 318		0 64, 218, 485		200. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-1306	Period: From 01/01/2019	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2019		pared:
				10 12/01/2017	6/29/2020 9:0	3 am
			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-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	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	T		-	[-	
50.00 05000 OPERATI NG ROOM	0. 000000	5, 679		40 C	-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	· · · · · · · · · · · · · · · · · · ·	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	50, 818		0 0	0 0	
60.00 06000 LABORATORY	0. 000000	69, 597		0 0	0 0	
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	72, 102		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	18, 634		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 841		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 067		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	121, 697		0 0	0	
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	-	
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0 0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0.000000	0		0 0	0	90.01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0.000000	0		0 0	0	90.02
91. 00 09100 EMERGENCY	0.000000	5, 221		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1, 050		0 0	0 0	92.00
OTHER REIMBURSABLE COST CENTERS			-			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		348, 706	5	40 C	0 0	200.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2019	Worksheet D Part V	
				To 12/31/2019	Date/Time Pre 6/29/2020 9:0	pared: 3 am
		Title	e 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.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		-		-1 -	-	
50. 00 05000 OPERATING ROOM	0. 439557		., =		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 211384				0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 229432		3, 636, 18		0	54.00
60. 00 06000 LABORATORY	0. 420798				0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 135362		544, 21		0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 587116		345, 53		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 747720		486, 22		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 628423	0	52, 71		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 712861	0	4,65		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 535917				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 678606				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 352409		3, 730, 94	0 968	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000			0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0. 000000			0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			0 0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1	1	1	- 1		
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
90. 00 09000 CLINIC	2. 175498				0	
90.01 09001 VISITING SPECIALTY CLINIC	1. 333846		344, 07	3 0	0	90.01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000			0 0	0	90.02
91. 00 09100 EMERGENCY	0. 240820				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 421207	0	1, 933, 61	7 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)		0	19, 701, 73	5 1, 303	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	19, 701, 73	5 1, 303	0	202.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provider C		Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pr 6/29/2020 9:	epared: 03 am
		Title	XVIII	Hospi tal	Cost	
		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			1			_
50. 00 05000 OPERATI NG ROOM	535, 413		1			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 843					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	834, 258					54.00
60. 00 06000 LABORATORY	755, 074	0				60.00
64.00 06400 INTRAVENOUS THERAPY	73, 666	0				64.00
65. 00 06500 RESPI RATORY THERAPY	202, 866					65.00
66. 00 06600 PHYSI CAL THERAPY	363, 557	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	33, 129					67.00
68.00 06800 SPEECH PATHOLOGY	3, 318	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 125	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 510	0)			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 314, 817	341				73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0				73.01
74.00 07400 RENAL DIALYSIS	0	0)			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0)			75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0)			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00 09000 CLINIC	77, 469	0				90.00
90.01 09001 VISITING SPECIALTY CLINIC	458, 940	0				90.01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0				90.02
91.00 09100 EMERGENCY	1, 331, 299	81				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	814, 453					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	6, 821, 737	422				200.00
201.00 Less PBP Clinic Lab. Services-Program						201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	6, 821, 737	422	1			202.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 01/01/2019 To 12/31/2019		paradi
		component	CCN: 15-Z306	To 12/31/2019	6/29/2020 9:0	
		Title	e XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Nursing Schoo	Allied Health		
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS		-	1	-	-	
50. 00 05000 OPERATI NG ROOM	517, 318	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.01
74. 00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					-	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0 0	0	90.01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0		0 0	0	90. 02
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	517, 318	0		0 0	0	200.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2019		norod.
		Component	CCN: 15-Z306	To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
·		Title	XVIII	Swing Beds - SNF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(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	1					
50. 00 05000 OPERATI NG ROOM	0	517, 318		0 5, 445, 245		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 085, 196		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 231, 451		
60. 00 06000 LABORATORY	0	0		0 5, 935, 659		
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 1, 719, 044		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 289, 470		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 537, 943		1
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 346, 999		
68.00 06800 SPEECH PATHOLOGY	0	0		0 201, 996		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 152, 990		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 94, 034		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 8, 393, 884		
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0 0	0. 000000	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0. 000000	1
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS	1	r		1		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000	89.00
90. 00 09000 CLINIC	0	0		0 64, 394		
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0 660, 046		1
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0		0 0		1
91. 00 09100 EMERGENCY	0	0		0 20, 666, 246		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 4, 393, 888	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVI CES	_					95.00
200.00 Total (lines 50 through 199)	0	517, 318	l	0 64, 218, 485		200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1306 Period: For 12/31/2019 Period: Part IV Date TTHE Program Program Charges (col. 6 + col. 7) Worksheet D Part IV Date TTHE XVIII Cost Center Description Outpatient to Charges (col. 6 + col. 7) Outpatient Program Charges (col. 6 + col. 7) Swing Beds - SNF Cost 50.00 OSC00 OPERATING ROOM 052000 OPERATING ROOM 0.000000 0 0	Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
Annobal Solo Component CCN: 15-2306 To D 12/31/2019 Date/Time Prepared: 6/29/2020 9:03 am Cost Center Description Outpatient Ratio of Cost (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Outpatient Program Casts (col. 8 x col. 10) Outpatient Program Charges Outpatient Program Casts (col. 8 x col. 10) Outpatient Program Casts (col. 9 x col. 12) 0.00 0 </td <td>APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF</td> <td>RVICE OTHER PASS</td> <td>Provider C</td> <td>CN: 15-1306</td> <td></td> <td></td> <td></td>	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-1306			
ANCI LLARY SERVICE COST CENTERS Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges (col. 6 + col. 7) Inpatient Program Charges Outpatient Program Charges 50.00 05000 (DPERATI NG ROOM 0.000000 0	THROUGH COSTS			00N 45 700/			
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges (col. 6 + col. 7) Inpatient Program Charges Outpatient Program Charges Program Charges Cost Costs (col. 8 ANCILLARY SERVICE COST CENTERS 9,00 10.00 11.00 12.00 13.00 50:00 05000 PERATING ROM 0.000000 0 0 0 50.00 50:00 05000 PERATING ROM 0.000000 0 0 0 0 52.00 50:00 05000 REAPTING ROM 0.000000 0 0 0 52.00 0 0 0 52.00 0 0 0 52.00 0 0 0 52.00 0 0 0 0 52.00 0			Component (LCN: 15-Z306	10 12/31/2019		pared: 3 am
Ratio of Cost to Charges Program Charges Program Costs (col. 8 x col. 10) Program Charges Program Costs (col. 8 x col. 10) Program Costs (col. 2) ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 S000 05000 OPERATING ROOM 0.000000 0 0 0 52.00 S100 05000 OPERATING ROOM 0.000000 0 0 0 52.00 S4.00 05000 OPERATING ROOM 0.000000 0 0 0 52.00 S4.00 054.00 05400 RADIOLOGY-DI AGNOSTIC 0.000000 14.03 0 0 66.00 S6000 RESPI RATORY 0.000000 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 68.00 66.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 71.00			Title	XVIII	Swing Beds - SNF		<u>5 ann</u>
to to Charges (col. 6 + col. 7) Charges (col. 6 + col. 7) Charges (col. 10) Pass-Through Costs (col. 9 x col. 10) Pass-Through Costs (col. 9 x col. 10) ANCILLARY SERVICE COST CENTERS 0.000000 0 10.00 11.00 12.00 13.00 50.00 05000 0FEATING ROOM 0.000000 0 0 0 50.00 52.00 52.00 05.000 0 0 0 0 50.00 54.00 05400 RANDI U.0CY-DI AGNOSTI C 0.000000 0 0 0 54.00 60.00 06000 LABOR ROAM 0.000000 0 0 0 64.00 66.00 06000 LABORATORY 0.000000 615 0 0 66.00 0.0500 PESH RATORY THERAPY 0.000000 28.652 0 0 66.00 0.0700 DCCUPATI ONAL THERAPY 0.000000 0 0 66.00 0.0700 DCUPATI ONAL THERAPY 0.000000 0 0 0 71.00 <t< td=""><td>Cost Center Description</td><td>Outpati ent</td><td>Inpati ent</td><td>Inpati ent</td><td>Outpati ent</td><td>Outpati ent</td><td></td></t<>	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$		Ratio of Cost	Program	Program	Program	Program	
T) x col 10) x col 12) 9.00 10.00 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 0.000000 0		to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 OPERATING ROM 0.000000 0 0 0 50.00 52.00 05200 DELI VERY ROM & LABOR ROM 0.000000 0 0 0 52.00 54.00 05400 RADIOLOGY-DI AGNOSTI C 0.000000 4.228 0 0 0 54.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 10.403 0 0 66.00 65.00 06500 RSPI RATORY THERAPY 0.000000 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 28,652 0 0 0 67.00 68.00 06800 SPECH PATHOLOCY 0.000000 0 0 0 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
ANCLILLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
50.00 05000 0PERATING ROOM 0.000000 0 0 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 52.00 64.00 06400 RADIOLOGY-DI AGNOSTI C 0.000000 10,403 0 0 0 64.00 64.00 06400 INTRAVENUS THERAPY 0.000000 0 0 0 65.00 65.00 06500 RESPIRATORY THERAPY 0.000000 615 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 28,652 0 0 0 66.00 0 66.00 0 66.00 0 66.00 0 66.00 0 66.00 0 66.00 0 0 0 0 67.00 68.00 SPECH PATHOLOGY 0.000000 0 0 0 0 67.00 0 68.00 71.00 0 71.00 0 72.00 0 0 67.00 0 0 73.01 73.01 73.01 73.01		9.00	10.00	11.00	12.00	13.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 4,228 0 0 0 54.00 60.00 06000 LABORATORY 0.000000 0		r			-	1	
