Heal th Financi	al Systems INDIANA UNIVERSITY HE	EALTH BEDFORD	In Lie	u of Form CMS-2552-10
This report is	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fail	ure to report can resul	t 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
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provi der CCN: 151328	Peri od: From 01/01/2014	Worksheet S Parts I-III
7 TELMENT			To 12/31/2014	Date/Time Prepared: 5/29/2015 8:58 am
PART I - COST	REPORT STATUS			
Provi der	 [X] Electronically filed cost report 		Date: 5/29/20	15 Time: 8:58 am
use only	2. [] Manually submitted cost report			
	3.[0] If this is an amended report enter the number 4.[F] Medicare Utilization. Enter "F" for full or "L	of times the provider re " for low.	esubmitted this c	ost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report for (3) Settled with Audit 9. [N]Final Report for	11. C r this Provider CCN 12. [

PART II - CERTIFICATION

(4) Reopened(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by INDI ANA UNIVERSITY HEALTH BEDFORD (151328) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)				
	Officer or	Administrator	of Provider(s)	
			• •	
Title				_
11 11 6				
Date				

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-451, 326	-400, 367	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	38, 277	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-413, 049	-400, 367	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151328 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2900 WEST SIXTEENTH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: BEDFORD Zip Code: 47421-County: LAWRENCE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 INDIANA UNIVERSITY 151328 99915 10/01/2005 Ν 0 0 3.00 HEALTH BEDEORD Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF IU HEALTH BEDFORD -157328 99915 0 10/01/2005 N 0 7 00 7.00 SWING BED 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 LCF/MR 10.01 10.01 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 12.00 Separately Certified ASC 13 00 13 00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital-Based (CMHC) I 17.00 17. 10 Hospital-Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19. 00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes 22 02 Ν 22.02 Ν or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22. 03 Did this hospital receive a geographic reclassification from urban to rural as a result N 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 3 N 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for yes or "N" for no In-State In-State Out-of Out-of Medi cai d 0ther HMO days Medi cai d Medi cai d Medi cai d State State paid days Medi cai d Medi cai d eligible days unpai d pai d days el i gi bl e days unpai d 1 00 2 00 3 00 5 00 6 00 4 00 24.00 If this provider is an IPPS hospital, enter the 0 0 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Heal th	Financial Systems INDIANA UNI	VFRSLTY F	HEALTH BEDFOR	D		In Lieu	of For	m CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			CCN: 151328	Peri od: From 01/0 To 12/3	1/2014	Worksho Part I Date/Ti	eet S-2	pared:
		In-State Medicaid paid day	d Medicaid		Out-of State Medi cai d el i gi bl e unpai d 4.00	Medicai HMO day 5.00	d 0 ys Med	ther di cai d days	
! ! !	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	0 0		0		0		25. 00
					1. (dural S	Date of 2.0		
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		us at the beg	jinning of th	е	2			26. 00
27. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	nge) statu "2" for cation in	rural. If ap n column 2.	ppl i cabl e,		2			27. 00
	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number o	of periods SC	CH status in		0			35. 00
					Begi ni		Endi 2. (
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		bscript line	36 for numbe	r				36. 00
37. 00	If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.		ber of period	ds MDH status		0			37. 00
38. 00 I	Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		bscript line	38 for numbe	r Y/	'NI	Υ/	'NI	38. 00
00.00		<u>.</u>			1. (00	2. (00	22.22
 	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage record (101(b)(2)(ii)? Enter in column 2 "Y" for yes to this hospital subject to the MAC management of the state of the)? Enter quirements or "N" fo	in column 1 s in accordar or no. (see i	"Y" for yes nce with 42 nstructions)			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.	er 1. En	ter "Y" for y			V	XVIII	XIX	40. 00
	(200)					1.00	2. 00	3.00	
45. 00 I	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for dis	sproporti onat	e share in a	ccordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	•		,		N	N	N	46. 00
48. 00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47. 00 48. 00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approved	GME programs	? Enter "Y"	for yes	N			56. 00
57. 00 (of N 101 no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or 'this'', comple	"N" for no ir s cost report ete Worksheet	n column 1. I ing period?	f column f Enter "Y				57. 00
58. 00	If line 56 is yes, did this facility elect cost reimble defined in CMS Pub. 15-1, § 2148? If yes, complete WM	ursement		ans' services	as	N			58. 00
59. 00 <i>i</i> 60. 00 <i>i</i>	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	s, complet	r a program t	hat meets th	e uctions)	N N			59. 00 60. 00
	provider operated eriteria under 3413.00: Efiter 1	Y/N	IME	Direct GME		IE	Di rec	t GME	
		1. 00	2. 00	3. 00	4.		5. (
:	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		n	_		0.00		0. 00	61.00
	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 instructions)		0. 00	0.	00				61. 01
61. 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 ACA). (see instructions)		0. 00	0.	00				61. 02
,									

Health Financial Systems INDIANA UNI	VERSI TY	/ HEALTH BEDFOR	RD	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre	
					5/28/2015 7:0	
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5.00	
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.00			61. 05
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61. 06
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. oc	0. 00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru	trai ne			od for which	0.00	62. 00
62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovid	a Teachi gram. (:	see instruction	ter (THC) into ns)	your hospital	0.00	62. 01
63.00 Has your facility trained residents in nonprovider s "Y" for yes or "N" for no in column 1. If yes, compl	ettings	during this co	instructions)		N	63. 00
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in N period that begins on or after July 1, 2009 and before		9	inis base year	is your cost r	eporting	
64.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter if of (column 1 divided by (column 1 + column 2)). (see	ty trai n-prima all non d non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	O. OC	O. OC	0. 000000	64. 00
Program Name	Pr	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2.00	3. 00	4. 00	5. 00	

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151328 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0. 00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no. N 75 00

Tot yes of it for no for each therapy.				
	-	1. 0	00	-
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.	or	N		110. 00
	1.00			
	1.00	2. 00	3.00	
Miscellaneous Cost Reporting Information				
115.00 is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1	N		0	115. 00
is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column				
3 either "93" percent for short term hospital or "98" percent for long term care (includes				
psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS				
Pub. 15-1, §2208. 1.	·	Į.		
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116. 00
117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118. 00

	Part A	Part B	Title V	Title XIX	
	1.00	2.00	3. 00	4. 00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs					
or charges? Enter "Y" for yes or "N" for no for each compon	ent for Part A	and Part B. (S	See 42 CFR §413	. 13)	
155. 00 Hospi tal	Υ	Υ	N	N	155. 00
156.00 Subprovider - IPF	N	N	N	N	156. 00
157.00 Subprovi der - IRF	N	N	N	N	157. 00
158. 00 SUBPROVI DER					158. 00
159. 00 SNF	Υ	N	N	N	159. 00
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00
161. 00 CMHC		N	N	N	161. 00
161. 10 CORF		N	N	N	161. 10

Health Financial Systems	INDIANA UNIVER	SITY HEALTH BEDFORD)		In Lie	u of Form CMS	-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	Provi der (CCN: 15132	From	01/01/2014	Worksheet S- Part I Date/Time Pr 5/28/2015 7:	epared:		
						3/20/2013 7.	OZ pili	
						1.00		
Mul ti campus								
165.00 Is this hospital part of a Multican Enter "Y" for yes or "N" for no.	165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for ves or "N" for no.							
	Name	County	State	Zip Code	e 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) Health Information Technology (HIT) 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI	under Section §1886(r 5 is "Y") and is a mea	n)? Enter "Y" for g aningful user (line	yes or "N	N" for no.		1.00	167. 00 0168. 00	
169.00 If this provider is a meaningful us transition factor. (see instruction	ser (line 167 is "Y")		line 105	is "N"),	enter the	0.0	00169.00	
,	·			E	Begi nni ng	Endi ng		
					1. 00	2. 00		
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	eginning date and endi	ng date for the re	porti ng				170. 00	
						1.00	_	
171.00 If line 167 is "Y", does this provi	dor have any days for	s individuals carel	lod in so	oction 10	76	1.00 N	171. 00	
Medicare cost plans reported on Wks (see instructions)						IN IN	171.00	

Ν

Ν

Ν

19.00

20.00

instructions.

the other adjustments:

included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments

If line 16 or 17 is yes, were adjustments

made to PS&R Report data for Other? Describe

made to PS&R Report data for corrections of other PS&R Report information? If yes, see

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFORD	In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:	STI ONNAI RE	Provi der	CCN: 151328	Peri od: From 01/01/2014 To 12/31/2014	Worksheet S- Part II Date/Time Pr 5/28/2015 7:	2 epared:	
			,	P	art A	Part B		
		Descrip	oti on	Y/N	Date	Y/N		
		0		1.00	2. 00	3. 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 HOSPIT	TALC ONLY (EVCER	OT CHILDDENS H	OCDITALC)		1.00		
	Capital Related Cost	IALS UNLT (EXCEP	T CHILDRENS H	USPITALS)			_	
22. 00	Have assets been relifed for Medicare purpose	oc2 If you soo	i netructi one			N	22. 00	
23. 00	Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.	ng the cost	N	23. 00				
24. 00	Were new leases and/or amendments to existing If yes, see instructions	g Leases entered	d into during	this cost rep	porting period?	N	24. 00	
25. 00	Have there been new capitalized leases entere instructions.	ed into during t	the cost repor	ting period?	If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	uired during the	e cost reporti	ng period? I1	yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy char copy. Interest Expense	nged during the	cost reportin	g period? If	yes, submit	N	27. 00	
28. 00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit ent	tered into dur	ing the cost	reporting	N	28. 00	
29. 00	Did the provider have a funded depreciation a treated as a funded depreciation account? If			bt Service Re	eserve Fund)	N	29. 00	
30. 00	Has existing debt been replaced prior to its instructions.	N	30. 00					
31. 00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N instructions.							
	Purchased Services Have changes or new agreements occurred in pa			d through cor	ntractual	N	32. 00	
33. 00	arrangements with suppliers of services? If y If line 32 is yes, were the requirements of S no, see instructions.			g to competi	tive bidding? If	N	33. 00	
		ty under an arr	angement with	provi der-bas	sed physi ci ans?	Y	34. 00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements		0 0	ts with the p	orovi der-based	N	35. 00	
	physicians during the cost reporting period?	IT yes, see ins	structions.		Y/N	Date		
					1. 00	2. 00		
	Home Office Costs					2.00		
	Were home office costs claimed on the cost re	eport?			Υ		36.00	
	If line 36 is yes, has a home office cost stallf yes, see instructions.		epared by the	home office?	Y		37. 00	
38. 00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the 1				N	12/31/2013	38. 00	
39. 00	If line 36 is yes, did the provider render se see instructions.				N		39. 00	
40. 00	If line 36 is yes, did the provider render seinstructions.	ervices to the h	nome office?	If yes, see	N		40. 00	
			1.	00	2.	00		
	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns of		RHONDA		UTTER		41. 00	
42. 00	respectively. Enter the employer/company name of the cost responses.	report	NDI ANA UNI VER	SITY HEALTH			42. 00	
43. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respective		317-962-1093		RUTTER@I UHEALT	H. ORG	43. 00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151328 Peri od: Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/28/2015 7:02 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 04/21/2014 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. 20.00 If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 report preparer in columns 1 and 2, respectively.

Heal th Fi nancialSystemsINDIANA UNIVERSITY HEALTH BEDFORDHOSPITALAND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider COMPLEX STATISTICAL DATA Provi der CCN: 151328

						5/28/2015 7:02	2 pm
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	1	9 6, 935	86, 184. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		1	9 6, 935	86, 184. 00	0	7. 00
	beds) (see instructions)				·		
8.00	INTENSIVE CARE UNIT	31.00		6 2, 190	18, 912. 00	0	8.00
9.00	CORONARY CARE UNIT	32. 00		ol o	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		ol o	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	l	ol o	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14. 00	Total (see instructions)			5 9, 125	105, 096. 00	0	14. 00
15. 00	CAH visits		_	1		0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		ol o		0	16. 00
17. 00	SUBPROVI DER – I RF	41. 00	.	ol o		0	17. 00
18. 00	SUBPROVI DER	42. 00	.			0	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00	ł	ol o		0	19. 00
20. 00	NURSING FACILITY	45. 00	.	ol o		0	20. 00
20. 01	I CF/MR	45. 01	ł		0.00	0	20. 01
21. 00	OTHER LONG TERM CARE	46. 00	l		0.00	J	21. 00
22. 00	HOME HEALTH AGENCY	101.00	ŀ	9		0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00	•			O	23. 00
24. 00	HOSPI CE	116. 00	ŀ	olo			24. 00
24. 00	HOSPICE (non-distinct part)	30.00	l	٥			24. 10
25. 00	CMHC - CMHC	99. 00				0	25. 00
25. 00	CMHC - CORF	99. 10	•			0	25. 00
			•			0	
26. 00	RURAL HEALTH CLINIC	88. 00	•				26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	•	_		0	26. 25 27. 00
27. 00	Total (sum of lines 14-26)			5		0	
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						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			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days		I				33. 00

Heal th Fi nancialSystemsINDIANA UNIVERSITY HEALTH BEDFORDHOSPITALAND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider COMPLEX STATISTICAL DATA