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 4,228 0 0 0 60.00 60.00 06000 LABORATORY 0.000000 10,403 0 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0.000000 615 0 0 66.00 67.00 06700 (DCUPATI ONAL THERAPY 0.000000 8,029 0 0 66.00 67.00 06700 (DCUPATI ONAL THERAPY 0.000000 0 0 0 68.00 71.00 07100 MEDI AL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 73.01 07300 DRUGS CHARGED TO			0		0 0	0	
60.00 06000 LABORATORY 0.000000 10,403 0 0 60.00 64.00 06400 INTRAVENUUS THERAPY 0.000000 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 615 0 0 64.00 65.00 06600 PHYSI CAL THERAPY 0.000000 28,652 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 8,029 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 74.00 07400 RENAL DI ALYSIS 0.000000 0 0 0 74.00 76.97 CARDI AC REHABILI TATI ON 0.0			0		0 0	0	52.00
64.00 06400 INTRAVENOUS THERAPY 0.00000 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0.000000 615 0 0 65.00 66.00 06700 0C0700 28,652 0 0 66.00 66.00 67.00 06700 0C0PATI ONAL THERAPY 0.000000 28,652 0 0 67.00 67.00 68.00 0 67.00 0 0 67.00 68.00 0 68.00 0 68.00 0 68.00 0 0 0 0 0 0 0 0 72.00 07.00 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 07.300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 73.00 73.00 73.01 73.01 73.01 73.01 73.01 73.01 74.00 74.00 74.00 74.00 74.00 74.00 74.00 76.97 76.97 76.97 76.97 76.97 76.97 76.97 76.97 97.00 0 <		0. 000000	4, 228		0 0	0	54.00
65.00 06500 RESPI RATORY THERAPY 0.000000 615 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 28,652 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0.000000 8,029 0 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 73.00 07300 REMAGED TO PATI ENTS 0.000000 0 0 0 73.01 74.00 07400 RENAL DI ALYSIS 0.000000 0 0 0 74.00 75.00 0500 RESOR (INN-L) IST INCT PART) 0.000000 0 0 0 75.00 76.97 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 76.97 00170 OTFORT CARDI AC REH	60. 00 06000 LABORATORY	0. 000000	10, 403		0 0	0	60.00
66.00 06600 PHYSI CAL THERAPY 0.000000 28,652 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 8,029 0 0 0 67.00 68.00 05800 SPEECH PATHOLOGY 0.000000 0 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.01 O7301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 73.01 O7301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 74.00 O7400 RENAL DI ALYSIS 0.000000 0 0 0 74.00 74.00 0 74.00 0 74.00 74.00 74.00 74.00 75.00 76.97 75.00 76.97 75.00 76.97 76.97 76.97 76.97 76.97 76.97 76.97					0 0	0	
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68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 68.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 55,180 0 0 73.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 73.01 75.00 07697 CARDI AC REHABILITATI ON 0.000000 0 0 0 75.00 76.97 O7697 CARDI AC REHABILITATI ON 0.000000 0 0 0 75.00 70.00 D8900 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 89.00 08900 RURAL HEALTH CLINIC 0.000000 0 0 0 90.00 90.00 90.00 90.00 90.00 9	66. 00 06600 PHYSI CAL THERAPY	0. 000000	28, 652		0 0	0	66.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.01 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 73.01 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 75.00 76.97 CARDI AC REHABILITATION 0.000000 0 0 0 76.97 00000 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 90.00 90.01 09000 VISITING SPECIALTY CLINIC 0.000000 0 0 0 0 90.00 90.01 09000 <	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	8, 029		0 0	0	67.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 55,180 0 0 0 73.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 0 0 0 0 75.00	68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 55, 180 0 0 0 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 73.01 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 0 75.00 76.97 CARDI AC REHABILITATION 0.000000 0 0 0 0 0 75.00 76.97 CARDI AC REHABILITATI ON 0.000000 0 0 0 0 76.97 0017801 BRUCC COST CENTERS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.01 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 0 75.00 76.97 OT697 CARDIA C REHABILITATION 0.000000 0 0 0 0 76.97 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.00 99.00 O9000 CLINIC 0.000000 0 0 0 90.00 <td>72.00 07200 IMPL. DEV. CHARGED TO PATIENTS</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>72.00</td>	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 0 75.00 76.97 07697 CARDIA C REHABILITATION 0.000000 0 0 0 0 76.97 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 89.00 90.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.01 09001 VISITING SPECIALTY CLINIC 0.000000 0 0 90.01 90.02 9002 PAOLI PRIMARY CARE CLINIC 0.000000 0 0 0 90.02 91.00 09100 EMERGENCY 0.000000 0 0 0 0 91.00 92.00 09200 DSERVATION BEDS (NON-DI ST	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	55, 180		0 0	0	73.00
75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 0 75.00 75.00 76.97 07697 CARDI AC REHABILI TATI ON 0.000000 0 0 0 0 0 75.00 000000000000000000000000000000000000	73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.01
76. 97 07697 CARDI AC REHABILITATION 0.000000 0 0 0 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 88.00 90.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.01 09001 VISITING SPECIALTY CLINIC 0.000000 0 0 0 90.01 90.02 09002 PAOLI PRIMARY CARE CLINIC 0.000000 0 0 0 90.02 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 91.00 92.00 0 0 0 91.00 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 92.00 92.00	74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 0 89.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.10 09000 CLINIC 0.000000 0 0 0 90.00 90.01 09001 VISITING SPECIALTY CLINIC 0.000000 0 0 0 90.01 90.02 09002 PAOLI PRIMARY CARE CLINIC 0.000000 0 0 0 90.02 91.00 09100 ERGENCY 0.000000 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00	75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.01 09000 IVISITING SPECIALTY CLINIC 0.000000 0 0 0 90.01 90.02 09002 PAOLI PRI MARY CARE CLINIC 0.000000 0 0 0 90.02 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 0 92.00 09200 DESERVATION BEDS COST CENTERS 95.00 0 0 0 92.00	76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76.97
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.01 09000 CLINIC 0.000000 0 0 0 90.00 90.01 09001 VISITING SPECIALTY CLINIC 0.000000 0 0 0 90.01 90.02 09002 PAOLI PRIMARY CARE CLINIC 0.000000 0 0 0 90.02 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0 0 0 92.00 01HER REI MBURSABLE COST CENTERS 0 0 0 0 92.00 95.00 95.00	OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC 0.00000 0 0 0 0 90.00 90.01 09001 VISITING SPECIALTY CLINIC 0.000000 0 0 0 90.01 90.02 09002 PAOLI PRIMARY CARE CLINIC 0.000000 0 0 0 90.02 91.00 09100 EMERGENCY 0.000000 0 0 0 90.02 92.00 085ERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 0 92.00 07HER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
90.01 09001 VISITING SPECIALTY CLINIC 0.00000 0 0 0 90.01 90.02 09002 PAOLI PRIMARY CARE CLINIC 0.000000 0 0 0 90.02 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.000000 0 0 0 92.00 01HER REIMBURSABLE COST CENTERS 95.00 950.0 MBULANCE SERVICES 95.00		0. 000000	0		0 0	0	89.00
90. 02 09002 PAOLI PRI MARY CARE CLINIC 0.000000 0 0 0 90. 02 91. 00 09100 EMERGENCY 0.000000 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 9500 AMBULANCE SERVICES 95. 00 95. 00 95. 00	90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 91.00 92.00 92.00 00 0 0 0 92.00	90.01 09001 VISITING SPECIALTY CLINIC	0. 000000	0		0 0	0	90.01
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	90.02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000	0		0 0	0	90.02
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199) 107, 107 0 0 0 200.00							
	200.00 Total (lines 50 through 199)		107, 107		0 0	0	200. 00

Health Financial Systems	IU HEALTH PAOL			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
		Component		From 01/01/2019 To 12/31/2019	Part V	narod
		component	CCN: 15-Z306	10 12/31/2019	Date/Time Pre 6/29/2020 9:0	aneu: 13 am
		Title	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	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0. 439557	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 211384	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 229432	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 420798	0		0 0	0	
64.00 06400 I NTRAVENOUS THERAPY	0. 135362	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 587116	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 747720	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 628423	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 712861	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 535917	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 678606	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 352409	0		0 0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90. 00 09000 CLINIC	2. 175498	0		0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	1. 333846	0		0 0	0	90.01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000	0		0 0	0	90.02
91.00 09100 EMERGENCY	0. 240820	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 421207	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			_			
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
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		0 0	0	202.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-25	52-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1306	Peri od:	Worksheet D	
			001 45 700/	From 01/01/2019	Part V	
		Component	CCN: 15-Z306	To 12/31/2019	Date/Time Prepa 6/29/2020 9:03	
		Title	× XVIII	Swing Beds - SNF	Cost	an
	Cos		1	10		
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS	-	-	1			
50. 00 05000 OPERATING ROOM	0	-	•			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0				73.01
74.00 07400 RENAL DIALYSIS	0	0				74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	-				75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			7	76. 97
OUTPATIENT SERVICE COST CENTERS	-	-	1			
88.00 08800 RURAL HEALTH CLINIC	0					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 VISITING SPECIALTY CLINIC	0	0				90.01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	0				90.02
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0			,	92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0		1			
	0					95.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program	0	0				00.00 01.00
5	0				20	J I. UU
Only Charges202.00Net Charges (line 200 - line 201)	0	0			2	02.00
202.00 met charges (The 200 - The 201)	1 0	1 0	1		120	JZ. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS Provider CCN: 15-1306 Period: From 01/01/2019 To 12/31/2019 Worksheet D Part I 0 dze/Time Prepar 6/29/2020 9:03 dze/Time Prepar 7	·ed:
To 12/31/2019 Date/Time Prepare/ 6/29/2020 9:03 a Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Swing Bed Adjustment Reduced Capital Related Cost (col. 1 - col. 2) Total Patient Days Per Diem (col. 3 / col. 4)	ed:
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. Swing Bed Adjustment Reduced Related Cost (col. 1 - col. Total Patient Days Per Diem (col. 3 / col. 4)	red:
Title XIXHospitalPPSCost Center DescriptionCapital Related Cost (from Wkst. B, Part II, col.Swing Bed AdjustmentReduced Capital Related Cost (col. 1 - col.Total Patient DaysPer Diem (col. Days3 / col. 4)	
Cost Center DescriptionCapital Related Cost (from Wkst. B, Part II, col.Swing Bed AdjustmentReduced Capital Related Cost (col. 1 - col.Total Patient DaysPer Diem (col. 3 / col. 4)	1111
Related CostAdjustmentCapitalDays3 / col. 4)(from Wkst. B, Part II, col. 26)(col. 1 - col. 2)2)	
(from Wkst. B, Part II, col.Related Cost (col. 1 - col.26)2)	
Part II, col. (col. 1 - col. 2)	
26) 2)	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 ADULTS & PEDI ATRI CS 425, 293 35, 165 390, 128 1, 359 287. 07 3	0.00
31.00 INTENSIVE CARE UNIT 0 0 0.00 3	1.00
43. 00 NURSERY 15, 513 15, 513 215 72. 15 4	3.00
200.00 Total (lines 30 through 199) 440,806 405,641 1,574 20	0. 00
Cost Center Description Inpatient Inpatient	
Program days Program	
Capital Cost	
(col. 5 x col.	