Provi der CCN: 151328

						5/28/2015 7:0	2 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 311	211	3, 591			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	368	13				2. 00
3.00	HMO I PF Subprovi der	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	627	0	627			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	47			6. 00
7. 00	Total Adults and Peds. (exclude observation	2, 938	211	4, 265			7. 00
0.00	beds) (see instructions)	500	4.0	700			0.00
8.00	INTENSIVE CARE UNIT	520	43	788			8. 00
9.00	CORONARY CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.450	0	0	0.00	050.75	13.00
14.00	Total (see instructions)	3, 458	254	5, 053	0.00	252. 75	
15.00	CAH visits	0	0	0	0.00	0.00	15.00
16.00	SUBPROVIDER - I PF	0	0	0		l e	16.00
17. 00	SUBPROVIDER - IRF	0	0	0	0.00	l e	17.00
18.00	SUBPROVI DER	0	0	0		ł	
19. 00	SKILLED NURSING FACILITY	U U	0	0		0.00	19.00
20. 00 20. 01	NURSING FACILITY ICF/MR	0	0	0			
21. 00	· ·	U U	۷	0			
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0	0	0			21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	۷	۷	U	0.00		
24. 00	HOSPICE	0	0	0			24.00
24. 00	HOSPICE (non-distinct part)		0	0		0.00	24. 00
25. 00	CMHC - CMHC		0	0		0.00	
25. 00	CMHC - CORF	0	0	0			
26. 00	RURAL HEALTH CLINIC		0	0			
26. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0		l	26. 25
27. 00	Total (sum of lines 14-26)	U U	٩	U	0.00		
28. 00	Observation Bed Days		99	691	0.00	252.75	28.00
29. 00	Ambul ance Trips	0	77	071			29.00
30.00	Employee discount days (see instruction)	U U		0			30.00
31. 00	Employee discount days (see firstruction)			0			31.00
32.00	Labor & delivery days (see instructions)	٥	0	0			32.00
32. 00	Total ancillary labor & delivery room	١	٩	0			32.00
32.01	outpatient days (see instructions)			U			32.01
33. 00		o					33. 00
		١	'		1	1	,

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 151328

Peri od: Worksheet S-3 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/28/2015 7:02 pm Full Time Di scharges Equi val ents Title V Title XVIII Title XIX Total All Component Nonpai d Workers Pati ents 12.00 13.00 14.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 716 57 1, 133 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 81 2 00 HMO IPF Subprovider 3.00 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 NURSERY 13.00 13.00 14.00 Total (see instructions) 0.00 0 716 57 1, 133 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 0.00 0 16.00 16.00 0 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0 17.00 18.00 SUBPROVI DER 0.00 0 0 0 0 18.00 SKILLED NURSING FACILITY 19.00 0.00 19.00 20.00 NURSING FACILITY 0 00 20.00 20.01 ICF/MR 0.00 0 0 0 0 20.01 21.00 OTHER LONG TERM CARE 0.00 21.00 HOME HEALTH AGENCY 22.00 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 0 00 23 00 24.00 HOSPI CE 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24.10 25.00 CMHC - CMHC 0.00 25.00 25. 10 CMHC - CORF 25.10 0.00 26.00 RURAL HEALTH CLINIC 0.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 0.00 27.00 27.00 28 00 Observation Bed Days 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

	FINDIANA UNIVERSITY HEALT				u of Form CMS-2	
HUSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	ı ovı aer	CCN: 151328	Peri od: From 01/01/2014	Worksheet S-10	U
				To 12/31/2014	Date/Time Prep 5/28/2015 7:02	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide Medicaid (see instructions for each line)	ed by li	ne 202 column	1 8)	0. 273407	1.00
2. 00	Net revenue from Medicaid				2, 258, 003	2.0
3. 00	Did you receive DSH or supplemental payments from Medicaid?				N	3.0
1. 00	If line 3 is "yes", does line 2 include all DSH or supplemental pa	ayments	from Medicaio	<u>ነ</u> ?		4.0
5. 00	If line 4 is "no", then enter DSH or supplemental payments from Me	edi cai d			0	5.0
5. 00	Medi cai d charges				18, 700, 050	6.0
7. 00	Medicaid cost (line 1 times line 6)				5, 112, 725	7. 0
3.00	Difference between net revenue and costs for Medicaid program (lir	ne 7 min	us sum of lir	nes 2 and 5; if	2, 854, 722	8. 0
	<pre>< zero then enter zero) Children</pre>		!:>			
	State Children's Health Insurance Program (SCHIP) (see instruction	is for ea	ach IIne)		0	
9.00	Net revenue from stand-alone SCHIP Stand-alone SCHIP charges				0	
10. 00 11. 00	Stand-alone SCHIP charges Stand-alone SCHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone SCHIP (li	no 11 m	inus lino O	if < zoro thon	0	
12.00	lenter zero)		illus Illie 4,	II < Zei o tileli	U	12.0
	Other state or local government indigent care program (see instruc					
3. 00	Net revenue from state or local indigent care program (Not include				2, 672, 955	
14. 00	Charges for patients covered under state or local indigent care pr	rogram (Not included	in lines 6 or	321, 604	14.0
15. 00	State or local indigent care program cost (line 1 times line 14)				87. 929	15. 0
16. 00	Difference between net revenue and costs for state or local indige	ent care	program (lir	ne 15 minus line	0	
	13; if < zero then enter zero)		1 3 7			
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fundi					17. 0
18. 00	Government grants, appropriations or transfers for support of hosp				0	18. 0
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local i 8, 12 and 16)	ndi gent	care program	ns (sum of lines	2, 854, 722	19. 0
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
20.00	Total initial obligation of patients approved for charity care (at	t full	1. 00 1, 428, 64	2. 00 43 882, 431	3. 00 2, 311, 074	20.0
0.00	charges excluding non-reimbursable cost centers) for the entire fa		1, 420, 0	+3 002, 431	2, 311, 074	20.0
21. 00	Cost of initial obligation of patients approved for charity care (times line 20)		390, 60	241, 263	631, 864	21. 0
22. 00	1		25, 29	99 91, 283	116, 582	22. 0
23. 00			365, 30	•	515, 282	
24. 00	Does the amount in line 20 column 2 include charges for patient da	avs hevo	nd a Length o	of stay limit	1. 00	24. 0
00	imposed on patients covered by Medicaid or other indigent care pro		na a rengtii t	Ji Stay IIIII t		24.0
25. 00						
26. 00	Total bad debt expense for the entire hospital complex (see instru		9	•	3, 686, 834	26. 0
27. 00	Medicare bad debts for the entire hospital complex (see instruction	ons)			343, 426	27. 0
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line	26 mi nu	s line 27)		3, 343, 408	28. 0
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expens	se (line	1 times line	28)	914, 111	29. 0
						l
30. 00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 429, 393	30.0

CLASS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A Date/Time Pre	pare
						5/28/2015 7:0	
	Cost Center Description	Sal ari es	0ther	lotal (col. 1 + col. 2)	Reclassifications (See A-6)	Trial Balance (col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4) 5. 00	
C	GENERAL SERVICE COST CENTERS				1		
	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 129, 866	1			
	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	1	1, 662, 472 0 0	1	
	DO300 OTHER CAPITAL RELATED COSTS DO400 EMPLOYEE BENEFITS DEPARTMENT	230, 231	4, 059, 541	1	-	1	1 -
	DOSOO ADMINISTRATIVE & GENERAL	1, 627, 382	8, 097, 208				
	00700 OPERATION OF PLANT	344, 254	1, 338, 681			1	
	DO800 LAUNDRY & LINEN SERVICE	0	119, 809			,	
	00900 HOUSEKEEPI NG	342, 795	156, 869	1		,	
	D1000 DI ETARY D1100 CAFETERI A	330, 920	178, 126 0	i .	6 -199, 514 0 199, 514	1	
1	D1200 MAINTENANCE OF PERSONNEL		Ö	1	0 0	l	1
00	01300 NURSING ADMINISTRATION	1, 132, 042	147, 323	1, 279, 36	5 0	1, 279, 365	13
	01400 CENTRAL SERVICES & SUPPLY	105, 277	603, 417			1	
	D1500 PHARMACY	104, 505	3, 103, 801			1	
	D1600 MEDICAL RECORDS & LIBRARY D1700 SOCIAL SERVICE		911, 209 0	1	9 0 0 40, 768	, == .	
	01900 NONPHYSICIAN ANESTHETISTS		0		0 10, 730	0	1
00	02000 NURSING SCHOOL	0	0		0	0	20
	D2100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0		0	0	
	D2200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0 0	0	1
-	NPATIENT ROUTINE SERVICE COST CENTERS	l o			J 0	0	23
	03000 ADULTS & PEDIATRICS	2, 138, 175	171, 007	2, 309, 18	2 -60, 970	2, 248, 212	30
	03100 INTENSIVE CARE UNIT	914, 061	40, 617	954, 67	-23, 283	931, 395	31
	D3200 CORONARY CARE UNIT	0	0	1	0	0	
1	D3300 BURN INTENSIVE CARE UNIT D3400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	
	04000 SUBPROVI DER - I PF		0		0 0	1	
	04100 SUBPROVI DER – I RF	l o	O		0	Ö	
	04200 SUBPROVI DER	0	0		0 0	-	
	04300 NURSERY	0	0		0	0	
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		0		0	0	
- 1	04510 CF/MR		Ö			Ö	
	04600 OTHER LONG TERM CARE	0	0		0 0	0	46
-	ANCILLARY SERVICE COST CENTERS	1 22 (21		1 = 5 < 5 1			١.,
	D5000 OPERATING ROOM D5100 RECOVERY ROOM	1, 212, 626 68, 224	383, 384 0	1			
	D5200 DELIVERY ROOM & LABOR ROOM	00, 224	0	1	0	00, 224	
00	D5300 ANESTHESI OLOGY	0	0)	0 0	0	53
	D5400 RADI OLOGY-DI AGNOSTI C	1, 526, 476	1, 480, 251	3, 006, 72	7 -98, 172	2, 908, 555	
	D5500 RADI OLOGY-THERAPEUTI C	0	120 522	222.14	0 0	1/2 02/	
	D5600 RADI 0I SOTOPE D5700 CT SCAN	102, 617	129, 523	232, 14	-69, 214	162, 926 0	1
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	l ő	Ö		0 0	ő	
	D5900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59
	D6000 LABORATORY	1, 315, 938	1, 788, 537	3, 104, 47	5 0	3, 104, 475	
1	06001 BLOOD LABORATORY	0	0		0	0	
1	D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0		1 .
1	06300 BLOOD STORING, PROCESSING & TRANS.	l ő	Ö		0 0	ő	
00	D6400 INTRAVENOUS THERAPY	0	O		0	0	64
	06500 RESPI RATORY THERAPY	0	0		0	0	
- 1	06600 PHYSI CAL THERAPY	781, 463	125, 411	906, 87	-20, 277		
1	D6700 OCCUPATI ONAL THERAPY D6800 SPEECH PATHOLOGY	0	0			0 0	1
	06900 ELECTROCARDI OLOGY	926, 265	144, 453	1, 070, 71	234, 414	l	1
00	D7000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	1, 025, 213	l	1
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 48, 533 0 2, 244, 893		
1	D7300 DRUGS CHARGED TO PATIENTS D7400 RENAL DIALYSIS		0		2, 244, 893 0	2, 244, 893	1
1	07500 ASC (NON-DISTINCT PART)		0			Ö	1
- 1	07697 CARDI AC REHABI LI TATI ON	232, 574	46, 692	279, 26	-266, 664		1
	DUTPATIENT SERVICE COST CENTERS						4.
	08800 RURAL HEALTH CLINIC	0	0		0	0	
1	D8900 FEDERALLY QUALIFIED HEALTH CENTER D9000 CLINIC	U	0		0	0 0	
	09000 CLINIC - DIABETES	71, 044	8, 856	79, 90	-105	1	
	09100 EMERGENCY	1, 305, 973	832, 284				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1		I .	1	İ	92

Health Financial Systems IND	I ANA UNI VERSI TY	HEALTH BEDFOR	RD.	In Lie	In Lieu of Form CMS-2552-		
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A		
				From 01/01/2014			
				To 12/31/2014			
Cook Cooks Doors at the	C-1:	0+1	T-+-1 /1 /	D1: 6:+:	5/28/2015 7:0	2 pm	
Cost Center Description	Sal ari es	0ther		Reclassificati			
			+ col . 2)	ons (See A-6)	(col. 3 +-		
					col. 4)		
	1.00	2.00	3. 00	4. 00	5. 00		
OTHER REIMBURSABLE COST CENTERS	1.00	2.00	3.00	4.00	5.00		
94. 00 09400 HOME PROGRAM DIALYSIS		٥		0	0	94. 00	
95. 00 09500 AMBULANCE SERVICES		0		0	0		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0		0	0	1	
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED		0		0	0	97.00	
99. 00 09900 CMHC		U O		0	0	99.00	
99. 10 09910 CORF	0	U		0	0		
	0	U		0			
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	U		0		100.00	
101. 00 10100 HOME HEALTH AGENCY	U	U		0 0	0	101. 00	
SPECIAL PURPOSE COST CENTERS	1 0	ما				105 00	
105. 00 10500 KI DNEY ACQUI SI TI ON	0	U		0		105.00	
106. 00 10600 HEART ACQUISITION	0	0		0		106.00	
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		107. 00	
108. 00 10800 LUNG ACQUISITION	0	0		0		108. 00	
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109. 00	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110. 00	
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111. 00	
113.00 11300 INTEREST EXPENSE		106, 708	106, 70	-106, 708		113. 00	
114.00 11400 UTILIZATION REVIEW-SNF	0	0		0 0		114. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115. 00	
116. 00 11600 H0SPI CE	0	0		0	l .	116. 00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	14, 812, 842	26, 103, 573	40, 916, 41	5 174, 153	41, 090, 568	118. 00	
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 925	2, 485	11, 41	0 -1, 022		190. 00	
191. 00 19100 RESEARCH	0	0		0		191. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	3, 893	191, 473	195, 36	6 -164, 565		192. 00	
192. 01 19201 VACANT SPACE	0	0		0		192. 01	
193.00 19300 NONPALD WORKERS	0	0		0		193. 00	
194.00 07950 MARKETING/PUBLIC RELATIONS	0	70, 525	70, 52	5 -4, 482		194. 00	
194.01 07951 CLARIAN HOME CARE	0	0		0		194. 01	
194.02 07952 BLOOMNGTN AMBULANCE AND OCC MED	144, 706	27, 177					
200.00 TOTAL (SUM OF LINES 118-199)	14, 970, 366	26, 395, 233	41, 365, 59	9 0	41, 365, 599	200.00	

Peri od: From 01/01/2014 To 12/31/2014 Worksheet A Date/Time Prepared: 5/28/2015 7:02 pm

				5/28/2015 7:0	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation	-	
	OFNEDAL CERVILOE COCT CENTERS	6.00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	122 270	727 101		1 00
1. 00 2. 00	OO100 NEW CAP REL COSTS-BLDG & FIXT OO200 NEW CAP REL COSTS-MVBLE EQUIP	122, 378			1. 00 2. 00
3. 00	1	-245, 359 0	1, 417, 113 0		3.00
	00300 OTHER CAPITAL RELATED COSTS	604, 169	-		4. 00
4. 00 5. 00	OO4OO	-835, 958			5.00
7. 00	00700 OPERATION OF PLANT	-035, 956			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 682, 935 119, 809		8.00
9. 00	00900 HOUSEKEEPING	0	499, 664		9. 00
10. 00	01000 DI ETARY	_			10.00
11. 00	01100 CAFETERI A	-1, 109 94 471			11.00
		-86, 671 0	112, 843		12.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL	0	-		13.00
14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	1, 279, 365 277, 790		14. 00
	01500 PHARMACY	0	877, 787		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-1, 703			16.00
17. 00	01700 SOCIAL SERVICE	-1, 703	40, 768		17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	40, 700		19.00
20. 00	02000 NURSI NG SCHOOL	0	٥		20.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	0	٥		21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	j o	l ol		22. 00
23. 00	02300 PARAMED ED PRGM	j o		l .	23. 00
20.00	I NPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>		20.00
30. 00	03000 ADULTS & PEDI ATRI CS	-11, 504	2, 236, 708		30.00
31. 00	03100 NTENSI VE CARE UNI T	0			31.00
32. 00	03200 CORONARY CARE UNIT	i o			32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	l ol		33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	o		34.00
40.00	04000 SUBPROVIDER - IPF	0	o		40.00
41. 00	04100 SUBPROVI DER - I RF	0	ol		41. 00
42. 00	04200 SUBPROVI DER	0	ol		42. 00
43. 00	04300 NURSERY	0	o o		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	o o		44. 00
45. 00	04500 NURSING FACILITY	0	ol		45. 00
45. 01	04510 I CF/MR	0	ol		45. 01
46. 00	04600 OTHER LONG TERM CARE	0		l .	46. 00
	ANCILLARY SERVICE COST CENTERS		-1		1
50.00	05000 OPERATI NG ROOM	-552, 301	902, 399		50.00
51.00	05100 RECOVERY ROOM	0	68, 224	l .	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	o		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-337, 790	2, 570, 765		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	O		55. 00
56.00	05600 RADI 0I SOTOPE	0	162, 926		56. 00
57.00	05700 CT SCAN	0	ol		57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	ol		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	ol		59.00
60.00	06000 LABORATORY	-271, 744	2, 832, 731		60.00
60. 01	06001 BLOOD LABORATORY	0			60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	ol		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	ol		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	ol		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	ol		64. 00
65.00	06500 RESPI RATORY THERAPY	0	ol		65.00
66.00	06600 PHYSI CAL THERAPY	-1, 563	885, 034		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	ol		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	ol		68. 00
69.00	06900 ELECTROCARDI OLOGY	-13, 200	1, 291, 932		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	ol		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 025, 213		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	48, 533		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 244, 893	l .	73. 00
	07400 RENAL DIALYSIS	0	o		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	l		75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	12, 602		76. 97
	OUTPATIENT SERVICE COST CENTERS				1
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o		89. 00
90.00	09000 CLI NI C	0	ol		90.00
90. 01	09001 CLINIC - DIABETES	0	79, 795		90. 01
91.00	09100 EMERGENCY	670, 602	2, 707, 722	·	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS]
94.00	09400 HOME PROGRAM DIALYSIS	0	0		94. 00

 Health Financial
 Systems
 INDIANA UNIVERSITY
 HEALTH BEDFORD

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CC
 Provi der CCN: 151328

			5/28/2015 7:02 pm	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
95. 00 09500 AMBULANCE SERVICES	0	0		5. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		b. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		7. 00
99. 00 09900 CMHC	0	0		9. 00
99. 10 09910 CORF	0	0		9. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	1 1 1	0. 00
101.00 10100 HOME HEALTH AGENCY	0	0	101	. 00
SPECIAL PURPOSE COST CENTERS	,			
105.00 10500 KIDNEY ACQUISITION	0	0	1 1 1	5. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	1 1 1	b. 00
107.00 10700 LIVER ACQUISITION	0	0		7. 00
108.00 10800 LUNG ACQUISITION	0	0		3. 00
109. 00 10900 PANCREAS ACQUISITION	0	0		9. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		. 00
113. 00 11300 I NTEREST EXPENSE	0	0		3. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		1. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		5. 00
116. 00 11600 HOSPI CE	0	0		b. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-961, 753	40, 128, 815	118	3. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 388		0. 00
191. 00 19100 RESEARCH	0	0		. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	30, 801		2. 00
192. 01 19201 VACANT SPACE	0	0		2. 01
193. 00 19300 NONPAI D WORKERS	0	0		3. 00
194. 00 07950 MARKETI NG/PUBLI C RELATI ONS	3, 763	69, 806		1.00
194. 01 07951 CLARI AN HOME CARE	0	1// 0/10		1. 01
194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED	-956	166, 843		1. 02
200.00 TOTAL (SUM OF LINES 118-199)	-958, 946	40, 406, 653	200	0. 00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-0 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Provi der CCN: 151328

					5/28/2015 7:0)2 pm
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2. 00	3. 00	4. 00	5. 00		
1 00	A - BILLABLE MEDICAL SUPPLIES	71 00	ما	1 005 010		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	1, 025, 213		1. 00
2.00	PATTENTS	0.00	o	0		2. 00
3.00		0.00	o	0		3. 00
4.00		0.00		0		4.00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	0	ő		8. 00
9. 00		0.00	0	Ö		9. 00
10. 00		0.00	0	o		10.00
11. 00		0.00	0	0		11.00
12.00		0.00	0	ő		12.00
13. 00		0.00	Ö	ő		13. 00
14. 00		0.00	0	0		14. 00
14.00			 	1, 025, 213		14.00
	B - IMPLANT SUPPLIES		<u> </u>	1,020,210		-
1.00	IMPL. DEV. CHARGED TO	72.00	0	48, 533		1.00
	PATI ENT			,		
				48, 533		
	C - BILLABLE DRUGS					ĺ
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	2, 244, 893		1.00
2.00		0.00	0	0		2. 00
	0		0	2, 244, 893		
	D - INTEREST					
1.00	ADMI NI STRATI VE & GENERAL		0_	10 <u>6, 7</u> 08		1.00
	0		0	106, 708		
	E - DI ETARY/CAFETERI A					
1.00	CAFETERI A	<u>11.</u> 00	12 <u>9, 7</u> 00	6 <u>9, 8</u> 14		1.00
	0		129, 700	69, 814		
	G - BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 139		1.00
2.00		000	•	0		2. 00
	U COCIAL CEDVICES		0	1, 139		
1 00	H - SOCIAL SERVICES	17 00	40.7(0	0		1 00
1. 00	SOCI AL SERVI CE	<u>17.</u> 00	4 <u>0, 7</u> 68 40, 768	0		1. 00
	I - ALLOWABLE ADVERTISING		40, 700	U		
1.00	ADMINISTRATIVE & GENERAL	5. 00	nl	4, 482		1.00
1.00	O OENEKAL			4, 482		1.00
	J - MME DEPR EXPENSE		<u> </u>	4, 402		
1.00	NEW CAP REL COSTS-MVBLE	2.00	ol	1, 662, 472		1.00
1.00	EQUI P	2.00	٩	1,002,472		1.00
	0	+		1, 662, 472		
	K - ECHO	L	-1	.,		
1.00	ELECTROCARDI OLOGY	69.00	220, 284	44, 224		1.00
			220, 284	44, 224		
	L - HOSP-PAID PHYSICIAN CLINIC	2	• •			1
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	147, 329		1.00
	FIXT					
2.00	ADMI NI STRATI VE & GENERAL		0_	1 <u>7, 1</u> 19		2. 00
	0		0	164, 448		
500.00	Grand Total: Increases		390, 752	5, 371, 926		500.00
500.00	Grand Total: Increases		390, 752	5, 371, 926		500.

Health Financial Systems RECLASSIFICATIONS

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 5/28/2015 7:02 pm

						5/28/2015 /: 0)2 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - BILLABLE MEDICAL SUPPLIES	;					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	6, 414	0		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	o	382, 371	o		2. 00
3.00	PHARMACY	15. 00	ol	86, 343			3.00
4. 00	ADULTS & PEDIATRICS	30.00	0	60, 970			4.00
5. 00	INTENSIVE CARE UNIT	31.00	ol	23, 283			5. 00
6. 00	OPERATING ROOM	50.00	o	141, 310	l .		6.00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	97, 455			7. 00
8. 00	RADI OLOGI - DI AGNOSTI C	56.00	0	69, 214			8.00
9. 00	PHYSICAL THERAPY		0				
		66.00		20, 277			9.00
10.00	ELECTROCARDI OLOGY	69. 00	0	30, 094			10.00
11. 00	CARDIAC REHABILITATION	76. 97	0	2, 156			11.00
12. 00	CLINIC - DIABETES	90. 01	0	105			12. 00
13.00	EMERGENCY	91. 00	0	101, 137			13. 00
14.00	BLOOMNGTN AMBULANCE AND OCC	194. 02	0	4, 084	0		14. 00
	MED						
	0		0	1, 025, 213]
	B - IMPLANT SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14. 00		4 <u>8, 5</u> 33	0		1.00
	0		0	48, 533			
	C - BILLABLE DRUGS						
1.00	PHARMACY	15. 00	0	2, 244, 176	0		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	ol	717	o		2.00
				2, 244, 893			1
	D - INTEREST	,			'		1
1.00	INTEREST EXPENSE	113.00	0	106, 708	0		1.00
				106, 708			
	E - DIETARY/CAFETERIA		-1		L		1
1.00	DI ETARY	10.00	129, 700	69, 814	0		1.00
	0		129, 700	69, 814			
	G - BENEFITS		,		1		i
1. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	1, 022	0		1.00
	CANTEEN	1,01.00	٦	., 522			
2.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	117	o		2.00
2.00	0		— — 				2.00
	H - SOCIAL SERVICES		<u> </u>	1, 137			i
1.00	ADMI NI STRATI VE & GENERAL	5. 00	40, 768	0	0		1.00
1.00	O O O O O O O O O O O O O O O O O O O		40, 768	— — <u> </u>			1.00
	I - ALLOWABLE ADVERTISING		40, 700				1
1.00	MARKETING/PUBLIC RELATIONS	194. 00	O	4, 482	0		1.00
1.00	O NEITHOFFODLIC KLLATIONS						1.00
	J - MME DEPR EXPENSE		U	4, 482			1
1 00		1 00	ما	1 (() 170	9		1 00
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	1, 662, 472	9		1. 00
	FIXT	+	+		 		
	U		0	1, 662, 472			-
	K - ECHO	==	200 004				
1. 00	CARDI AC REHABI LI TATI ON	<u>76.</u> 97	220, 284	44, 224			1. 00
	U	•	220, 284	44, 224			
	L - HOSP-PAID PHYSICIAN CLINI		1				4
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	164, 448			1. 00
2.00		0.00	0	0			2. 00
	0		0	164, 448			
500.00	Grand Total: Decreases		390, 752	5, 371, 926			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151328 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 912, 711 1.00 18, 624 18, 624 0 1.00 0 2.00 Land Improvements 1, 174, 400 0 2.00 12, 469, 097 0 3.00 518, 235 3.00 Buildings and Fixtures 664, 163 664, 163 0 4.00 Building Improvements 3, 148, 388 50, 490 50, 490 0 4.00 5.00 Fixed Equipment 3, 957, 851 0 5.00 0 6.00 Movable Equipment 16, 753, 494 2, 761, 271 2, 761, 271 575, 469 6.00 0 7.00 HIT designated Assets 1, 845, 472 0 7.00 8.00 Subtotal (sum of lines 1-7) 40, 261, 413 3, 494, 548 3, 494, 548 1, 093, 704 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 40, 261, 413 1, 093, 704 10.00 3, 494, 548 0 3, 494, 548 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 931, 335 0 1.00 2.00 Land Improvements 1, 174, 400 0 2.00 3.00 Buildings and Fixtures 12, 615, 025 0 3.00 0 4.00 Building Improvements 3, 198, 878 4.00 5.00 Fi xed Equipment 3, 957, 851 0 5.00 Movable Equipment 18, 939, 296 0 6.00 6.00 7. 00 7.00 HIT designated Assets 1, 845, 472 0 Subtotal (sum of lines 1-7) 8.00 42, 662, 257 0 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 42, 662, 257 0 10.00