6)	
6.00 7.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
	0.00
31.00 I NTENSI VE CARE UNI T 0 0 3	1.00
	3.00
200.00 Total (lines 30 through 199) 49 7,833 20	0.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1306	Peri od:	Worksheet D	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/29/2020 9:0	pared:
		Titl	e XIX	Hospi tal	PPS	5 am
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	-		- F		
50. 00 05000 OPERATI NG ROOM	255, 680					
52.00 05200 DELIVERY ROOM & LABOR ROOM	13, 323					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	256, 242					
60. 00 06000 LABORATORY	97,663				405	
64.00 06400 INTRAVENOUS THERAPY	22, 245				-	64.00
65. 00 06500 RESPI RATORY THERAPY	29, 952				70	
66. 00 06600 PHYSI CAL THERAPY	146, 573				0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	32, 609				0	67.00
68.00 06800 SPEECH PATHOLOGY	21, 618				0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 478	152, 990	0. 03580	6 929	33	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 255				Ũ	
73.00 07300 DRUGS CHARGED TO PATIENTS	88, 171	8, 393, 884			280	
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.00000	0 0	0	73.01
74. 00 07400 RENAL DIALYSIS	0	0	0.00000	0 0	0	74.00
75.00 07500 ASC (NON-DI STI NCT PART)	0	0	0.00000		0	75.00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89.00
90. 00 09000 CLINIC	3, 454				0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	145, 697	660, 046			0	90.01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0	0.00000		0	90.02
91. 00 09100 EMERGENCY	268, 434				69	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	190, 901	4, 393, 888	0. 04344	7 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	1, 582, 295	64, 218, 485		186, 450	4, 778	200.00

Health Financial Systems	IU HEALTH PAOL	I HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School N Post-Stepdown Adjustments 1A	ursing School	Allied Health Post-Stepdowr Adjustments 2A		All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	28	2.00	3.00	-
All ENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	000000000000000000000000000000000000000	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	31.00
Cost Center Description	Adjustment (Amount (see instructions) m	Total Costs (sum of cols. 1 through 3, hinus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	000000000000000000000000000000000000000	21	0 0.00 5 0.00	0 29	31.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			·1	· · · · ·	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0 0 0 0					30.00 31.00 43.00 200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR THROUGH COSTS	I U HEALTH PAO Y SERVI CE OTHER PASS			Period: From 01/01/2019 To 12/31/2019		pared:
		Titl	e XIX	Hospi tal	PPS	<u>o un </u>
Cost Center Description	Non Physi ci an			Allied Health		
		Post-Stepdown	J	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	517, 318	C		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	C		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	TS 0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	l o	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1	·	. · · · ·	
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0	89.00
90. 00 09000 CLINIC	0	C		0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	C		0 0	0	90.01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	C		0 0	0	90.02
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	ТО			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	517, 318	C		0 0	0	200.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	6/29/2020 9:0	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATING ROOM		517, 318		0 5, 445, 245	0. 095004	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	517, 316		0 1, 085, 196		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 231, 451		54.00
60. 00 06000 LABORATORY	0	0		0 5, 935, 659		60.00
64. 00 06400 INTRAVENOUS THERAPY				0 1, 719, 044		64.00
65. 00 06500 RESPIRATORY THERAPY				0 1, 289, 470		
66. 00 06600 PHYSI CAL THERAPY	0			0 1, 537, 943		
67. 00 06700 OCCUPATI ONAL THERAPY				0 346, 999		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 201, 996		68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 152, 990		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 94,034		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 8, 393, 884		
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0		0 0	0. 000000	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.000000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000	89.00
90. 00 09000 CLINIC	0	0		0 64, 394	0.000000	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0 660, 046		90.01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0		0 0		
91. 00 09100 EMERGENCY	0	0		0 20, 666, 246		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 4, 393, 888	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1			
95. 00 09500 AMBULANCE SERVICES		E47.010				95.00
200.00 Total (lines 50 through 199)	0	517, 318	l	0 64, 218, 485		200. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-1306	Period: From 01/01/2019	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2019		pared.
				10 12/01/2017	6/29/2020 9:0	3 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col. 10)	40.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	0.000000	(7 5 4	()	10		
50. 00 05000 OPERATING ROOM	0.000000	67, 564			-	
52.00 05200 DELIVERY ROOM & LABOR ROOM		54, 555		0 0	-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 763		0 0	0	
	0. 000000	24, 611		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0. 000000 0. 000000	0		0 0	0	
	0.000000	3, 017		0 0	0	•
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0. 000000	0		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0.000000	0		0 0	0	67.00
	0.000000	929		0 0		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL, DEV. CHARGED TO PATIENTS	0.000000	929		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	26, 689		0 0	0	
73. 01 07301 DRUGS CHARGED TO PATTENTS	0.000000	20, 009		0 0	0	
74.00 07400 RENAL DIALYSIS	0.000000	0		0 0	0	
75. 00 07500 ASC (NON-DI STI NCT PART)	0.000000	0				
76. 97 07697 CARDIAC REHABILITATION	0.000000	0				
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0 0	/0. 7/
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0			0	
90. 00 09000 CLINIC	0. 000000	0		0 0	0	
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000	0		0 0	0	
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000	0		0 0	0	
91. 00 09100 EMERGENCY	0. 000000	5, 322		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0,022		0 0	-	•
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		186, 450	6, 4	19 0	0	200.00
						•

)MPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 15-1306	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hospi tal	6/29/2020 9:0 Cost	3 ar
	Cost Center Description				
	PART I – ALL PROVIDER COMPONENTS			1.00	
	NPATI ENT DAYS		1		
	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 627 1, 359	
	Private room days (excluding private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days,	1, 337	
	do not complete this line.		<u> </u>		
	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	694 116	4
	reporting period	on days) thi dugh becenbe	a si oi the cost	110	
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m dave) through December	31 of the cost	152	-
	reporting period	in days) through becchiber	ST OF the cost	152	'
	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	a the Program (aveluding	swing bod and	223	Ģ
	newborn days) (see instructions)		J Swillig-bed and	225	
	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	116	10
	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	''
	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12
	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar y			0	
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16
	SWING BED ADJUSTMENT			0	
	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost		17
	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18
	reporting period				
	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	118.90	19
	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction			4, 123, 090	
	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	er 31 of the cost report	ing 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) Swing-bed cost applicable to NF type services through Decembe	r 21 of the cost reporti	ng pariod (line	18, 073	2
	7 x line 19)	a si oi the cost reporti	ng period (inne	10, 073	24
	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)			340, 908	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 782, 182	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cr	arges)	0	28
	Semi -private room charges (excluding swing bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
00	Average per diem private room cost differential (line 34 x li			0.00	35
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and privato room cost di	fforential (line	0 3 782 182	36
	27 minus line 36)	and private room cost di		3, 782, 182	37
Ī	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		1	2 702 04	1
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		2, 783. 06 620, 622	
	Medically necessary private room cost applicable to the Progr	-		020, 022	40
. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		620, 622	41

OMPUT	TATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1306	Peri od:	Worksheet D-1	
					From 01/01/2019 To 12/31/2019		epare
						6/29/2020 9:0	
	Cost Center Description	Total	litle Total	XVIII Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
				col . 2)		4)	
00		1.00	2.00	3.00	4.00	5.00	10
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42
. 00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43
. 00	CORONARY CARE UNIT		-			_	44
. 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 cost (Wk	st. D-3, col. 3,	line 200)	-		146, 922	48
. 00		41 through 48)(s	ee instructio	ns)		767, 544	49
~~	PASS THROUGH COST ADJUSTMENTS			What D av	n ef Dente I and		
. 00	Pass through costs applicable to Program inp	atient routine s	ervices (Trom	WKST. D, SU	m of Parts I and	0	50
. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51
	and IV)	5					
. 00	Total Program excludable cost (sum of lines		- 4 1			0	
. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		ated, non-phy	sician anest	hetist, and	0	53
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndina 1996. u	pdated and c	ompounded by the	-	
	market basket						
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(TTHES 54 X	00), 01 1% 0	i the target		
2. 00	Relief payment (see instructions)					0	62
. 00		ent (see instruc	tions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Dooom	han 21 of the	aget report	ing pariod (Caa	222.025	
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through becell	ber 31 OF the	cost report	ing period (see	322, 835	04
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	g period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	322, 835	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	f the cost r	eporting period	0	67
. 00	(line 12 x line 19)	e costs through			opor tring porrou		
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)			(0)			
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69
. 00	Skilled nursing facility/other nursing facil)		7 70
. 00	Adjusted general inpatient routine service c	2			÷		71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost applic						73
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74
	26, line 45)	Satine service	55513 (TTOM W	STREET D,			'
. 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	,	oviden noto				78
00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 70)		80
. 00	Inpatient routine service costs for comp						81
. 00	Inpatient routine service cost limitation (I						82
. 00	Reasonable inpatient routine service costs ()				83
. 00	Program inpatient ancillary services (see in						84
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					1	
. 00	Total observation bed days (see instructions					665	87
	Adjusted general inpatient routine cost per	diem (line 27 ∸	line 2)			2, 783. 06	88 18
. 00 . 00	Observation bed cost (line 87 x line 88) (se	•				1, 850, 735	

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		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	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	425, 293	4, 123, 090	0. 10314	9 1, 850, 735	190, 901	90.00
91.00 Nursing School cost	0	4, 123, 090	0.00000	0 1, 850, 735	0	91.00
92.00 Allied health cost	0	4, 123, 090	0.00000	0 1, 850, 735	0	92.00
93.00 All other Medical Education	0	4, 123, 090	0. 00000	0 1, 850, 735	0	93.00

	Financial Systems IU HEALTH PAOLI HOSPITAL ATION OF INPATIENT OPERATING COST Provider CCN:	15-1306	Period: From 01/01/2019 To 12/31/2019	u of Form CMS-2 Worksheet D-1 Date/Time Pre 6/29/2020 9:00	pare
	Title X	(I X	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed days, excluding ne	ewborn)		1, 627	1
00	Inpatient days (including private room days, excluding swing-bed and newbor	n days)		1, 359	2
00	Private room days (excluding swing-bed and observation bed days). If you hav do not complete this line.	/e only pri	vate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation bed days)			694	4
00	Total swing-bed SNF type inpatient days (including private room days) throug	gh December	31 of the cost	116	
~~	reporting period	December (1 of the east	0	
00	Total swing-bed SNF type inpatient days (including private room days) after reporting period (if calendar year, enter 0 on this line)	December 3	si oi the cost	0	6
00	Total swing-bed NF type inpatient days (including private room days) through	n December	31 of the cost	152	7
00	reporting period)	-6		
00	Total swing-bed NF type inpatient days (including private room days) after D reporting period (if calendar year, enter 0 on this line)	Jecember 3	or the cost	0	8
00	Total inpatient days including private room days applicable to the Program ((excl udi ng	swing-bed and	20	9
00	newborn days) (see instructions)			0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including through December 31 of the cost reporting period (see instructions)	private ro	oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including		oom days) after	0	11
00	December 31 of the cost reporting period (if calendar year, enter 0 on this			0	1.
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (includi through December 31 of the cost reporting period	ng private	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (includi			0	13
00	after December 31 of the cost reporting period (if calendar year, enter 0 or Medically necessary private room days applicable to the Program (excluding s			0	1
	Total nursery days (title V or XIX only)	swing-bea d	lays)	215	14 15
	Nursery days (title V or XIX only)				16
~~~	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to services through Dece reporting period	ember 31 of	the cost		17
. 00	Medicare rate for swing-bed SNF services applicable to services after Decemb	ber 31 of t	he cost		18
	reporting period			110.00	
. 00	Medicaid rate for swing-bed NF services applicable to services through Decem reporting period	nder 31 of	the cost	118.90	
. 00	Medicaid rate for swing-bed NF services applicable to services after December	er 31 of th	ne cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instructions)			4 122 000	21
	Swing-bed cost applicable to SNF type services through December 31 of the co	ost reporti	na period (line	4, 123, 090 0	22
	5 x line 17)			-	
. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost x line 18)	reportinț	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 31 of the cost	st reportir	na period (line	18, 073	24
	7 x line 19)		51 (		
. 00	Swing-bed cost applicable to NF type services after December 31 of the cost x line 20)	reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			340, 908	26
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus	line 26)		3, 782, 182	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observati	on had ahr	vrace)	0	28
	Private room charges (excluding swing-bed charges)		ii ges)	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) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 minus line 33)(se	e instruct	i ons)	0.00	
	Average per diem private room cost differential (line 34 x line 31)			0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private roo	m cost dit	ferential (line)	0 3 782 182	36
. 00	27 minus line 36)	m cost ul l		3, 782, 182	3/
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY				1
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			2 702 04	
	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)			2, 783. 06 55, 661	
	Medically necessary private room cost applicable to the Program (line 14 x l	ine 35)		0	40
	Total Program general inpatient routine service cost (line 39 + line 40)			55, 661	41

MPUTATION OF INP	ATIENT OPERATING COST		Provider C	CN: 15-1306	Period:	Worksheet D-1	1
					From 01/01/2019 To 12/31/2019	Date/Time Pre	
				e XIX	Hospi tal	6/29/2020 9:0 PPS	03 am
Cost C	enter Description	Total	Total	Average Per		Program Cost	
		Inpatient Costl	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	+
. 00 NURSERY (ti	le V & XIX only)	196,099	215				42.
Intensive Ca	re Type Inpatient Hospital Unit				-		
. 00 INTENSIVE CA		0	0	0.0	0 00	C	
. 00 CORONARY CAI							44
	VE CARE UNIT ENSIVE CARE UNIT						45
	L CARE (SPECIFY)						47
	enter Description						
00 0			1.1 000)			1.00	10
	tient ancillary service cost (W m inpatient costs (sum of lines			nc)		65, 405 147, 517	
	COST ADJUSTMENTS	5 41 through 40)(S		115)		147, 517	47
	costs applicable to Program in	patient routine s	ervices (from	Wkst. D, sur	n of Parts I and	7, 833	50
111)							
U U	costs applicable to Program in	patient ancillary	services (fr	om Wkst. D, s	sum of Parts II	11, 197	51
and IV) .00 Total Progra	m excludable cost (sum of lines	50 and 51)				19.030	52
	m inpatient operating cost excl		ated, non-phy	sician anesth	netist, and	128, 487	
	ation costs (line 49 minus line	52)	. ,				
	T AND LIMIT COMPUTATION						1 = 4
.00 Program dise .00 Target amou	narges it per discharge					0.00	
5	it (line 54 x line 55)					0.00	
	etween adjusted inpatient opera	ting cost and tar	get amount (I	ine 56 minus	line 53)	C	
	t (see instructions)					C	
.00 Lesser of Li market bask	nes 53/54 or 55 from the cost r	reporting period e	nding 1996, u	pdated and co	ompounded by the	0.00	59
	nes 53/54 or 55 from prior year	cost report. upd	ated by the m	arket basket		0.00	60
	4 is less than the lower of lin				the amount by	C	
	ing costs (line 53) are less th		(lines 54 x	60), or 1% of	f the target		
	e 56), otherwise enter zero (see	e instructions)					62
	ent (see instructions) upatient cost plus incentive pay	ment (see instruc	tions)				
	TIENT ROUTINE SWING BED COST						
	ng-bed SNF inpatient routine co	sts through Decem	ber 31 of the	cost reporti	ng period (See	C	64
	s)(title XVIII only) ng-bed SNF inpatient routine co	ote ofter Decembe	r 21 of the $c$	act reporting	a pariod (Saa		65
	s) (title XVIII only)	ISTS ATTEL DECEMBE		σει τεροιτιτή	g period (see		
	ire swing-bed SNF inpatient rout	ine costs (line 6	4 plus line 6	5)(title XVII	I only). For	c c	66
CAH (see ins							
	(IX swing-bed NF inpatient routi	ne costs through	December 31 c	f the cost re	eporting period	C	67
(line 12 x ) 3.00 Title V or 2	(IX swing-bed NF inpatient routi	ne costs after De	cember 31 of	the cost rep	orting period		68
(line 13 x				110 0001 Fopt	si ting por ou		
	V or XIX swing-bed NF inpatient					C	69
	KILLED NURSING FACILITY, OTHER				<b>`</b>	1	
	ing facility/other nursing faci meral inpatient routine service				)		70
	ine service cost (line 9 x line			/			72
-	cessary private room cost appli						73
Ŭ	m general inpatient routine ser	•			Dort II or !!!!!		74
00 Capital-rel 26, line 45	ited cost allocated to inpatient	Toutine service	LUSIS (TROM W	UIKSNEET B, H	aitií, column		75
	nital-related costs (line 75 ÷ l	ine 2)					76
.00 Program cap	tal-related costs (line 9 x lin	,					77
	outine service cost (line 74 min						78
00 0	arges to beneficiaries for exce				aus lino 70)		80
Ű	m routine service costs for com outine service cost per diem lim	•	st i i i i i i i i i i i i i i i i i i i		103 I I I E /7)		80
	outine service cost limitation (						82
	npatient routine service costs	·	)				83
	tient ancillary services (see i		``````````````````````````````````````				84
	review - physician compensation						85
	m inpatient operating costs (su MPUTATION OF OBSERVATION BED PA		ougn 85)			I	86
	ation bed days (see instruction					665	5 87
	eral inpatient routine cost per	diem (line 27 ÷	line 2)			2, 783. 06	88
, ,	bed cost (line 87 x line 88) (s					1, 850, 735	

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	425, 293	4, 123, 090	0. 10314	9 1, 850, 735	190, 901	90.00
91.00 Nursing School cost	0	4, 123, 090	0.00000	0 1, 850, 735	0	91.00
92.00 Allied health cost	0	4, 123, 090	0.00000	1, 850, 735	0	92.00
93.00 All other Medical Education	0	4, 123, 090	0.00000	1, 850, 735	0	93.00

Health Financial Systems IU HEALTH PAOL	I HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1306	Peri od:	Worksheet D-3	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	$(col \cdot 1 \times col \cdot$	
			g	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			437, 953		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 4395	57 5, 679	2, 496	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2113	84 O	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2294	32 50, 818	11, 659	54.00
60. 00 06000 LABORATORY		0. 4207	98 69, 597	29, 286	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 1353	62 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 5871	16 72, 102	42, 332	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 7477	20 18, 634	13, 933	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6284	23 1, 841	1, 157	67.00
68.00 06800 SPEECH PATHOLOGY		0. 7128	61 2, 067	1, 473	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5359	17 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6786	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3524	09 121, 697	42, 887	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS		0.0000	0 00	0	73.01
74. 00 07400 RENAL DI ALYSI S		0.0000	0 00	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)		0.0000	0 00	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000	0 00	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		2. 1754	98 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC		1. 3338	46 O	0	90.01
90. 02 09002 PAOLI PRIMARY CARE CLINIC		0.0000	0 00	0	90.02
91. 00 09100 EMERGENCY		0. 2408	20 5, 221	1, 257	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4212	07 1, 050	442	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			348, 706	146, 922	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			348, 706		202.00

5	LTH PAOLI HOSPITAL	01 45 4007		eu of Form CMS-2	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1306	Period: From 01/01/2019	Worksheet D-3	5
	Component	CCN: 15-Z306	To 12/31/2019		pared
				6/29/2020 9:0	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
		1.00	2.00	3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1	0		1 20 0
			0		30.0
31.00 03100 I NTENSI VE CARE UNI T			0		31.0
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.0
50. 00 05000 OPERATING ROOM		0. 4395	57 0	0	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2113		-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2294		-	
50. 00 06000 LABORATORY		0. 4207			
54. 00 06400 I NTRAVENOUS THERAPY		0. 1353			
55. 00 06500 RESPIRATORY THERAPY		0. 5871		-	
56. 00 06600 PHYSI CAL THERAPY		0. 74772			
57. 00 06700 OCCUPATI ONAL THERAPY		0. 62842			
58. 00 06800 SPEECH PATHOLOGY		0. 7128			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5359		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6786		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 35240		-	
73. 01 07301 DRUGS CHARGED TO PATIENTS		0.0000		0	
74. 00 07400 RENAL DI ALYSI S		0.0000		0	
75. 00 07500 ASC (NON-DI STI NCT PART)		0.0000		0	
76. 97   07697   CARDI AC REHABI LI TATI ON		0.0000		0	
OUTPATI ENT SERVICE COST CENTERS		0.0000	0		, 0. /
38. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 0
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
20. 00 09000 CLINIC		2. 1754		0	
PO. 01 09001 VISITING SPECIALTY CLINIC		1. 3338		0	
PO. 02 09002 PAOLI PRIMARY CARE CLINIC		0.0000		0	
91. 00 09100 EMERGENCY		0. 24082		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 42120		0	
OTHER REIMBURSABLE COST CENTERS		0. 72120	0	. <u> </u>	1 /2.0
25. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through	1h 98)		107, 107	51, 625	
201.00 Less PBP Clinic Laboratory Services-Program on			0	01,020	200.0
202.00 Net charges (line 200 minus line 201)	, s.a. gos (1110 01)	1	0	1	1-01.0

Health Financial Systems	HEALTH PAOLI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1306	Peri od:	Worksheet D-3	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
		e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		10 ondiges	Charges	$(col \cdot 1 \times col \cdot$	
			51121 955	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				•	
30. 00 03000 ADULTS & PEDI ATRI CS			43, 390		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY			39, 716		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 4395	57 67, 564	29, 698	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2113	54, 555	11, 532	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 2294	32 3, 763	863	54.00
60. 00 06000 LABORATORY		0. 4207	24, 611	10, 356	60.00
64.00 06400 INTRAVENOUS THERAPY		0. 1353	52 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 5871	16 3, 017	1, 771	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 7477	20 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 62842	23 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 7128	61 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5359	17 929	498	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6786	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 35240	26, 689	9, 405	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS		0.0000	0 00	0	73.01