Heal th	Financial Systems IND	IANA UNIVERSIT	Y HEALTH BEDFOR	RD	In Lie	eu of Form CMS-:	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151328	Peri od: From 01/01/2014	Worksheet A-7	
						Date/Time Pre 5/28/2015 7:0	pared: 2 pm
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,	
					instructions)	instructions)	
		9.00	10.00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FLXT	2, 129, 866	0		0 0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	2, 129, 866	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				

1. 00 2. 00 3. 00

Heal th	n Financial Systems IND	IANA UNIVERSIT	Y HEALTH BEDFOR	RD	In Lie	u of Form CMS-	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	'
					From 01/01/2014 To 12/31/2014	Part III	narodi
					10 12/31/2014	Date/Time Pre 5/28/2015 7:0	pareu. 12 nm
		COME	PUTATION OF RAT	TIOS	ALLOCATION OF		_ p
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE				1		
1.00	NEW CAP REL COSTS-BLDG & FIXT	19, 734, 853		19, 734, 85		0	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	22, 927, 403		22, 927, 40		0	2. 00
3.00	Total (sum of lines 1-2)	42, 662, 256		42, 662, 25			3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				F CAPITAL			
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0)	737, 101	0	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0)	1, 417, 113		2.00
3.00	Total (sum of lines 1-2)	0)	2, 154, 214	0	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13.00	14. 00	15. 00	
	DADT III DECONCILIATION OF CADITAL COSTS OF	MITEDO					1

0 0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
NEW CAP REL COSTS-BLDG & FIXT

2.00 NEW CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

0 0 0

0 0 0

737, 101 1. 00 1, 417, 113 2. 00 2, 154, 214 3. 00

0 0 0

1.00

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 Provi der CCN: 151328 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1. 00 1.00 REL COSTS-BLDG & FLXT (chapter IFT XT 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter FOUI P 3 00 Investment income - other 0 3 00 0 00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evision and radio service 0 0.00 8.00 0 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 0

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0.00

ADJUSTMENTS TO EXPENSES Provi der CCN: 151328 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 33.00 INVESTMENT INCOME -106, 708 ADMI NI STRATI VE & GENERAL 33. 00 В 5.00 CAFETERIA SALES-OTHER REVENUE -86, 671 CAFETERI A 34.00 В 11.00 0 34.00 35.00 SRVE SAVE CLASS/DIET-NON OPER В -1, 109 DI ETARY 10.00 35.00 COMDATA REV-NON OPER REV В -11, 197 ADMI NI STRATI VE & GENERAL 5.00 37.00 37.00 0 HIT DEPR EXP -366, 289 NEW CAP REL COSTS-MVBLE 38.00 38.00 Α 2.00 EQUI P 39.00 IU HEALTH PAOLI-NON OPER REV В -23, 968 ADMI NI STRATI VE & GENERAL 5.00 39.00 A/R R KALARI-NON OPER REV -3, 130 ADMI NI STRATI VE & GENERAL 40.00 В 5.00 40.00 M/R TRANSCRIPT FEE-NON OPER -1, 703 MEDI CAL RECORDS & LI BRARY 16.00 41.00 41.00 В **RFV** CABLE TV -956 BLOOMNGTN AMBULANCE AND OCC 42.00 Α 194.02 42.00 PURCH DI SCOUNTS/LATE FEES -1, 220 ADMI NI STRATI VE & GENERAL 43.00 В 5.00 43.00 CABLE TV -11,504 ADULTS & PEDIATRICS 44.00 30.00 0 44.00 Α CABLE TV -1, 563 PHYSI CAL THERAPY 45.00 Α 66.00 45 00 45. 01 RECRUI TMENT -104, 219 ADMI NI STRATI VE & GENERAL 5.00 45.01 Α -2, 920 ADMI NI STRATI VE & GENERAL 45.02 CABLE TV Α 5.00 45.02 -4.668ADMINISTRATIVE & GENERAL MISCELL INCOME 45.03 45.03 5.00 0 В -2, 820, 841 ADMI NI STRATI VE & GENERAL 45.04 HAF FEES Α 5.00 45.04 FOUNDATION EXPENSE 3, 763 MARKETING/PUBLIC RELATIONS 194.00 45.05 45.05 Α PATIENT PHONE COSTS -39,659 ADMINISTRATIVE & GENERAL 45.06 Α 5.00 45.06 -2, 333, 560 EMPLOYEE BENEFITS DEPARTMENT 45.07 BENEFITS OFFSET 4.00 45.07 Δ 45.08 PUBLIC RELATIONS COSTS Α -1, 953 ADMINISTRATIVE & GENERAL 5.00 45.08 HAF FOUNDATION CONTRIBUTION 15, 248 ADMINI STRATI VE & GENERAL 45.09 45.09 5.00 45.10 0.00 45. 10 0 0

00000

0

-958 946

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

(2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

B. Amount Received - if cost cannot be determined.

See instructions for column 5 referencing to Worksheet A-7.

A. Costs - if cost, including applicable overhead, can be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Heal th	Financial Systems	INDIANA UNIVERSI	TY HEALTH BEDFORD	In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HO				Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2014 To 12/31/2014		
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE ALLOCATED COSTS	122, 378	0	1.00
2.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE ALLOCATED COSTS	120, 930	0	2.00
3.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATED COSTS	2, 937, 729	0	3.00
3. 01	5. 00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	2, 632, 631	2, 632, 631	3. 01
3.02	5. 00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	106, 708	106, 708	3. 02
4.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATED COSTS	1, 887, 099	o	4.00

ADMIN - BLOOMINGTON

SHARED EMPLOYEES

BLOOMINGTON - ER

0

29, 230

1.037

11, 504

60, 365

89.616

150, 750

6, 334

5, 107

304

814.470

382, 178

814, 470

11,504

60, 365

89, 616

150, 750

1, 895, 709

6, 334

304

29, 230

1.037

4.01

4.02

4 03

4.04

4.05

4.06

4 07

4.08

4.09

4.10

4 11

5.00 11, 248, 972 3, 908, 056 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1. 00	2. 00	3.00	4. 00	5. 00	
•	B. INTERRELATIONSHIP TO RELAT	ED 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

i ei ilibui	Sellett under title Aviii.		
6.00	В	0. 00 I U HEALTH, I NC. 50. 00	6. 00
7. 00	F	0. 00 I UH BLOOMI NGTO 50. 00	7. 00
8.00		0.00	8. 00
9. 00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

5. 00 ADMINISTRATIVE & GENERAL

16.00 MEDICAL RECORDS & LIBRARY

194. 00 MARKETI NG/PUBLI C RELATIONS

7. 00 OPERATION OF PLANT

30. 00 ADULTS & PEDIATRICS

66. 00 PHYSI CAL THERAPY

69. 00 ELECTROCARDI OLOGY

54. 00 RADI OLOGY-DI AGNOSTI C

10. 00 DI ETARY

60. 00 LABORATORY

91. 00 EMERGENCY

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

4.01

4.02

4.03

4.04

4.05

4.06

4 07

4.08

4.09

4.10

4 11

							10	12/31/2014	Date/Time Pr 5/28/2015 7:	epared:
	Net	Wkst. A-7 Ref.	,						3/20/2013 /.	
	Adjustments	WKSt. A / KCI.								
	(col. 4 minus									
	col. 5)*									
	6, 00	7. 00								
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANS	ACTIONS WITH R	ELATED O	RGANI Z	ZATI ONS OR	CLAIMED	
	HOME OFFICE CO									
1.00	122, 378	9								1. 00
2.00	120, 930	9								2.00
3.00	2, 937, 729	0								3.00
3.01	0	0								3. 01
3.02	0	0								3. 02
4.00	1, 887, 099	0								4. 00
4.01	382, 178	0								4. 01
4.02	0	0								4. 02
4.03	0	0								4. 03
4.04	0	0								4. 04
4.05	0	0								4. 05
4.06	0	0								4. 06
4.07	0	0								4. 07
4.08	0	0								4. 08
4.09	0	0								4. 09
4. 10	1, 890, 602	0								4. 10
4. 11	0	0								4. 11
5.00	7, 340, 916									5. 00

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

Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	FED 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.

Termbursement under title AVIII.								
6.00	HOME OFFICE		6. 00					
7.00	HEALTHCARE		7.00					
8.00			8.00					
9.00			9.00					
10.00			10.00					
100.00			100.00					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 151328 Peri od: Worksheet A-8-2 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 7.00 1. 00 2. 00 3. 00 4.00 5. 00 6. 00 60. 00 LABORATORY 1.00 290, 944 271, 744 1. 00 19, 200 0 0 2.00 50.00 OPERATING ROOM 611, 178 552, 301 58, 877 0 2.00 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 337, 790 337, 790 0 3.00 13, 200 4.00 69. 00 ELECTROCARDI OLOGY 13, 200 0 0 4.00 91. 00 EMERGENCY 5.00 1, 895, 709 1, 220, 000 675, 709 0 5.00 6.00 0.00 6.00 0 0 7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 8.00 0 0 0 9.00 0.00 0 0 9.00 10.00 0.00 0 10.00 3, 148, 821 2, 395, 035 753, 786 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 1. 00 2.00 8.00 9.00 12. 00 13.00 14.00 60. 00 LABORATORY 1. 00 1.00 0 0 0 0 2.00 50. 00 OPERATING ROOM 0 0 0 0 0 2.00 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 3.00 0 0 4.00 69. 00 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 4.00 91. OO EMERGENCY 5.00 0 5 00 6.00 0.00 0 6.00 7.00 0.00 o 0 0 7.00 0 0.00 0 0 8.00 8.00 0.00 0 0 9.00 9.00 10.00 0.00 10.00 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 60. 00 LABORATORY 1. 00 1.00 271, 744 0 0 0 0 2.00 50.00 OPERATING ROOM 0 0 552, 301 2.00 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 337, 790 3.00 4.00 69. 00 ELECTROCARDI OLOGY 0 0 0 13, 200 4.00 91. 00 EMERGENCY 5.00 0 0 0 1, 220, 000 5 00 6.00 0.00 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00

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2, 395, 035

8.00

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8.00

9.00

10.00

200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151328

					To	12/31/2014	Date/Time Prep 5/28/2015 7:03	
				CAPI TAL REI	ATED COSTS		5/26/2015 7.0.	z piii
				NEW BLBG &	NEW MARKE	511D1 01/55		
		Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation	117	24011	DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	4. 00	4A	
	GENER	AL SERVICE COST CENTERS		1.00	2. 00	1. 00	171	
1.00		NEW CAP REL COSTS-BLDG & FIXT	737, 101	737, 101				1. 00
2. 00 4. 00		NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	1, 417, 113 4, 895, 080	0	1, 417, 113 0	4, 895, 080		2. 00 4. 00
5.00		ADMINISTRATIVE & GENERAL	8, 969, 759	60, 261	172, 491	526, 902	9, 729, 413	5. 00
7.00	1	OPERATION OF PLANT	1, 682, 935	73, 814		114, 324	2, 082, 358	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	119, 809	0	0	0	119, 809	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	499, 664 308, 423	11, 454 14, 861	32, 785 42, 538	113, 839 66, 823	657, 742 432, 645	9. 00 10. 00
11. 00		CAFETERI A	112, 843	9, 579		43, 072	192, 913	11. 00
12. 00		MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	1, 279, 365	18, 968		375, 942 34, 962	1, 728, 568 329, 158	13. 00 14. 00
15. 00		PHARMACY	277, 790 877, 787	4, 248 7, 746		34, 705	942, 410	15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	909, 506	27, 238		0	1, 014, 712	
17.00	1	SOCIAL SERVICE	40, 768	0	0	13, 539	54, 307	17. 00
19. 00 20. 00		NONPHYSICIAN ANESTHETISTS NURSING SCHOOL	0	0) 0	0	0	19. 00 20. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	Ö	0	Ö	Ö	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00		PARAMED ED PRGM I ENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00		ADULTS & PEDIATRICS	2, 236, 708	43, 347	124, 076	710, 072	3, 114, 203	30. 00
31.00		INTENSIVE CARE UNIT	931, 395	12, 070		303, 552	1, 281, 565	31. 00
32.00		CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00 34. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00		SUBPROVI DER - I PF	O	0	Ö	0	0	40. 00
41. 00	1	SUBPROVI DER - I RF	0	0	0	0	0	41. 00
42. 00 43. 00	1	SUBPROVI DER NURSERY	0	0	0	0	0	42. 00 43. 00
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500	NURSING FACILITY	O	0	0	0	0	45. 00
45. 01	1	I CF/MR	0	0	0	0	0	45. 01
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	l o	0	U	U	U	46. 00
50.00	05000	OPERATING ROOM	902, 399	56, 660	162, 183	402, 703	1, 523, 945	50. 00
51.00		RECOVERY ROOM	68, 224	0	0	22, 657	90, 881	51.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0	0	0	0	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	2, 570, 765	61, 303	175, 474	506, 930	3, 314, 472	
55. 00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	162, 926 0	0	0	34, 078 0	197, 004 0	56. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	o o	0	0	0	0	58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	2, 832, 731	20, 641	59, 083	437, 012	3, 349, 467 0	60. 00 60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		J	0	61. 00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0	0	0	0	0	64. 00 65. 00
66. 00		PHYSI CAL THERAPY	885, 034	16, 880	48, 318	259, 518	1, 209, 750	
67. 00		OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0 1, 291, 932	0 25, 698	73, 559	0 380, 760	0 1, 771, 949	68. 00 69. 00
70.00		ELECTROENCEPHALOGRAPHY	0	23, 070	73,337	0	0	70. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 025, 213	0	0	0	1, 025, 213	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	48, 533 2, 244, 893	0	0	0	48, 533 2, 244, 893	
74.00		RENAL DIALYSIS	2, 244, 693	0	0	0	2, 244, 693	74.00
75. 00	07500	ASC (NON-DISTINCT PART)		0	o	o	0	75. 00
76. 97		CARDIAC REHABILITATION	12, 602	4, 183	11, 973	4, 081	32, 839	76. 97
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	ol	0	0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	O	0	o	ő	0	89. 00
90.00	09000	CLINIC DIABETES	0	0	0	0	111 000	90.00
90.01	U9001	CLINIC - DIABETES	79, 795	1, 996	5, 715	23, 593	111, 099	90.01