74.00 07400 RENAL DIALYSIS		0.0000	0 00	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)		0.0000	0 00	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000	0 00	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	0 00	0	89.00
90. 00 09000 CLINIC		2. 1754	98 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC		1. 33384	46 0	0	90.01
90.02 09002 PAOLI PRIMARY CARE CLINIC		0.0000	0 00	0	90.02
91. 00 09100 EMERGENCY		0. 2408	20 5, 322	1, 282	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 42120	07 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 thr	rough 98)		186, 450	65, 405	200.00
201.00 Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			186, 450		202.00
		I	1 100, 400	I	1-02.00

	Financial Systems         IU HEALTH PAOLI HOSPI           ATION OF REIMBURSEMENT SETTLEMENT         Prov	ider CCN: 15-1306	Period: From 01/01/2019	u of Form CMS-2 Worksheet E Part B	
			To 12/31/2019	Date/Time Pre	
		Title XVIII	Hospi tal	6/29/2020 9:03 Cost	3 am
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			6, 822, 159	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	)		0	
3.00 4.00	OPPS payments Outlier payment (see instructions)			0	3.00 4.00
4.00	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions	3)		0.000	5.00
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	6.00 7.00
8.00	Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co	ol. 13, line 200		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 822, 159	10.00 11.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 022, 137	11.00
	Reasonable charges			_	
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69	2)		0	12.00 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	')		0	
	Customary charges				
15.00 16.00	Aggregate amount actually collected from patients liable for paymer			0	15.00 16.00
10.00	Amounts that would have been realized from patients liable for paym had such payment been made in accordance with 42 CFR §413.13(e)	Jent for services c	ni a chargebasis	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if	ling 19 overede li	no 11) (coo	0	18.00
19. 00	instructions)	TTHE TO EXCEEDS TT	ne II) (see	0	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			6, 890, 381	21.00
21.00	Interns and residents (see instructions)			0, 090, 301	
23. 00	Cost of physicians' services in a teaching hospital (see instruction	ons)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			74, 790	25.00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (	•	,	3, 604, 762	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus t instructions)	the sum of lines 22	2 and 23] (see	3, 210, 829	27.00
28.00	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)			0	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 210, 829 7, 783	
32.00	Subtotal (line 30 minus line 31)			3, 203, 046	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00 34.00	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0 1, 325, 405	
35.00	Adjusted reimbursable bad debts (see instructions)			861, 513	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)		1, 168, 916	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			4, 064, 559 0	37.00 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39.97	Demonstration payment adjustment amount before sequestration	ulass (see instruc	tione)	0	
39.98 39.99	Partial or full credits received from manufacturers for replaced de RECOVERY OF ACCELERATED DEPRECIATION	svices (see instruc	trons)	0	39.98 39.99
40.00	Subtotal (see instructions)			4, 064, 559	
40.01	Sequestration adjustment (see instructions)			81, 291	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
	Interim payments			4, 109, 729	
41.01	Interim payments-PARHM				41.01
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00 42.01
43.00	Balance due provider/program (see instructions)			-126, 461	
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accordance wi §115.2	τη CMS Pub. 15-2,	cnapter 1,	246, 518	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	91.00 92.00
92.00 93.00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.00

NALYS	GIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1306	Period: From 01/01/2019 To 12/31/2019		pared
		Title	XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		726, 07	79 0	4, 109, 729 0	1. ( 2. (
. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
	Program to Provider					
. 01 . 02	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	3. 3.
04				0	0	
05				0	0	3.
	Provider to Program			- 1		
50	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	3.
53				0	0	
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		726, 07	79	4, 109, 729	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	
03				0	0	5.
	Provider to Program					
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		10 - T	0	0	6.
)2 )0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		43, 04		126, 461 3, 983, 268	
.0			683, 03	Contractor	3,983,268 NPR Date	
				Number	(Mo/Day/Yr)	
		C		1,00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 01/01/201		
		component	CCN: 15-Z306	To 12/31/201	9 Date/Time Pro 6/29/2020 9:0	eparec 03 am
		Title	XVIII	Swing Beds - SN		
		I npati en	t Part A	Pa	nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		388, 4	36	(	) 1.
00	Interim payments payable on individual bills, either			0	(	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				-1	
01	ADJUSTMENTS TO PROVIDER			0	(	3.
)2				0	0	) 3.
)3				0	(	) 3.
)4				0	(	
)5				0	(	) 3
	Provider to Program			-	1	
0	ADJUSTMENTS TO PROGRAM			0	(	
51				0		
52 53				0		
53 54				0		
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		
, ,	3. 50-3. 98)			0		1
00	Total interim payments (sum of lines 1, 2, and 3.99)		388, 4	36	(	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				1	÷ .
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					-
)1	TENTATI VE TO PROVI DER			0	(	5 5
)2				0		
)3				0	(	5
	Provider to Program					
50	TENTATIVE TO PROGRAM			0	(	
51				0	(	
52				0	(	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	(	5
0	5.50-5.98) Determined net settlement amount (balance due) based on					6
,0	the cost report. (1)					
)1	SETTLEMENT TO PROVIDER			0	(	6 10
)2	SETTLEMENT TO PROGRAM		23, 6	-		
00	Total Medicare program liability (see instructions)		364, 7			5 7
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	1	1.00	2.00	

2.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.03.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.04.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-123.05.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2004.06.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.07.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I6.01 ine 1688.00Calculation of the HIT incentive payment (see instructions)8.09.00Sequestration adjustment amount (see instructions)9.010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.010.00Initial/interim HIT payment adjustment (see instructions)10.030.00Initial/interim HIT payment adjustment (see instructions)30.0	Heal th	Financial Systems IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-	-2552-10				
To       12/31/2019       Date/Time Prepared 6/29/2020 9:03 am         Title XVIII       Hospital       Cost         Image: To       BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS       Image: Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14       1.00         Image: Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14       1.00         Image: Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14       1.00         Image: Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14       1.00         Image: Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 6 line 2       1.00         Image: Total hospital discharges from Wkst. S-3, Pt. I, col. 6 line 2       1.00         Image: Total hospital charges from Wkst C, Pt. I, col. 8 line 200       1.00         Image: Total hospital charity care charges from Wkst. S-10, col. 3 line 20       5.00         Image: Total hospital charity care charges from Wkst. S-10, col. 3 line 20       6.0         Image: Total hospital charity care charges from Wkst. S-10, col. 3 line 20       8.0         Image: Total hospital charity care charges from Wkst. S-10, col. 3 line 20       9.0       9.0       9.0       9.0         Sequestration adjustment amount (see instructions)       9.0       9.0       9.0       9.0       9.0	CALCUL									
1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14         2.00         Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12         3.00         Medicare HMO days from Wkst. S-3, Pt. I, col. 8 sum of lines 1, 8-12         3.00         Medicare HMO days from Wkst. S-3, Pt. I, col. 8 line 200         Colspan="2">6.00         Total hospital charity care charges from Wkst. S-10, col. 3 line 20         7.00         CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I         Intent 168         8.00         Calculation of the HIT incentive payment (see instructions)         1.00         Intent HOSPITAL SERVICES UNDER THE IPPS & C		To 12/31/2019 Date/Time								
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from Wst. S-3, Pt. I, col. 8 line 203.005.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 206.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0030.00Initial/interim HIT payment adjustment (see instructions)30.00		Cost								
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from Wst. S-3, Pt. I, col. 8 line 203.005.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 206.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0030.00Initial/interim HIT payment adjustment (see instructions)30.00										
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.02.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.03.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.04.00Total inpatient days from Wkst. S-3, Pt. I, col. 8 sum of lines 1, 8-123.05.00Total inpatient days from Wkst C, Pt. I, col. 8 line 2004.06.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.06.00Total hospital charity care charges from Wkst. S-10, col. 3 line 206.07.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.08.00Calculation of the HIT incentive payment (see instructions)8.09.00Sequestration adjustment amount (see instructions)9.010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH9.030.00Initial/interim HIT payment adjustment (see instructions)30.0					1.00					
1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.02.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.03.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.04.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-123.05.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2004.06.00Total hospital charity care charges from Wkst S-10, col. 3 line 205.07.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.01 ine 1688.00Calculation of the HIT incentive payment (see instructions)8.09.00Sequestration adjustment amount (see instructions)9.010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH9.030.00Initial/interim HIT payment adjustment (see instructions)30.0										
2.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.03.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.04.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.05.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.06.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.07.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.08.00Calculation of the HIT incentive payment (see instructions)8.09.00Sequestration adjustment amount (see instructions)9.010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0030.00Initial/interim HIT payment adjustment (see instructions)30.0										
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 1, 8-12       4.00         5.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 200       5.00         6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       5.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168       6.00         8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         10.00       Initial/interim HIT payment adjustment (see instructions)       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00	1.00		l	1.00						
4.00       Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12       4.0         5.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 200       5.0         6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       6.0         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       6.0         8.00       Calculation of the HIT incentive payment (see instructions)       8.0         9.00       Sequestration adjustment amount (see instructions)       9.0         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.0         10.101       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00	2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12								
5.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 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 of certified HIT technology Wkst. S-2, Pt. I       6.00         8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       Initial/interim HIT payment adjustment (see instructions)       9.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00	3.00	.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2								
6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       6.0         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.0         1 ine 168       8.00       Calculation of the HIT incentive payment (see instructions)       8.0         9.00       Sequestration adjustment amount (see instructions)       9.0         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.0         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.0         30.00       Initial/interim HIT payment adjustment (see instructions)       30.0	4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12								
7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.0         1 ine 168       8.00       Calculation of the HIT incentive payment (see instructions)       8.0         9.00       Sequestration adjustment amount (see instructions)       8.0         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.0         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       9.0         30.00       Initial/interim HIT payment adjustment (see instructions)       30.0	5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			l	5.00				
I ine 168         8.00       Cal culation of the HIT incentive payment (see instructions)         9.00       Sequestration adjustment amount (see instructions)         10.00       Cal culation of the HIT incentive payment after sequestration (see instructions)         10.00       INPATI ENT HOSPITAL SERVICES UNDER THE IPPS & CAH         30.00       Initial /interim HIT payment adjustment (see instructions)	6.00	0 Total hospital charity care charges from Wkst. S-10, col. 3 line 20								
9.00       Sequestration adjustment amount (see instructions)       9.0         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.0         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial /interim HIT payment adjustment (see instructions)       30.00	7.00									
10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.0         INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial /interim HIT payment adjustment (see instructions)       30.0	8.00	Calculation of the HIT incentive payment (see instructions)			l	8.00				
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH         30.00         Initial /interim HIT payment adjustment (see instructions)         30.00	9.00	Sequestration adjustment amount (see instructions)								
30.00 Initial/interim HIT payment adjustment (see instructions) 30.0	10.00	) Calculation of the HIT incentive payment after sequestration (see instructions)								
		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH								
31 00 Other Adjustment (specify) $31$	30.00	30.00 Initial/interim HIT payment adjustment (see instructions)								
	31.00	1.00 Other Adjustment (specify)								
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.0	32.00	00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)								

CALCULATI	ON OF REIMBURSEMENT SETTLEMENT - SWING BEDS P	rovider CCN: 15-1306	Peri od:	Worksheet E-2	
	C	omponent CCN: 15-Z3O6	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 9:0	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
0.01			1.00	2.00	
	MPUTATION OF NET COST OF COVERED SERVICES		224 042	0	1.0
	patient routine services – swing bed-SNF (see instructions) patient routine services – swing bed-NF (see instructions)		326, 063	0	2.0
	cillary services (from Wkst. D-3, col. 3, line 200, for Part A	and cum of Wkst D	52, 141	0	3.0
	rt V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-		52, 141	0	3.0
	istructions)	bed pass-through, see			
	rsing and allied health payment-PARHM (see instructions)				3.0
1	r diem cost for interns and residents not in approved teaching	program (see		0.00	
	istructions)				
.00 Pr	ogram days		116	0	5.0
.00 In	terns and residents not in approved teaching program (see inst	ructions)		0	6.0
	ilization review - physician compensation - SNF optional metho	d only	0		7.0
	btotal (sum of lines 1 through 3 plus lines 6 and 7)		378, 204	0	8.0
	imary payer payments (see instructions)		0	0	9.0
	btotal (line 8 minus line 9)		378, 204	0	10.0
	ductibles billed to program patients (exclude amounts applicab	le to physician	0	0	11.0
	ofessional services)		270 204	0	12 0
	btotal (line 10 minus line 11) insurance billed to program potients (from provider records) (	aveluda, coi neuranca	378, 204	0	12.0 13.0
	insurance billed to program patients (from provider records) ( n physician professional services)	exclude collisulance	5, 968	0	13.0
	% of Part B costs (line 12 x 80%)			0	14. C
	btotal (see instructions)		372, 236	0	15.0
	HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		072,200	0	16.0
	oneer ACO demonstration payment adjustment (see instructions)			Ū	16.5
	ral community hospital demonstration project (§410A Demonstrat	ion) payment	0		16.5
	ljustment (see instructions)	× 1 5			
6.99 De	monstration payment adjustment amount before sequestration		0	0	16.9
7.00 AI	lowable bad debts (see instructions)		0	0	17.C
	justed reimbursable bad debts (see instructions)		0	0	17.0
	lowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	
	tal (see instructions)		372, 236	0	19. C
	questration adjustment (see instructions)		7, 445	0	
	monstration payment adjustment amount after sequestration)		0	0	
	questration adjustment-PARHM pass-throughs		200 404	0	19.0
	terim payments terim payments-PARHM		388, 486	0	20. C
	entative settlement (for contractor use only)		0	0	
	Intative settlement-PARHM (for contractor use only)		0	0	21.0
1	lance due provider/program (line 19 minus lines 19.01, 20, and	21)	-23, 695	0	
	lance due provider/program-PARHM (see instructions)	2.)	207070	Ū	22.0
	otested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	13, 532	0	
ch	apter 1, §115.2				
	ral Community Hospital Demonstration Project (§410A Demonstrat				
	this the first year of the current 5-year demonstration perio	d under the 21st			200. 0
	ntury Cures Act? Enter "Y" for yes or "N" for no.				
	st Reimbursement		I		
	dicare swing-bed SNF inpatient routine service costs (from Wks	st. D-1, Pt. II, line			201. C
	(title XVIII hospital)) dicare swing-bed SNF inpatient ancillary service costs (from W	Ket D 2 col 2 lin			202.0
	0 (title XVIII swing-bed SNF))	KSt. D-3, COL. 3, TH	-		202.0
	tal (sum of lines 201 and 202)				203. 0
	dicare swing-bed SNF discharges (see instructions)				204.0
	mputation of Demonstration Target Amount Limitation (N/A in fi	rst vear of the curre	nt 5-vear demonst	ration	
	ri od)	3	5		
05.00 Me	dicare swing-bed SNF target amount				205.0
06.00 <u>Me</u>	dicare swing-bed SNF inpatient routine cost cap (line 205 time	s line 204)			206. C
Ad	justment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem	ent			
1	ogram reimbursement under the §410A Demonstration (see instruc	-			207.0
	dicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1		208. 0
	d 3)	>			-
	justment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209.0
	served for future use				210. C
	mparision of PPS versus Cost Reimbursement tal adjustment to Medicare swing-bed SNF PPS payment (line 209	Indus line 210) (act			215 0
13.0010	istructions)	prus rine 210) (see			215. (

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1306	Period: From 01/01/2019 To 12/31/2019	Date/Time Prep 6/29/2020 9:03	pare
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
. 00	Inpatient services			767, 544	1.
. 00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.
00	Organ acquisition			0	3.
. 00	Subtotal (sum of lines 1 through 3)			767, 544	4.
. 00	Primary payer payments			0	5.
. 00	Total cost (line 4 less line 5). For CAH (see instructions)			775, 219	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable charges Routine service charges			0	7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	9
0.00	Total reasonable charges			0	
	Customary charges				1.0
. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	11
2.00	Amounts that would have been realized from patients liable for	r payment for services o	n a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.13(e)	)	Ũ		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 14 exceeds li	ne 6) (see	0	15
	instructions)				
b. 00	Excess of reasonable cost over customary charges (complete onl	y if line 6 exceeds lin	e 14) (see	0	16
7.00	instructions) Cost of physicians' services in a teaching hospital (see instr	suctions)		0	17
7.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 ''
3. 00	Direct graduate medical education payments (from Worksheet E-4	4. line 49)		0	1 18
. 00	Cost of covered services (sum of lines 6, 17 and 18)	.,		775, 219	
. 00	Deductibles (exclude professional component)			91, 388	
. 00	Excess reasonable cost (from line 16)			0	21
. 00	Subtotal (line 19 minus line 20 and 21)			683, 831	22
. 00	Coinsurance			0	23
. 00	Subtotal (line 22 minus line 23)			683, 831	
5.00	Allowable bad debts (exclude bad debts for professional servic	ces) (see instructions)		20, 217	
. 00	Adjusted reimbursable bad debts (see instructions)			13, 141	26
7.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		13, 749	
. 00	Subtotal (sum of lines 24 and 25, or line 26)			696, 972	
00 EO	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-)		0	29
9.50 9.99	Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	>)		0	
0.99 0.00	Subtotal (see instructions)			696, 972	
). 00	Sequestration adjustment (see instructions)			13, 939	
). 02	Demonstration payment adjustment amount after sequestration			13, 939	30
0.03	Sequestration adjustment-PARHM			0	30
. 00	Interim payments			726, 079	
. 01	Interim payments-PARHM				31
2.00	Tentative settlement (for contractor use only)			0	32
2. 01	Tentative settlement-PARHM (for contractor use only)				32
3.00	Balance due provider/program (line 30 minus lines 30.01, 30.02			-43, 046	33
3. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, mi				33
4.00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	27, 743	34

	Financial Systems IU HEALTH PAO E SHEET (If you are nonproprietary and do not maintain	Provider C		eriod: rom 01/01/2019	u of Form CMS-: Worksheet G	
nd-t Iy)	ype accounting records, complete the General Fund column			o 12/31/2019	Date/Time Pre 6/29/2020 9:0	
		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	11, 705, 236	0	0	0	1 1.