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm CAPITAL RELATED COSTS NEW BLDG & **EMPLOYEE** Cost Center Description Net Expenses NEW MVBLE Subtotal for Cost **BENEFITS** FIXT **FOULP** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 91. 00 09100 EMERGENCY 2, 707, 722 19, 641 56, 220 433, 703 3, 217, 286 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 95.00 Ω 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09900 CMHC 0 99.00 0 0 0 0 0 99.00 0 99. 10 09910 CORF 99. 10 0 0 0 100.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105 00 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109. 00 10900 PANCREAS ACQUISITION Ω 0 0 109 00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 40, 128, 815 490, 588 1, 404, 258 4, 842, 767 39, 817, 134 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 27, 070 190. 00 10, 388 3, 552 10, 166 2, 964 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 228, 997 192. 00 30, 801 196, 903 0 1, 293 192. 01 19201 VACANT SPACE 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194. 00|07950|MARKETING/PUBLIC RELATIONS 939 2.689 73, 434 194. 00 69,806 0 194. 01 07951 CLARIAN HOME CARE 0 0 194. 01 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 0 48, 056 260, 018 194. 02 166, 843 45, 119 200.00 Cross Foot Adjustments 0 200. 00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201) 40, 406, 653 737, 101 1, 417, 113 4, 895, 080 40, 406, 653 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 151328

Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/28/2015 7:02 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 9, 729, 413 5 00 5 00 7.00 00700 OPERATION OF PLANT 660, 428 2, 742, 786 7.00 00800 LAUNDRY & LINEN SERVICE 37, 998 157, 807 8.00 8.00 9.00 00900 HOUSEKEEPI NG 208, 606 52, 095 918, 443 9.00 676, 499 01000 DI ETARY 39, 047 10.00 10.00 137, 215 67.592 0 01100 CAFETERI A 61, 183 25, 169 11.00 11.00 43, 568 0 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 01300 NURSING ADMINISTRATION 548, 222 86, 272 0 49 838 13 00 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 104, 394 19, 320 11, 161 0 14.00 15.00 01500 PHARMACY 298, 889 35, 232 0 20, 353 15.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 321.820 123, 891 71, 569 0 16,00 01700 SOCIAL SERVICE 0 17.00 17, 224 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS C 0 0 19.00 02000 NURSING SCHOOL 0 20 00 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22 00 0 r 0 0 22 00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 987, 682 570, 994 30.00 197, 156 61,634 113.894 30.00 31.00 03100 INTENSIVE CARE UNIT 406, 453 54, 897 15, 490 31, 713 105, 505 31.00 32.00 03200 CORONARY CARE UNIT 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 0 Λ 34 00 40.00 04000 SUBPROVIDER - IPF 0 C 0 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 0 04200 SUBPROVI DER 0 42.00 0 0 42.00 04300 NURSERY 43.00 C 0 0 43.00 0 0 44.00 04400 SKILLED NURSING FACILITY 0 44.00 04500 NURSING FACILITY 0 0 45.00 0 0 45.00 0 45 01 04510 | CF/MR O 0 45 01 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 483, 325 257, 709 6.826 148.874 0 50.00 05100 RECOVERY ROOM 51.00 28,823 1,032 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM C 0 0 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 1, 051, 198 278, 827 161, 073 54 00 14.213 0 05500 RADI OLOGY-THERAPEUTI C 55.00 C 0 55.00 0 05600 RADI OI SOTOPE 0 0 56.00 62.481 844 56.00 57.00 05700 CT SCAN ol 0 57.00 0 0 C 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58 00 58 00 0 C 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 60.00 06000 LABORATORY 1, 062, 302 93, 882 0 54, 234 0 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS 0 63.00 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 0 64.00 0 0 06500 RESPIRATORY THERAPY 65 00 0 0 65 00 66.00 06600 PHYSI CAL THERAPY 383, 677 76, 777 7,664 44, 352 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 C 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 561, 981 116,886 0 67.523 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 325, 150 7, 289 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 15.392 C C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 711, 977 C 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 07697 CARDIAC REHABILITATION 19, 026 76.97 10, 415 0 10, 991 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 C 0 0 0 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 CLINIC - DIABETES 90.01 35, 235 9.080 C 5, 246 0 90.01 91.00 09100 EMERGENCY 1,020,375 89.333 42, 815 51,606 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 95. 00 09500 AMBULANCE SERVICES 0 0 0 95.00 n

676, 499 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

TOTAL (sum lines 118-201)

202.00

Provi der CCN: 151328 Pe

157, 807

918, 443

Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/28/2015 7:02 pm ADMINISTRATIVE OPERATION OF Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96. 00 0 n 0 0 97.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 C 0 0 99.00 09900 CMHC 0 0 0 0 99.00 0 0 99. 10 09910 CORF 0 99. 10 0 0 0 0 100.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM Ω 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 105. 00 0 0 106, 00 0 0 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 109, 00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 906, 643 9, 542, <u>445</u> 676, 499 118. 00 118.00 1, 621, 543 157, 807 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 8,585 16, 154 9, 332 0 190. 00 191. 00 19100 RESEARCH 0 0 191.00 895, 601 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 72,627 0 192. 01 19201 VACANT SPACE 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 MARKETING/PUBLIC RELATIONS 0 0 194.00 23, 290 4, 272 2.468 194. 01 07951 CLARI AN HOME CARE 0 0 194. 01 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 82, 466 205, 216 0 0 0 194. 02 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 0 201.00 0

9, 729, 413

2, 742, 786

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			10	3 12/31/2014	5/28/2015 7:0	
Cost Center Description	CAFETERI A	MAINTENANCE OF		CENTRAL	PHARMACY	
		PERSONNEL	ADMI NI STRATI ON	SERVICES &		
	11.00	12. 00	13. 00	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	15.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	322, 833					11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	C	0				12.00
13.00 O1300 NURSING ADMINISTRATION	29, 118	0	2, 442, 018			13. 00
14.00 01400 CENTRAL SERVI CES & SUPPLY	5, 473		0	469, 506		14. 00
15. 00 01500 PHARMACY	10, 417	0	0	0	1, 307, 301	
16.00 01600 MEDICAL RECORDS & LIBRARY	C	0	0	0	0	1
17. 00 01700 SOCIAL SERVICE	1, 042	0	0	0	0	1
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	C	0	0	0	0	1
20. 00 02000 NURSI NG SCHOOL	C	0	0	0	0	
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD		0	0	0	0	
22. 00 02200 1&R SERVI CES-OTHER PRGM COSTS APPRVD	C	_		0	0	
23. 00 O2300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	C	<u> </u>	y U	U	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	59, 627	0	1, 109, 477	0	0	30.00
31. 00 03100 NTENSIVE CARE UNIT	18, 172			0	0	1
32. 00 03200 CORONARY CARE UNIT	10, 172		330, 133	0	0	
33. 00 03300 BURN INTENSIVE CARE UNIT				0	0	
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		0	Ö	1
40. 00 04000 SUBPROVI DER - PF		0		0	ő	
41. 00 04100 SUBPROVI DER - RF		0	o o	0	Ö	
42. 00 04200 SUBPROVI DER	i c	0	0	0	0	
43. 00 04300 NURSERY	l c	Ö	o o	0	Ö	1
44.00 04400 SKILLED NURSING FACILITY	l c	Ō	o	0	0	
45. 00 04500 NURSING FACILITY	i c	Ō	o	0	0	
45. 01 04510 I CF/MR	C	O	o	0	0	
46.00 04600 OTHER LONG TERM CARE	C	0	o	0	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	21, 711	0	403, 978	0	0	50.00
51.00 05100 RECOVERY ROOM	1, 604	0	29, 844	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0	0	0	0	
53. 00 05300 ANESTHESI OLOGY	C	0	0	0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	38, 841	0	0	0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	1
56. 00 05600 RADI OI SOTOPE	2, 265	0	0	0	0	
57. 00 05700 CT SCAN		0	0	0	0	
58.00 O5800 MAGNETI C RESONANCE I MAGING (MRI) 59.00 O5900 CARDI AC CATHETERI ZATI ON		0		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	42, 710	0	0	0	0	1
60. 00 06000 LABORATORY	42,710			0	0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				U	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.				0	Ö	1
64. 00 06400 I NTRAVENOUS THERAPY		0		0	Ö	
65. 00 06500 RESPIRATORY THERAPY	0	l o	ا م	0	ő	
66. 00 06600 PHYSI CAL THERAPY	19, 644	0	0	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY		0	o	0	0	1
68. 00 06800 SPEECH PATHOLOGY	C	O	o	0	0	1
69. 00 06900 ELECTROCARDI OLOGY	31, 417	0	o	0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	0	o	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	o	448, 284	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C	0	o	21, 222	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	0	0	1, 307, 301	73.00
74.00 07400 RENAL DIALYSIS	C	0	0	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	C	0	0	0	0	75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	314	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS		I	1			1
88. 00 08800 RURAL HEALTH CLINIC	C	0	0	0	0	1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0	0	0	0	1
90. 00 09000 CLI NI C	2 C	0	<u>[</u>	0	0	
90. 01 09001 CLI NI C - DI ABETES	1, 670	l .] [, 0	0	0	1
		. ^	560, 584	0	l 0	91.00
91. 00 09100 EMERGENCY	30, 127] 000, 001	- 1	_	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	30, 127		300, 001		_	92.00
	30, 127			0		92. 00

In Lieu of Form CMS-2552-10 Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON SERVICES & SUPPLY 11. 00 12.00 13.00 15.00 14.00 95. 00 09500 AMBULANCE SERVICES 95. 00 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 0 0 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 0 99.00 09900 CMHC 0 0 99.00 0 99. 10 09910 CORF 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 0 0 105. 00 0 0 0 0 0 0 0 0 0 0 106. 00 0 0 107. 00 0 0 0 0 108. 00 0 0 0 109. 00 0 0 110.00 0 111.00 0 0

105.00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION 109. 00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION 111.00 11100 I SLET ACQUISITION 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 0 116. 00 11600 HOSPI CE 0 0 116, 00 C \cap 0 SUBTOTALS (SUM OF LINES 1-117) 118.00 314, 152 0 2, 442, 018 469, 506 1, 307, 301 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 909 0 190. 00 0 191. 00 19100 RESEARCH 0 191.00 0 0 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00 0 0 0 192. 01 19201 VACANT SPACE 0 0 192. 01 0 0 0 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 MARKETING/PUBLIC RELATIONS 0 0 0 0 194. 00 194. 01 07951 CLARIAN HOME CARE 0 0 0 0 194. 01 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 0 194. 02 7,772 0 0 ol Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 0 201. 00 1, 307, 301 202. 00 202.00 TOTAL (sum lines 118-201) 2, 442, 018 322, 833 469, 506