00	Temporary investments	0	0	0	0	2
00	Notes receivable	101, 973	0	0	0	3
00	Accounts receivable	3, 051, 761	0	0	0	
00	Other receivable	-1, 202, 319	0	0	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	435, 686	0	0	0 0	6
00	Prepai d expenses	121, 799		0	0	8
00	Other current assets	0	0	0	0	9
00	Due from other funds	0	0	0	0	10
00	Total current assets (sum of lines 1-10)	14, 214, 136	0	0	0	11
	FIXED ASSETS		-			l
00	Land	148,000	0		0	12
00 00	Land improvements Accumulated depreciation	438, 464 -370, 610	0	0	0	13
00	Buildings	6, 153, 159		Ŭ	0	15
00	Accumulated depreciation	-3, 544, 505	0	0	0	16
00	Leasehold improvements	791, 602	0	Ő	0	17
00	Accumulated depreciation	-511, 257	0	0	0	18
00	Fixed equipment	0	0	0	0	19
	Accumulated depreciation	0	0	0	0	20
	Automobiles and trucks	22, 679	0	0	0	21
	Accumulated depreciation		0	0	0	22
	Major movable equipment Accumulated depreciation	11, 293, 717 -6, 830, 122		0	0	23
	Mi nor equipment depreciable	-0, 030, 122		0	0	24
	Accumulated depreciation	0		0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	28
. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29
. 00	Total fixed assets (sum of lines 12-29)	7, 591, 127	0	0	0	30
00	OTHER ASSETS	1 000 001				
00	Investments Deposits on Leases	1, 333, 331 0	0	0	0 0	31
00	Due from owners/officers			0	0	33
00	Other assets	7, 741, 349	0	0	0	34
00	Total other assets (sum of lines 31-34)	9,074,680	0	0	0	35
00	Total assets (sum of lines 11, 30, and 35)	30, 879, 943	0	0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	970, 680	0	-	0	37
00	Salaries, wages, and fees payable	780, 506	0		0	
00 00	Payroll taxes payable Notes and Loans payable (short term)	-603	0	0	0 0	
	Deferred income			0	0	
00	Accel erated payments	0		Ū	0	42
00	Due to other funds	0	0	0	0	43
00	Other current liabilities	3, 788, 930	0	0	0	44
00	Total current liabilities (sum of lines 37 thru 44)	5, 539, 513	0	0	0	45
	LONG TERM LI ABI LI TI ES					l
00 00	Mortgage payable Notes payable	0		0	0	
00	Unsecured Loans	0		0	0	47
00	Other long term liabilities	38, 181		0	0	40
	Total long term liabilities (sum of lines 46 thru 49)	38, 181	0	0	0	
00	Total liabilities (sum of lines 45 and 50)	5, 577, 694	0	0	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	25, 302, 249				52
00	Specific purpose fund		0	_		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55 56
00 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	
00	Plant fund balance - reserve for plant improvement,				0	
00	replacement, and expansion				0	
		25, 302, 249	o	0	0	59
. 00	Total fund balances (sum of lines 52 thru 58)	20,002,247		01	0	

STATEMENT OF CHANGES IN FUND BALANCES         Provider CON: 15-1306         Period: For U201/201 To 12/31/2019         Worksheet 6-1 bate/Time Presented: Date/Time Prese	Heal th	Financial Systems	IU HEALTH PAOL	I HOSPI TAL			In Lie	u of Form CMS-	2552-10
General Fund         Special Purpose Fund         Endowment Fund           1.00         Fund balances at beginning of period         2.00         3.00         4.00         5.00         1.00           2.00         Net income (loss) (from Wst. 6-3, line 29)         1.01, 466         29, 216, 555         0         0         2.00         0         0         0         3.00         4.00         0.04, 666         2.00         2.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td></td><td></td><td></td><td></td><td>CN: 15-1306</td><td>Fr</td><td>riod: om 01/01/2019</td><td>Worksheet G-1 Date/Time Pre</td><td>pared:</td></t<>					CN: 15-1306	Fr	riod: om 01/01/2019	Worksheet G-1 Date/Time Pre	pared:
1.00         Fund balances at beginning of period         28, 201, 859         0         1.00           2.00         Net income (loss) (from Wst. G-3, line 29)         1.101, 4.966         29, 216, 555         0         3.00           3.00         DONATED PPE         27, 858         0         0         0         3.00           5.00         0         0         0         0         0         0         3.00           6.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			General	Fund	Speci al	Pur	pose Fund		
1.00         Fund balances at beginning of period         28, 201, 859         0         1.00           2.00         Net income (loss) (from Wst. G-3, line 29)         1.101, 4.966         29, 216, 555         0         3.00           3.00         DONATED PPE         27, 858         0         0         0         3.00           5.00         0         0         0         0         0         0         3.00           6.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			1.00	2.00	2.00		4.00	E 00	
2.00         Net income (loss) (from West. 6-3, line 29)         1,014,696         2.00         2.00         0         2.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td>1.00</td> <td>Fund balances at beginning of period</td> <td>1.00</td> <td></td> <td>3.00</td> <td></td> <td></td> <td>5.00</td> <td>1.00</td>	1.00	Fund balances at beginning of period	1.00		3.00			5.00	1.00
4.00         DONATED PPE         27,858         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0							-		
5.00         0         0         0         0         0         0         0         6.00           7.00         0         0         0         0         0         0         0         6.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         <				29, 216, 555			0		
6.00         0         0         0         0         0         0         0         0         7.00           8.00         9.00         0         0         27,858         0         10.00         7.00           1.00         Subtotal (line 3 pius line 10)         27,858         0         10.00         11.00           2.00         HTRCOMPANY CAPITAL TRANSFER         3,942,162         0         0         12.00           1.00         ROUNDING         0         0         0         0         13.00           14.00         0         0         0         0         0         13.00           15.00         0         0         0         0         0         14.00           15.00         0         0         0         0         0         15.00           16.00         Fund balance at end of period per balance steps theset (line 11 minus line 18)         18.00         18.00         18.00         18.00           1.00         Fund balances at beginning of period         0         0         0         2.00         18.00         2.00         2.00         3.00         4.00         2.00         3.00         4.00         2.00         3.00         4.00		DONATED PPE							•
7.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0						-			
8.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			0						•
9.00         ctal additions (sum of line 4-9)         0         27,858         0         0         9.00           11.00         Subtotal (line 3 plus line 10)         3,942,162         0         0         11.00           12.00         INTERCOMPANY CAPITAL TRANSFER         3,942,162         0         0         0         0         0         0         0         11.00           13.00         ROUNDING         0         0         0         0         0         0         0         0         0         0         11.00         0         12.00         0         13.00         0         0         14.00         0         14.00         0         14.00         0         15.00         0         0         0         15.00         0         15.00         0         15.00         0         15.00         16.00         17.00         18.00         18.00         18.00         18.00         18.00         18.00         18.00         19.00         19.00         19.00         10.00         25.302,249         0         19.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td>			0			0			
10:00       Total additions (sum of line 4-9)       27,858       0       10.00         11:00       Subtotal (line 3 plus line 10)       29,244,413       0       11.00         12:00       INTERCOMPARY CAPITAL TRANSFER       3,942,162       0       0       0       12.00         13:00       ROUNDING       0       0       0       0       0       0       0       0       0       12.00       0       0       0       0       0       0       0       0       0       12.00       0       0       0       0       0       0       13.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td>0</td><td></td><td></td><td></td></t<>			0			0			
11.00         Subtotal (line 3 plus line 10)         3,942,162         0         11.00           12.00         INTERCOMPANY CAPITAL TRANSFER         3,942,162         0         0         12.00           13.00         ROUNDING         0         0         0         12.00         0         12.00           14.00         0         0         0         0         0         0         13.00           14.00         0         0         0         0         0         0         14.00           15.00         0         0         0         0         0         14.00         0         14.00           16.00         0         0         0         0         0         0         15.00           17.00         Fund balance at end of period per balance         25,302,249         0         18.00         18.00           19.00         Fund balances at beginning of period         0         0         0         10.00         10.00         10.00         10.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00		Total additions (sum of line 4-9)		27,858		Ŭ	0	c.	
13.00         ROUNDING         2         0         0         13.00           14.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	11.00			29, 244, 413			0		11.00
14.00       0       0       0       0       14.00         15.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	12.00	INTERCOMPANY CAPITAL TRANSFER	3, 942, 162			0		C	12.00
15.00         0         0         0         0         0         0         15.00         0         15.00         0         15.00         0         15.00         0         15.00         0         15.00         0         15.00         0         15.00         0         15.00         0         16.00         0         15.00         0         16.00         0         16.00         0         16.00         0         16.00         0         16.00         0         16.00         0         16.00         0         16.00         0         16.00         17.00         18.00         18.00         18.00         18.00         18.00         18.00         18.00         18.00         18.00         18.00         19.00         19.00         10.00         18.00         19.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00         2.00         10.00		ROUNDING	2						•
16.00 17.00       0       0       0       0       0       0       16.00         18.00 19.00       Fund balance at end of period per balance sheet (line 11 minus line 18)       0       3,942,164       0       0       17.00         19.00       Fund balance at end of period per balance sheet (line 11 minus line 18)       Endowment Fund       Plant Fund       0       19.00         1.00       Fund balances at beginning of period 2.00       Net income (loss) (from Wkst. G-3, line 29) 3.00       0       0       0       2.00         1.00       DONATED PPE       0       0       0       0       3.00       0       3.00         1.00       DONATED PPE       0       0       0       0       3.00       1.00         1.00       Subtotal (time 3 plus line 10)       0       0       0       9.00       0       0       9.00         1.00       Subtotal (line 3 plus line 10)       0       0       0       10.00       10.00       10.00       10.00         1.00       Subtotal (line 3 plus line 10)       0       0       0       10.00       10.00         1.00       Subtotal (line 3 plus line 10)       0       0       0       10.00       10.00       10.00			0			0			
17.00       0       0       0       0       17.00         18.00       Total deductions (sum of lines 12-17)       0       3,942,164       0       0       18.00         19.00       Fund balance at end of period per balance sheet (line 11 minus line 18)       Endowment Fund       Plant Fund       0       19.00         1.00       Fund balances at beginning of period       0       0       0       1.00         2.00       Net income (loss) (from Wkst. 6-3, line 29)       0       0       0       2.00         3.00       Total (sum of line 1 and line 2)       0       0       0       3.00         3.00       DONATED PPE       0       0       0       3.00         6.00       0       0       0       0       3.00         6.00       0       0       0       0       3.00         6.00       0       0       0       0       3.00         7.00       0       0       0       0       0       0         1.00       Subtotal (line 3 plus line 10)       0       0       0       11.00       12.00         1.00       Subtotal (line 3 plus line 10)       0       0       0       11.00       12.00			0			0			
18.00         Total deductions (sum of lines 12-17)         3,942,164         0         18.00           19.00         Fund balance at end of period per balance sheet (line 11 minus line 18)         Endowment Fund         Plant Fund         0         19.00           1.00         Fund balances at beginning of period         0         0         0         1.00           1.00         Fund balances at beginning of period         0         0         0         1.00           2.00         Net income (loss) (from Wkst. G-3, line 29)         0         0         0         2.00           3.00         DONATED PPE         0         0         0         3.00         4.00         5.00         6.00         7.00         8.00         9.00         0         3.00         4.00         5.00         6.00         7.00         8.00         9.00         0         0         6.00         7.00         8.00         9.00         0         0         9.00         10.00         11.00         2.00         9.00         10.00         10.00         11.00         2.00         9.00         10.00         10.00         11.00         2.00         10.00         10.00         10.00         10.00         11.00         10.00         11.00         10.00			0			0			