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

		1			1	5/28/2015 7:0	2 pm
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICIAN	NURSI NG SCHOOL	SERVI CES-SALAR	
		RECORDS &		ANESTHETI STS		Y & FRINGES	
		LI BRARY					
		16.00	17. 00	19. 00	20.00	21. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	•					5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11. 00
12.00	01200 MAINTENANCE OF PERSONNEL						12. 00
	01300 NURSING ADMINISTRATION						13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
		1 521 002					
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 531, 992	l				16. 00
17. 00	01700 SOCI AL SERVI CE	0	72, 573				17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(19. 00
20. 00	02000 NURSI NG SCHOOL	0	0	(C	0		20. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	C	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	1	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			_	_		
30. 00	03000 ADULTS & PEDI ATRI CS	75, 234	61, 255	C	0	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	20, 073				•	31. 00
		1	· ·		0	•	
32. 00	03200 CORONARY CARE UNIT	0	0		U	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	(0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	C	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	C	0	0	41.00
42.00	04200 SUBPROVI DER	0	0		0	0	42.00
43.00	04300 NURSERY	0	0		0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	i n		0	0	44. 00
45. 00	04500 NURSING FACILITY		0			0	45. 00
	1		0			1	
	04510 CF/MR	0	1	-		0	45. 01
46. 00	04600 OTHER LONG TERM CARE	0	0	<u> </u>	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS		_	1 -	_	_	
50. 00	05000 OPERATING ROOM	137, 181	0				50. 00
51. 00	05100 RECOVERY ROOM	6, 153	0	(0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	399, 383	0		0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	16, 577	ĺ	1	0	١	56. 00
57. 00	05700 CT SCAN	10, 377	١			0	57. 00
58. 00	1		0			1	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
	06000 LABORATORY	353, 128	0	0	0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	(0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	[C	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	1	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	47, 899	l n	·	n n	l n	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	17,577) o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY		^				68. 00
69. 00	1 · · · · · · · · · · · · · · · · · · ·	104 020]			69. 00
	06900 ELECTROCARDI OLOGY	106, 920	0				
70.00	07000 ELECTROENCEPHALOGRAPHY		0]] 0] 0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 714	0	l c	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	3, 975		(0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	191, 929	0	[C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(C	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	3, 988	0	l .	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	5,700	'	'			1 ,,
88. 00	08800 RURAL HEALTH CLINIC	^	0			0	88. 00
	1						
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0				89. 00
	09000 CLINIC	0] 0] 0	0	90.00
90. 01	09001 CLINIC - DIABETES	388	l e	T C	0	0	90. 01
91.00	09100 EMERGENCY	121, 450	0	l c	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00

194. 01 07951 CLARIAN HOME CARE

200.00

201.00

202.00

194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

0 194. 01

0 194. 02 0 200.00

0 201.00

0 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm INTERNS & **RESI DENTS** NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description MEDI CAL SOCIAL SERVICE Y & FRINGES RECORDS & **ANESTHETISTS** LI BRARY 17.00 19.00 20.00 21.00 16.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 0 0 0 95. 00 95.00 0 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 00 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 Ω 0 109.00 109.00 10900 PANCREAS ACQUISITION 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 111.00 113. 00 113.00 11300 I NTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116. 00 SUBTOTALS (SUM OF LINES 1-117) 118.00 1, 531, 992 72, 573 0 0 0 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 00000 0 0 0 0 0 0 0 0 0 0 191.00 191. 00 19100 RESEARCH 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 192. 01 19201 VACANT SPACE 0 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 0 194. 00 07950 MARKETING/PUBLIC RELATIONS 0 194. 00

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0

1, 531, 992

0

0

72, 573

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0 0 Health Financial Systems In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm INTERNS & **RESI DENTS** SERVI CES-OTHER PARAMED ED Subtotal Intern & Total Cost Center Description PRGM COSTS **PRGM** Residents Cost & Post Stepdown Adjustments 22.00 23. 00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5 00 00500 ADMINISTRATIVE & GENERAL 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 02000 NURSING SCHOOL 20.00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22, 00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 351, 156 6, 351, 156 30.00 03100 INTENSIVE CARE UNIT 0 0 2, 283, 321 0 2, 283, 321 31.00 31.00 32.00 03200 CORONARY CARE UNIT 0 C 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 33.00 000000 0 0 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 40.00 04000 SUBPROVIDER - IPF 0 0 40.00 04100 SUBPROVIDER - IRF 41.00 41.00 04200 SUBPROVI DER 42.00 0 0 0 42.00 04300 NURSERY 0 43 00 C Λ 43 00 0 44.00 04400 SKILLED NURSING FACILITY C 0 44.00 0 04500 NURSING FACILITY 0 0 45.00 0 0 45.00 04510 | CF/MR 45.01 45.01 0 0 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 983, 549 2, 983, 549 50.00 0 05100 RECOVERY ROOM 000000000000 0 51 00 158 337 158 337 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 C 52.00 53.00 05300 ANESTHESI OLOGY o 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 5, 258, 007 5, 258, 007 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 0 55 00 56.00 05600 RADI OI SOTOPE 279, 171 0 279, 171 56.00 05700 CT SCAN 0 57.00 57.00 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 05900 CARDIAC CATHETERIZATION 59 00 0 0 59 00 60.00 06000 LABORATORY 0 4, 955, 723 o 4, 955, 723 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62 00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 0 06400 I NTRAVENOUS THERAPY 0000000000 0 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 65.00 0 65 00 0 66.00 06600 PHYSI CAL THERAPY 1, 789, 763 1, 789, 763 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 C 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 0 06900 ELECTROCARDI OLOGY 69.00 2, 656, 676 2, 656, 676 69 00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 1, 853, 650 0 1, 853, 650 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 89, 122 72.00 0 89, 122 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 C 4, 456, 100 4, 456, 100 73.00 0 07400 RENAL DIALYSIS 0 0 74.00 74.00 0 o 75.00 07500 ASC (NON-DISTINCT PART) C C 75.00 07697 CARDI AC REHABI LI TATI ON 76.97 0 0 77, 573 0 77, 573 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 С 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 89.00 0 0 0 0 09000 CLINIC 0 0 90 00 90 00 \cap Λ 90.01 09001 CLINIC - DIABETES 0 162, 718 0 162, 718 90.01

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm INTERNS & **RESI DENTS** PARAMED ED Cost Center Description SERVI CES-OTHER Subtotal Intern & Total PRGM COSTS PRGM Residents Cost & Post Stepdown Adjustments 22. 00 23. 00 24.00 25. 00 26.00 91. 00 09100 EMERGENCY 0 5, 133, 576 5, 133, 576 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 09900 CMHC 0 0 99.00 0 0 99.00 99. 10 09910 CORF 0 99. 10 0 0 0 100.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 105. 00 105.00 10500 KIDNEY ACQUISITION 00000 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION C 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 0 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 0 0 118.00 0 38, 488, 442 38, 488, 442 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 62, 050 190. 00 62, 050 o 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 1, 197, 225 192. 00 0 1, 197, 225 192. 01 19201 VACANT SPACE 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 0 193. 00 194.00 07950 MARKETING/PUBLIC RELATIONS 0 103, 464 194. 00 103, 464 194. 01 07951 CLARIAN HOME CARE 0 0 194. 01 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 0 555, 472 194. 02 555, 472 0 200.00 Cross Foot Adjustments 0 0 200. 00 0 0 0 201.00 201.00 Negative Cost Centers

0

40, 406, 653

40, 406, 653 202. 00

202.00

TOTAL (sum lines 118-201)

Provi der CCN: 151328

Peri od:

From 01/01/2014

ALLOCATION OF CAPITAL RELATED COSTS

Part II

Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm CAPITAL RELATED COSTS Directly NEW BLDG & NEW MVBLE Subtotal **EMPLOYEE** Cost Center Description Assigned New FIXT **FOULP BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 60, 261 172, 491 232, 752 5.00 00700 OPERATION OF PLANT 7 00 211, 285 285, 099 73, 814 0 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 0 8.00 9.00 00900 HOUSEKEEPI NG 11, 454 32, 785 44, 239 9.00 01000 DI ETARY 0 0 42.538 57.399 10 00 14 861 0 10 00 01100 CAFETERI A 11.00 9, 579 27, 419 36, 998 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 0 0 18, 968 54, 293 73, 261 13.00 01400 CENTRAL SERVICES & SUPPLY 4, 248 12, 158 16, 406 14 00 14 00 01500 PHARMACY 15.00 7, 746 22, 172 29, 918 15.00 01600 MEDICAL RECORDS & LIBRARY 0000 27, 238 77, 968 105, 206 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 C 0 0 0 19 00 20.00 02000 NURSING SCHOOL C 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 0 21.00 02200 & SERVICES-OTHER PRGM COSTS APPRVD 0 0 ol 22.00 0 22.00 02300 PARAMED ED PRGM 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 43.347 124, 076 167, 423 30.00 0 03100 INTENSIVE CARE UNIT 31.00 12,070 34, 548 46, 618 0 31.00 03200 CORONARY CARE UNIT 32.00 0 0 32 00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 33.00 0000000 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 40.00 0 41.00 0 0 41.00 04200 SUBPROVI DER 42.00 42.00 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44 00 Λ 44 00 0 45.00 04500 NURSING FACILITY 0 0 45.00 0 o 45.01 04510 I CF/MR 0 O 45.01 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 56, 660 162, 183 218, 843 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 \cap 0 Λ 52.00 0 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 61, 303 175, 474 236, 777 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55.00 C 05600 RADI OI SOTOPE 56.00 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 0 0 0 06000 LABORATORY 60.00 20, 641 59,083 79, 724 0 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0 0 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 0 0 0 63.00 0 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 06600 PHYSI CAL THERAPY 16, 880 66.00 48, 318 65, 198 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 99, 257 69.00 25, 698 73, 559 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 C 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 C 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 C 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 76.97 07697 CARDIAC REHABILITATION 4, 183 11, 973 16, 156 0 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 0 09000 CLINIC 90.00 90.00 0 0 0 09001 CLINIC - DIABETES 0 90.01 1.996 5.715 7.711 0 90.01 91. 00 09100 EMERGENCY 19,641 56, 220 75, 861 0 91.00

0 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm CAPITAL RELATED COSTS NEW BLDG & **EMPLOYEE** Cost Center Description Directly NEW MVBLE Subtotal Assigned New **BENEFITS** FIXT **FOULP** DEPARTMENT Capi tal Related Costs 0 1.00 2.00 2A 4.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 00000 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 99. 00 09900 CMHC 0 99.00 0 0 99. 10 09910 CORF 0 0 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 o 0 0 100.00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 000000 0 0 106. 00 10600 HEART ACQUISITION 0 106.00 0 0 107.00 107. 00 10700 LIVER ACQUISITION 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 0 115.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 116. 00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 490, 588 1, 404, 258 1, 894, 846 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 3.552 10, 166 13.718 191. 00 19100 RESEARCH 000000 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 196, 903 0 196, 903 192. 01 19201 VACANT SPACE 0 192. 01 0 C 0 193. 00 19300 NONPALD WORKERS 0 193. 00 0 194.00 07950 MARKETING/PUBLIC RELATIONS 939 2,689 0 194. 00 3, 628 194. 01 07951 CLARI AN HOME CARE 0 194. 01 0 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 0 194. 02 45, 119 0 45.119 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00

1, 417, 113

2, 154, 214

737, 101

TOTAL (sum lines 118-201)

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				, '	0 12/31/2014	5/28/2015 7:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	232, 752					5. 00
7.00	00700 OPERATION OF PLANT	15, 799	300, 898	В			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	909	0	909			8. 00
9.00	00900 HOUSEKEEPI NG	4, 990	5, 715		54, 944	70 422	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	3, 282 1, 464	7, 415 4, 780		2, 336 1, 506	70, 432 0	10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	1, 404	4, 780		1, 300	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	13, 115	9, 464	1	2, 981	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 497	2, 119	0		0	14. 00
15. 00	01500 PHARMACY	7, 150	3, 865	1	1, 218	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	7, 699	13, 591	0	4, 281	0	16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	412	0		0	0	17. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0	o o		0	0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	O	o o	o	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	O) o	o	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	22 427	21 420	355	4 012	EO 440	20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	23, 627 9, 723	21, 629 6, 023	1		59, 448 10, 984	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0, 023	ól ő	0	10, 704	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	O	o o	o	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	O	0	O	0	34. 00
40. 00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	0		0	0	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	o o		o	0	44. 00
45. 00	04500 NURSING FACILITY	0	O	o o	Ö	0	45. 00
45. 01	04510 I CF/MR	0	O	0	0	0	45. 01
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	11 5/0	20. 272	20	0.004	0	 EO OO
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	11, 562 690	28, 272 0	1	·	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0,70	o o		_	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	O	o o	Ö	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 147	30, 589	82	9, 638	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	1, 495	0	5	0	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	o o		o	0	59.00
60.00	06000 LABORATORY	25, 417	10, 299	Ō	3, 244	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	1						61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	63. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	0	O	o o	o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	9, 178	8, 423	44	2, 653	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	10.000	0	0	0	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	13, 444	12, 823	0	4, 039	0	69. 00 70. 00
70.00		7, 778	n	42		0	70.00
72. 00		368	Ö	0	o	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	17, 032	O) o	o	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00		0	0) 0	0	0	75.00
76. 97	07697 CARDI AC REHABI LI TATI ON	249	2, 087	′] 0	657	0	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		n n	0	88. 00
89. 00			l a		0	0	89.00
90.00	09000 CLI NI C	0	0) 0	o	0	90.00
90. 01	09001 CLINIC - DIABETES	843	996	1	314	0	90. 01
91.00	09100 EMERGENCY	24, 410	9, 800	247	3, 087	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	O) 0	ol	0	94. 00
	09500 AMBULANCE SERVI CES	0	O				
					-1		