19.00 sheet (line 11 minus line 18)         Endowment Fund         Plant Fund         0         19.00           1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 4.00 DONATED PPE         6.00 7.00 8.00         7.00 8.00         0 0 0         1.00 2.00 0         1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00         0 0 0         0 0         0 0         1.00 2.00         2.00 3.00         3.00 0         2.00 3.00         3.00 0         2.00 3.00         3.00         4.00         3.00         4.00         3.00         4.00         3.00         4.00         5.00         6.00         7.00         8.00         9.00         10.00         4.00         5.00         6.00         7.00         8.00         9.00         10.00         10.00         8.00         9.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         11.00         12.00         13.00         13.00         13.00         13.00         13.00         14.00         15.00         16.00         16.00         16.00         17.00         18.00         19.00         19.00         19.00         19.00		Total deductions (sum of lines 12-17)	0	3 942 164		0	0	U	
sheet (line 11 minus line 18)         Endowment Fund         Plant Fund							-		
Image: Note of the second se							-		
1.00         Fund balances at beginning of period         0         1.00           2.00         Net income (loss) (from Wkst. G-3, line 29)         0         0         2.00           3.00         Total (sum of line 1 and line 2)         0         0         3.00           4.00         DONATED PPE         0         0         4.00           5.00         0         0         4.00         5.00           6.00         0         0         6.00         7.00           8.00         9.00         0         0         8.00           9.00         Total additions (sum of line 4-9)         0         0         9.00           10.00         Total additions (sum of line 4-9)         0         0         9.00           11.00         Subtotal (line 3 plus line 10)         0         0         11.00           12.00         INTERCOMPANY CAPITAL TRANSFER         0         12.00         12.00           13.00         ROUNDING         0         15.00         15.00         16.00           15.00         0         0         15.00         16.00         19.00			Endowment Fund	PI ant	Fund				
2.00       Net income (loss) (from Wkst. G-3, line 29)       0       0       3.00         3.00       Total (sum of line 1 and line 2)       0       0       4.00       0         0.00       DONATED PPE       0       0       4.00       0       4.00         6.00       0       0       0       0       6.00       5.00       6.00         7.00       0       0       0       0       6.00       7.00       8.00       9.00       9.00       9.00       9.00       9.00       9.00       9.00       9.00       9.00       9.00       10.00       11.00       11.00       12.00       11.00       11.00       11.00       11.00       11.00       12.00       13.00       14.00       13.00       14.00       13.00       14.00       15.00       16.00       17.00       18.00       17.00       0       16.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00       17.00 <td></td> <td></td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td></td> <td></td> <td></td> <td></td>			6.00	7.00	8.00				
3.00       Total (sum of line 1 and line 2)       0       0       3.00         4.00       DONATED PPE       0       4.00         5.00       0       0       6.00         6.00       0       0       6.00         7.00       0       0       6.00         8.00       0       0       7.00         9.00       0       0       9.00         10.00       Total additions (sum of line 4-9)       0       0         11.00       Subtotal (line 3 plus line 10)       0       0       10.00         12.00       INTERCOMPANY CAPITAL TRANSFER       0       11.00       12.00         13.00       ROUNDI NG       0       14.00       15.00         14.00       0       0       15.00       16.00         17.00       0       0       17.00       19.00         18.00       Total deductions (sum of lines 12-17)       0       0       18.00         19.00       Fund balance at end of period per balance       0       0       19.00			0			0			
4.00       DONATED PPE       4.00         5.00       0       0         6.00       0       0         7.00       0       0         8.00       0       0         9.00       0       0         10.00       Total additions (sum of line 4-9)       0         0       0       0         11.00       Subtotal (line 3 plus line 10)       0         12.00       INTERCOMPANY CAPI TAL TRANSFER       0         13.00       ROUNDI NG       11.00         14.00       0       0       15.00         15.00       0       0       15.00         16.00       0       0       15.00         17.00       0       0       18.00         19.00       Fund bal ance at end of peri od per bal ance       0       0									
5.00       0       5.00         6.00       0       6.00         7.00       0       0         8.00       0       0         9.00       0       0         10.00       Total additions (sum of line 4-9)       0         11.00       Subtotal (line 3 plus line 10)       0         12.00       INTERCOMPANY CAPITAL TRANSFER       0         13.00       ROUNDING       0         14.00       0       13.00         14.00       0       0         15.00       0       15.00         16.00       0       16.00         17.00       0       0         18.00       Total deductions (sum of lines 12-17)       0         19.00       Fund balance at end of period per balance       0       0			0	0		0			
6.00       0       0       6.00         7.00       0       0       7.00         8.00       0       0       8.00         9.00       0       0       9.00         10.00       Total additions (sum of line 4-9)       0       0       9.00         11.00       Subtotal (line 3 plus line 10)       0       0       11.00         12.00       INTERCOMPANY CAPITAL TRANSFER       0       12.00         13.00       ROUNDING       0       13.00         14.00       0       0       14.00         15.00       0       0       16.00         17.00       0       0       18.00         18.00       Total deductions (sum of lines 12-17)       0       0         19.00       Fund balance at end of period per balance       0       0       19.00		DUNATED PPE		0					
7.00       0       0       7.00         8.00       0       0       8.00         9.00       0       0       9.00         10.00       Total additions (sum of line 4-9)       0       0       9.00         11.00       Subtotal (line 3 plus line 10)       0       0       10.00         12.00       INTERCOMPANY CAPITAL TRANSFER       0       12.00       13.00         14.00       0       0       14.00       14.00         15.00       0       0       15.00       16.00         17.00       0       0       18.00       10.01 lines 12-17)       0         18.00       Total deductions (sum of lines 12-17)       0       0       18.00         19.00       Fund balance at end of period per balance       0       0       19.00				0					
9.00       0       0       9.00         10.00       Total additions (sum of line 4-9)       0       0       10.00         11.00       Subtotal (line 3 plus line 10)       0       0       0       11.00         12.00       INTERCOMPANY CAPITAL TRANSFER       0       0       12.00       13.00         14.00       0       0       0       14.00       15.00       16.00       15.00         17.00       0       0       0       17.00       17.00       18.00       19.00       18.00				0					
10.00       Total additions (sum of line 4-9)       0       0       10.00         11.00       Subtotal (line 3 plus line 10)       0       0       0       11.00         12.00       INTERCOMPANY CAPITAL TRANSFER       0       12.00       13.00       13.00         14.00       0       0       0       14.00       14.00         15.00       0       0       15.00       16.00       15.00         17.00       0       0       17.00       18.00       17.00         19.00       Fund balance at end of period per balance       0       0       19.00	8.00			0					8.00
11.00       Subtotal (line 3 plus line 10)       0       0       11.00         12.00       INTERCOMPANY CAPITAL TRANSFER       0       12.00         13.00       ROUNDING       0       13.00         14.00       0       0       14.00         15.00       0       0       15.00         16.00       0       0       16.00         17.00       0       0       17.00         18.00       Total deductions (sum of lines 12-17)       0       0       18.00         19.00       Fund balance at end of period per balance       0       0       19.00	9.00			0					9.00
12.00       INTERCOMPANY CAPITAL TRANSFER       0       12.00         13.00       ROUNDING       0       13.00         14.00       0       0       14.00         15.00       0       0       15.00         16.00       0       0       16.00         17.00       0       0       17.00         18.00       Total deductions (sum of lines 12-17)       0       0       18.00         19.00       Fund balance at end of period per balance       0       0       19.00			0						
13.00       ROUNDING       0       13.00         14.00       0       0       14.00         15.00       0       0       15.00         16.00       0       0       16.00         17.00       0       10       16.00         18.00       Total deductions (sum of lines 12-17)       0       0       18.00         19.00       Fund balance at end of period per balance       0       0       19.00			0			0			•
14.00       0       14.00         15.00       0       0         16.00       0       0         17.00       0       0         18.00       Total deductions (sum of lines 12-17)       0       0         19.00       Fund balance at end of period per balance       0       0				-					
15.00       0       15.00         16.00       0       0         17.00       0       0         18.00       Total deductions (sum of lines 12-17)       0         19.00       Fund balance at end of period per balance       0         19.00       Fund balance at end of period per balance       0				0					•
16.00       0       16.00       16.00         17.00       0       0       17.00         18.00       Total deductions (sum of lines 12-17)       0       0       18.00         19.00       Fund balance at end of period per balance       0       0       19.00				0					•
17.00       0       17.00         18.00       Total deductions (sum of lines 12-17)       0       0         19.00       Fund balance at end of period per balance       0       0				0					
19.00Fund balance at end of period per balance0019.00				0					•
	18.00		0						•
sheet (line 11 minus line 18)	19.00		0			0			19.00
		sheet (line 11 minus line 18)	I I		l				I

STATE	Financial Systems         IU HEALTH PAO           MENT OF PATIENT REVENUES AND OPERATING EXPENSES	LI HOSPITAL Provider CO	CN: 15-1306	Period: From 01/		u of Form CMS-: Worksheet G-2 Parts I & II	
				To 12/	31/2019	Date/Time Pre 6/29/2020 9:0	
	Cost Center Description		I npati ent	Outpa	tient	Total	
	1		1.00	2.	00	3.00	
	PART I - PATIENT REVENUES						-
1 00	General Inpatient Routine Services		1 004 5	24		1 004 504	1 1 00
1.00	Hospi tal SUBPROVI DER – I PF		1, 924, 5	26		1, 924, 526	•
2.00 3.00	SUBPROVIDER - IRF						2.00
4.00	SUBPROVIDER - TRF						4.00
5.00	Swing bed - SNF		103, 1	24		103, 124	
6.00	Swing bed - NF		105, 1	0		03,124	
7.00	SKILLED NURSING FACILITY			U		0	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, 027, 6	50		2, 027, 650	10.00
	Intensive Care Type Inpatient Hospital Services				1	·	1
11.00	I NTENSI VE CARE UNI T			0		0	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	oflines		0		0	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and	16)	2,027,6			2, 027, 650	
18.00	Ancillary services		3, 291, 9		141, 933	38, 433, 910	
19.00	Outpatient services		186, 2		598, 325	25, 784, 574	
20.00	RURAL HEALTH CLINIC			0	0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0	0	0	
22.00	AMBULANCE SERVICES			0	0	0	
23.00	CMHC			0	U	0	23.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )						24.00
26.00	HOSPICE						26.00
27.00	OTHER NRCC			0	80, 344	80, 344	
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	5, 505, 8	76 60.	820, 602	66, 326, 478	
	G-3, line 1)		-,, -	-			
	PART II - OPERATING EXPENSES						1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			25,	428, 873		29.00
30.00	ADD (SPECI FY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0	_		35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00 40.00				0			39.00
40.00				0			40.00
41.00	Total deductions (sum of lines 37-41)			5	0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		25	428, 873		42.00
10.00	to Wkst. G-3, Line 4)	12) (11 01131 01		20,	120,073		-5.00

Heal th	Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-1306	Peri od:	Worksheet G-3	
				From 01/01/2019 To 12/31/2019		
					6/29/2020 9:0	3 am
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	L column 3 line	28)		66, 326, 478	1.00
2.00	Less contractual allowances and discounts on				41, 526, 886	2.00
3.00	Net patient revenues (line 1 minus line 2)				24, 799, 592	3.00
4.00	Less total operating expenses (from Wkst. G-2	, Part II, line 4	13)		25, 428, 873	4.00
5.00	Net income from service to patients (line 3 m				-629, 281	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 miscellaneo	us communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from laundry and linen service				0	13.00
14.00	Revenue from meals sold to employees and gues	ts			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical sup		nan patients		0	16.00
17.00	Revenue from sale of drugs to other than pati				0	17.00
18.00	Revenue from sale of medical records and abst				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, an	d 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	
24.00	MI SCELLANEOUS I NCOME				1, 643, 977	
25.00	Total other income (sum of lines 6-24)				1, 643, 977	
26.00	Total (line 5 plus line 25)				1, 014, 696	
	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27 and subs				0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)		l	1, 014, 696	29.00