194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

200.00

201.00

202.00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm ADMINISTRATIVE OPERATION OF Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96. 00 0 n 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 C 0 0 99.00 09900 CMHC 0 0 0 99.00 0 0 99. 10 09910 CORF 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY 0 0 100.00 Ω 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 0 0 105. 00 0 0 106, 00 0 107.00 10700 LIVER ACQUISITION 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 109, 00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 228, 280 177, 890 909 70, 432 118. 00 54, 238 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 205 558 0 190. 00 1,772 191. 00 19100 RESEARCH 0 0 191.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 1,737 98, 254 0 192. 01 19201 VACANT SPACE 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194. 00 07950 MARKETI NG/PUBLIC RELATIONS 0 0 194.00 557 469 148 194. 01 07951 CLARI AN HOME CARE 0 0 194. 01 0

1,973

232, 752

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300, 898

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70, 432 202. 00

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From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY PERSONNEL** ADMI NI STRATI ON SERVICES & **SUPPLY** 11. 00 12.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 44,748 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 102, 857 13.00 4.036 13.00 22, 449 14.00 01400 CENTRAL SERVICES & SUPPLY 759 14.00 15.00 01500 PHARMACY 43, 595 15.00 1.444 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 0 0 0 0 17.00 01700 SOCIAL SERVICE 144 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 0 20.00 02000 NURSING SCHOOL 0 0 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 21 00 C Λ 21.00 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 C 0 0 0 22.00 02300 PARAMED ED PRGM 0 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 265 0 46, 731 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 2,519 0 14, 242 0 0 31.00 03200 CORONARY CARE UNIT 32.00 0 0 0 0 32.00 33 00 03300 BURN INTENSIVE CARE UNIT 0 Ω 0 33 00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 C 0 34.00 04000 SUBPROVI DER - I PF 0 0 40.00 40.00 04100 SUBPROVIDER - IRF 41.00 0 0 0 0 0 41.00 04200 SUBPROVI DER 0 42.00 C 0 42.00 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 0 0 0 0 44.00 45 00 04500 NURSING FACILITY Ω O 0 45 00 0 45.01 04510 I CF/MR 0 0 45.01 04600 OTHER LONG TERM CARE 0 46.00 46.00 C ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 17 015 50 00 3 009 Ω 0 0 05100 RECOVERY ROOM 51.00 222 0 1, 257 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 5.384 0 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 56.00 05600 RADI OI SOTOPE 314 0 0 56.00 05700 CT SCAN 57.00 0 0 57.00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 59.00 60 00 06000 LABORATORY 5, 920 60.00 06001 BLOOD LABORATORY 0 60.01 0 0 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 06400 INTRAVENOUS THERAPY 64.00 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 2.723 0 0 66.00 0 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 4, 355 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 21, 434 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 C 0 1, 015 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 43, 595 73.00 0 0 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 C 0 75.00 07697 CARDIAC REHABILITATION 0 44 0 0 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 C 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09001 CLINIC - DIABETES 90. 01 231 C 0 0 90.01 09100 EMERGENCY 0 91 00 91 00 r 23 612 0 4 176 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00 Health Financial Systems In Lieu of Form CMS-2552-10 INDIANA UNIVERSITY HEALTH BEDFORD ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON SERVICES & SUPPLY 11. 00 12.00 13.00 15.00 14.00 95. 00 09500 AMBULANCE SERVICES 95. 00 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 0 0 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 0 99. 00 99. 00 09900 CMHC 0 0 0 99. 10 09910 CORF 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105. 00 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 0 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 111.00 11100 I SLET ACQUISITION 0 0 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.00 0 116.00 116. 00 11600 HOSPI CE 0 C \cap SUBTOTALS (SUM OF LINES 1-117) 43, 595 118. 00 118.00 43, 545 0 102, 857 22, 449 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 126 0 191.00 191. 00 19100 RESEARCH 0 0 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00 0 0 192. 01 19201 VACANT SPACE 0 0 0 192. 01 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194. 00 07950 MARKETING/PUBLIC RELATIONS 0 0 0 0 194. 00

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43, 595 202. 00

200.00

194. 01 07951 CLARIAN HOME CARE

200.00

201.00

202.00

194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

90.01

91.00

92.00

In Lieu of Form CMS-2552-10 Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm INTERNS & **RESI DENTS** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description RECORDS & ANESTHETI STS Y & FRINGES LI BRARY 19.00 16.00 17.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 130, 777 16.00 01700 SOCIAL SERVICE 17.00 556 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 0 19 00 20.00 02000 NURSING SCHOOL 0 C 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 21.00 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 0 02300 PARAMED ED PRGM 23 00 23.00 C INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 6.422 469 31.00 03100 INTENSIVE CARE UNIT 1.713 87 31.00 03200 CORONARY CARE UNIT 32 00 32 00 0 C 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 34.00 04000 SUBPROVIDER - IPF 00000 40.00 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 42.00 04200 SUBPROVI DER 0 42.00 04300 NURSERY 43 00 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 04500 NURSING FACILITY 45 00 Ω 45 00 04510 | CF/MR 45.01 45.01 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 710 0 50.00 51.00 05100 RECOVERY ROOM 525 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 53.00 Ω 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 34,096 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 1, 415 0 57.00 05700 CT SCAN 0 C 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 59.00 06000 LABORATORY 30, 144 60.00 C 60 00 60.01 06001 BLOOD LABORATORY 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 06600 PHYSI CAL THERAPY 66 00 4 089 Ω 66 00 06700 OCCUPATIONAL THERAPY 67.00 C 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 9, 127 70 00 07000 ELECTROENCEPHALOGRAPHY 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4,073 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 339 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 16, 384 0 73.00 07400 RENAL DIALYSIS 74.00 Ω 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07697 CARDIAC REHABILITATION 76.97 340 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 90.00 09000 CLI NI C 0 0 90.00

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09001 CLINIC - DIABETES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

09100 EMERGENCY

194. 01 07951 CLARIAN HOME CARE

200.00

201.00

202.00

194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

194. 01

194. 02 0 200. 00

0 201.00

0 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm INTERNS & **RESI DENTS** NONPHYSI CI AN NURSING SCHOOL SERVICES-SALAR Cost Center Description MEDI CAL SOCIAL SERVICE Y & FRINGES RECORDS & **ANESTHETISTS** LI BRARY 17.00 19.00 20.00 21.00 16.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 0 0 0 94.00 95. 00 09500 AMBULANCE SERVICES 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 0 106.00 10600 HEART ACQUISITION 0 106.00 107. 00 10700 LIVER ACQUISITION 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 | SLET ACQUISITION 111. 00 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 C 116. 00 SUBTOTALS (SUM OF LINES 1-117) 118.00 130, 777 556 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 192. 01 19201 VACANT SPACE 0 192. 01 193. 00 19300 NONPALD WORKERS 0 193. 00 194. 00 07950 MARKETING/PUBLIC RELATIONS 194. 00 0

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In Lieu of Form CMS-2552-10

		JIANA UNIVERSITY				U OT FORM CMS-2	2552-10
ALLOCA	NTION OF CAPITAL RELATED COSTS		Provi der	1	Period: From 01/01/2014 Fo 12/31/2014	Worksheet B Part II Date/Time Pre	pared:
						5/28/2015 7:0	2 pm
		I NTERNS &					
	Cook Cooker Doorwinking	RESI DENTS	DADAMED ED	C	1 + 0	T-4-1	
	Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM COSTS	PRGM		Residents Cost		
					& Post		
					Stepdown		
		22.00	22.00	24.00	Adjustments	27, 00	
	GENERAL SERVICE COST CENTERS	22.00	23. 00	24. 00	25. 00	26. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17.00	01700 SOCIAL SERVICE						17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS						19. 00
20.00	02000 NURSI NG SCHOOL						20. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD						21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0					22. 00
23. 00	02300 PARAMED ED PRGM		0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS			341, 18:		341, 182	30.00
31. 00	03100 I NTENSI VE CARE UNI T			93, 89	1	93, 895	1
32. 00	03200 CORONARY CARE UNIT				0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT				0	0	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT			1	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF			(0	0	40. 00
41.00	04100 SUBPROVI DER – I RF			1	0	0	41.00
42. 00	04200 SUBPROVI DER					0	42.00
43.00	04300 NURSERY					0	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY					0	44. 00 45. 00
45. 00	04510 CF/MR			1		0	45. 00
46. 00	04600 OTHER LONG TERM CARE			1		0	46. 00
10.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>		10.00
50.00	05000 OPERATING ROOM			299, 35	6 0	299, 356	50.00
51.00	05100 RECOVERY ROOM			2, 700	1	2, 700	
52.00	05200 DELIVERY ROOM & LABOR ROOM				o o	0	52. 00
53.00	05300 ANESTHESI OLOGY				o o	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C			341, 71	3 0	341, 713	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C				0	0	55. 00
56.00	05600 RADI OI SOTOPE			3, 22	9 0	3, 229	56. 00
57. 00	05700 CT SCAN				0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)				0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				0	0	59. 00
60.00	06000 LABORATORY			154, 74	3 0	154, 748	
60. 01	06001 BLOOD LABORATORY			1	اه اب	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				_	_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			'		0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			'		0	
64.00	06400 I NTRAVENOUS THERAPY			'		0	64.00
65.00	06500 RESPIRATORY THERAPY			02.20		02 209	65.00
66.00	06600 PHYSI CAL THERAPY			92, 30		92, 308	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY					0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY			143, 04		143, 045	
70.00	07000 ELECTROENCEPHALOGRAPHY			143, 04		143,043	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			33, 32	7 0	33, 327	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENT			1, 72	1	1, 722	1
73. 00	07300 DRUGS CHARGED TO PATIENTS			77, 01	1	77, 011	
74. 00	07400 RENAL DIALYSIS			1		0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)				ol ol	0	75. 00
	07697 CARDI AC REHABI LI TATI ON			19, 53	3 0	19, 533	
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC				0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				이	0	
90.00	09000 CLINIC			10.40		10 130	90.00
90. 01	09001 CLINIC - DIABETES			10, 12	3 0	10, 128	90. 01

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm INTERNS & **RESI DENTS** PARAMED ED Cost Center Description SERVI CES-OTHER Subtotal Intern & Total PRGM COSTS Residents Cost PRGM & Post Stepdown Adjustments 22. 00 23. 00 24. 00 25. 00 26. 00 91. 00 09100 EMERGENCY 151, 560 151, 560 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS ol 92.00 92.00 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 95.00 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09900 CMHC 0 99.00 99.00 0 99. 10 09910 CORF 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105. 00 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 0 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 0 118.00 0 1, 765, 457 1, 765, 457 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 16, 379 190. 00 16, 379 0 191. 00 19100 RESEARCH 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 296, 894 192. 00 296, 894 192. 01 19201 VACANT SPACE 0 0 0 0 0 0 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 193. 00 194.00 07950 MARKETING/PUBLIC RELATIONS 4, 802 194. 00 4,802 194. 01 07951 CLARIAN HOME CARE 0 194. 01 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 70, 682 194. 02 70,682 Cross Foot Adjustments 200.00 0 200. 00 0 C 0 0 201.00 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118-201) 2, 154, 214 2, 154, 214 202. 00

	*	I ANA UNI VERSI I			Peri od:	Workshoot P 1	
CUST	NLLOCATION - STATISTICAL BASIS		Provider	F	rom 01/01/2014		
				,	o 12/31/2014	5/28/2015 7:0	2 pm
		CAPITAL REL	LATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FIXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	
		1221)		SALARI ES)		0031)	
	OFNEDAL CERVI OF COCT OFNITERS	1.00	2. 00	4. 00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	193, 838					1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	170,000	130, 192				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	,			4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	15, 847 19, 411	15, 847 19, 411			30, 677, 240 2, 082, 358	1
8. 00	00800 LAUNDRY & LINEN SERVICE	19, 411	19, 411	344, 252		119, 809	
9. 00	00900 HOUSEKEEPI NG	3, 012	3, 012	342, 795	0	657, 742	
10.00	01000 DI ETARY	3, 908	3, 908			432, 645	
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	2, 519 0	2, 519 0	1		192, 913 0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 988	4, 988	1		1, 728, 568	
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 117	1, 117			329, 158	
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 037 7, 163	2, 037 7, 163			942, 410 1, 014, 712	
17. 00	01700 SOCIAL SERVICE	7,103	7, 103	40, 768		54, 307	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	. (0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	(0	0	
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0			0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	0	0	Ó	o o	1	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	44.000	44 000	0.400.475	-1	0.444.000	
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	11, 399 3, 174	11, 399 3, 174			3, 114, 203 1, 281, 565	1
32. 00	03200 CORONARY CARE UNIT	0	0	714, 001		0	1
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	(-	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	(0	0	
40. 00 41. 00	04100 SUBPROVIDER - TPF	0	0			0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	0	· ·	Ö	0	42. 00
43.00	04300 NURSERY	0	0	(0	0	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0) 0			0	
45. 01	04510 I CF/MR	0	Ö		o o	1	1
46. 00	04600 OTHER LONG TERM CARE	0	0	(0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	14, 900	14, 900	1, 212, 626	0	1, 523, 945	50.00
51.00	05100 RECOVERY ROOM	0	0	68, 224		90, 881	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	16, 121	16, 121	1, 526, 476	0	0 3, 314, 472	
	05500 RADI OLOGY-THERAPEUTI C	0	0	1, 020, 170	o o	0,011,172	1
56. 00	05600 RADI OI SOTOPE	0	0	102, 617	0	197, 004	1
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	
59.00	05900 CARDIAC CATHETERIZATION	0	0			0	1
60.00	06000 LABORATORY	5, 428	5, 428	1, 315, 938	0	3, 349, 467	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(0	0	
62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	,		0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		Ö	Ō	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 439	0 4, 439	781, 463	0	0 1, 209, 750	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	701, 400	o o	1, 207, 730	1
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	6, 758	6, 758	1, 146, 550	0	1, 771, 949	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0 1, 025, 213	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	Ö		o o		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	2, 244, 893	
74.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0		0	0	
	07697 CARDI AC REHABILITATI ON	1, 100	1, 100	12, 290		32, 839	
	OUTPATIENT SERVICE COST CENTERS	, .55	.,	1			
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0	
	09000 CLINIC		0		0	0	1
	09001 CLINIC - DIABETES	525	525	71, 044	0	111, 099	

Heal th Finar	ncial Systems IND	IANA UNIVERSITY	Y HEALTH BEI	DFOR	D	In Lie	eu of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi	der (CCN: 151328 P	CN: 151328 Peri od:		
						rom 01/01/2014		
					1	o 12/31/2014	Date/Time Pre 5/28/2015 7:0	
		CAPITAL REL	ATED COSTS				3/26/2013 /.0	2 piii
		CALLIAL KEE	LATED COSTS					
	Cost Center Description	NEW BLDG &	NEW MVBL	F	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FLXT	EQUI P	_	BENEFITS		& GENERAL	
		(SQUARE	(SQUARE FE	ET)	DEPARTMENT		(ACCUM.	
		FEET)	(´	(GROSS		COST)	
		ŕ			SALARI ES)		ĺ	
		1. 00	2. 00		4. 00	5A	5. 00	
91.00 09100		5, 165	5,	165	1, 305, 973	0	3, 217, 286	
	OBSERVATION BEDS (NON-DISTINCT PART)							92. 00
	REIMBURSABLE COST CENTERS							
	HOME PROGRAM DIALYSIS	0		0	0		0	
	AMBULANCE SERVICES	0		0	0	0	0	95. 00
	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	0	96. 00
	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	0	97. 00
99.00 09900	CMHC	0		0	0	0	0	99. 00
99. 10 09910	CORF	0		0	0	0	0	99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	0	100.00
101. 00 10100	HOME HEALTH AGENCY	0		0	0	0	0	101.00
	AL PURPOSE COST CENTERS							
	KIDNEY ACQUISITION	0		0	0	0		105. 00
	HEART ACQUISITION	0		0	0	0		106. 00
	LIVER ACQUISITION	0		0	0	0		107. 00
	LUNG ACQUISITION	0		0	0	0		108. 00
109.00 10900	PANCREAS ACQUISITION	0		0	0	0	0	109. 00
	INTESTINAL ACQUISITION	0		0	0	0	0	110. 00
111. 00 11100	ISLET ACQUISITION	0		0	0	0	0	111. 00
113.00 11300	INTEREST EXPENSE							113. 00
114. 00 11400	UTILIZATION REVIEW-SNF							114. 00
115. 00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0		0	0	0	0	115. 00
116. 00 11600		0		0	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	129, 011	129,	011	14, 582, 611	-9, 729, 413	30, 087, 721	118. 00
	I MBURSABLE COST CENTERS							
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	934		934	8, 925	0		190. 00
191. 00 19100		0		0	0	0		191. 00
	PHYSICIANS' PRIVATE OFFICES	51, 781		0	3, 893	0	228, 997	192. 00
	VACANT SPACE	0		0	0	0		192. 01
193. 00 19300	NONPALD WORKERS	0		0	0	0	0	193. 00
194. 00 07950	MARKETING/PUBLIC RELATIONS	247		247	0	0	73, 434	194. 00
194. 01 07951	CLARIAN HOME CARE	0		0	0	0	0	194. 01
194. 02 07952	BLOOMNGTN AMBULANCE AND OCC MED	11, 865		0	144, 706	0	260, 018	194. 02
200. 00	Cross Foot Adjustments							200. 00
201. 00	Negative Cost Centers							201. 00
202.00	Cost to be allocated (per Wkst. B,	737, 101	1, 417,	113	4, 895, 080		9, 729, 413	202. 00
	Part I)							
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 802665	10. 884	793	0. 332092		0. 317154	203. 00
204.00	Cost to be allocated (per Wkst. B,				0		232, 752	204. 00
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part				0.000000		0. 007587	205. 00
	11)							

	Financial Systems INI NLLOCATION - STATISTICAL BASIS	DIANA UNIVERSIT	Y HEALTH BEDFOR Provi der	CCN: 151328 Pe	eriod: com 01/01/2014	u of Form CMS-2 Worksheet B-1 Date/Time Pre	
	Cost Center Description	OPERATION OF PLANT (SQUARE	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	5/28/2015 7: 0 CAFETERI A (FTE)	2 pm
		7. 00	LAUNDRY) 8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	1					
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 21. 00 22. 00 23. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	158, 580 0 3, 012 3, 908 2, 519 0 4, 988 1, 117 2, 037 7, 163 0 0	257, 366 0 0 0 0 0 0 0 0 0 0 0 0	91, 922 3, 908 2, 519 0 4, 988 1, 117 2, 037 7, 163 0 0 0	40, 402 0 0 0 0 0 0 0 0 0 0	19, 524 0 1, 761 331 630 0 63 0 0	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
30. 00 31. 00 32. 00 33. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04510 ICF/MR 04600 OTHER LONG TERM CARE	11, 399 3, 174 0 0 0 0 0 0 0 0 0	25, 262 0 0 0 0 0 0 0 0 0 0 0	11, 399 3, 174 0 0 0 0 0 0 0 0 0 0	34, 101 6, 301 0 0 0 0 0 0 0 0 0	3, 606 1, 099 0 0 0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 45. 01
56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	14, 900 00 16, 121 00 00 00 5, 428 00 00 4, 439 00 6, 758 00 00 00 00 1, 100	1, 683 0 0 23, 180 0 1, 376 0 0 0 0 0 0 0 12, 499 0 0 0 11, 888 0 0 0	0 0 0 16, 121 0 0 0 0 0 5, 428 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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, 313 97 0 0 2, 349 0 137 0 0 2, 583 0 0 1, 188 0 0 1, 900 0 0 0 0 0 0 1, 1900	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
90. 00 90. 01 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0 0 525 5, 165		0 0 0 525 5, 165	0 0 0 0	0 0 0 101 1,822	89. 00 90. 00 90. 01

Cost Center Description OPERATION OF LAUNDRY & PLANT LINEN SERVI (SQUARE (POUNDS OF FEET) LAUNDRY) 7.00 8.00	1 `		28/2015 7: 02 pm AFETERI A (FTE)
	0 0		11.00
	-1	O	
OTHER REIMBURSABLE COST CENTERS	-1		
94. 00 09400 HOME PROGRAM DI ALYSIS 0	ol o	-1	0 94.00
95. 00 09500 AMBULANCE SERVI CES 0		0	0 95.00
96.00 O9600 DURABLE MEDICAL EQUIP-RENTED O	0 0	0	0 96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0	0 0	0	0 97.00
99. 00 09900 CMHC 0	0 0	0	0 99.00
99. 10 09910 CORF 0 0	0 0	0	0 99. 10
100.00 10000 1 &R SERVICES-NOT APPRVD PRGM 0	0 0	0	0 100.00
101.00 10100 HOME HEALTH AGENCY 0	0 0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS			
105. 00 10500 KI DNEY ACQUI SI TI ON 0	0 0	0	0 105. 00
106. 00 10600 HEART ACQUI SI TI ON 0	0 0	0	0 106. 00
107. 00 10700 LIVER ACQUISITION 0	0 0	0	0 107. 00
108.00 10800 LUNG ACQUISITION 0	0 0	0	0 108. 00
109. 00 10900 PANCREAS ACQUISITION 0	0 0	0	0 109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0	0 0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON 0	0 0	0	0 111.00
113. 00 1300 I NTEREST EXPENSE			113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF			114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0 0	0	0 115. 00
116. 00 11600 H0SPI CE 0	0 0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) 93,753 257,3	90, 741	40, 402	18, 999 118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 934	0 934	0	55 190. 00
191. 00 19100 RESEARCH 0	0 0	0	0 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 51, 781	0 0	0	0 192. 00
192. 01 19201 VACANT SPACE 0	0 0	0	0 192. 01
193. 00 19300 NONPALD WORKERS 0	0 0	0	0 193. 00
194.00 07950 MARKETING/PUBLIC RELATIONS 247	0 247	0	0 194. 00
194.01 07951 CLARIAN HOME CARE 0	0 0	0	0 194. 01
194.02 07952 BLOOMNGTN AMBULANCE AND OCC MED 11,865	0 0	0	470 194. 02
200.00 Cross Foot Adjustments			200. 00
201.00 Negative Cost Centers			201. 00
202.00 Cost to be allocated (per Wkst. B, 2,742,786 157,8	918, 443	676, 499	322, 833 202. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 17.295914 0.6131	62 9. 991547	16. 744196	16. 535187 203. 00
	54, 944	70, 432	44, 748 204. 00
205.00 Unit cost multiplier (Wkst. B, Part 1.897452 0.0035	0. 597724	1. 743280	2. 291948 205. 00

Cost Center Description	Heal th	Financial Systems IN	DIANA UNIVERSIT	Y HEALTH BE	DFOR	D	In Lie	eu of Form CMS-2	2552-10
Cost Center Description	COST A	LLOCATION - STATISTICAL BASIS		Provi	der			Worksheet B-1	
Cost Content Description								Date/Time Prepared	
PRESIDENT (NUMBER) PRESIDE					'	0 12/31/2014			
CONSERT SUPPLY		Cost Center Description	MAINTENANCE OF	NURSI NG		CENTRAL	PHARMACY	MEDI CAL	
				ADMI NI STRAT	LI ON				
SERIOR - SERVICE DOT CENTERS 12.00 13.00 14.00 15.00 16.00 1.00							REQUIS.)		
The Color The			HOUSED)			•			
SPERION SERVICE DOSI CRITICIS 1.00 OCCODINE CAP REL COSTS-MORE POINT			10.00		S)		45.00		
1.00 1.00		CENEDAL SEDVICE COST CENTEDS	12.00	13.00		14.00	15.00	16.00	
2.00 DOZDO JAME CAP REL COSTS-MANUE CODIT 4.00 5.00	1 00			I	П				1 00
0.000 DOTO					ŀ				
0.000 0.000 D. MINISTRATIVE & CENERAL		1 1							ł
7.00 007000 PREMITION OF PLANT 9.00 000000 LAURINGY & LINEN SERVICE 9.00 00000 LAURINGY & LINEN SERVICE 9.00 00000 LAURINGY & LINEN SERVICE 9.00 00000 LAURINGY & LINEN SERVICE 12.00 00000 LAURINGY & LINEN SERVICE 12.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & & SUPPLY 10.00 00000 LAURINGY & LINEN SERVICE & SUPPLY 10.00 00000 LAURING & LINEN SERVICE &		1 1							ł
8.00 00000 LAURDRY & LINEN SERVICE 8.00 10.00 11.00									ł
9.00 0.0900 IUSEKEEPI MS		00800 LAUNDRY & LINEN SERVICE							ł
11.00 0 1100 CAFETERIA 11.00 0 12.00 13.00 WIRSING ADEIN STRATI ON 0 7,937 1.073, 746 13.00 13.00 WIRSING ADEIN STRATI ON 0 7,937 1.073, 746 13.00 13.00 WIRSING ADEIN STRATI ON 0 0 0 0 0 14.0774, 179 16.00 17.00	9.00				İ				9. 00
12.00 01200 MAINTENNANCE OF PRESONNEL 0 1.073,746 1.00 1.0	10.00	01000 DI ETARY							10.00
13.00 01300 NURSING CABON HISTRATION 0 7,937 1 14.00 1	11.00	01100 CAFETERI A							11. 00
14 00 1400 CFNTRAL SERVICES & SUPPLY 0 0 0 1,073,746 1 14,00 15.00 15.00 15.00 1600 PERMARCY 0 0 0 0 0 140,774,179 16.00 176,00 176,00 176,00 176,00 1770,0170,01	12.00	01200 MAINTENANCE OF PERSONNEL	0						12. 00
15.00 01500 PMASMACY 0 0 0 0 0 100 170 15.00 170		1 1	0	7,	937				
16.00 01-000 MEDICAL RECORDS & LIBRARY 0 0 0 0 140,774,179 16.00 170.00			0		0	1, 073, 746			
17. 00 0 1700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 17. 00 19. 00			0	1	0	C		1	1
19.00 01900 MONPHYSICI AN ARESTHETISTS 0 0 0 0 0 0 0 0 0		· ·	0		0	C	0		1
20.00 02000 MURSINS SCHOOL 0 0 0 0 0 0 0 0 0			0		0	C	0		1
21.00 02100 IAR SERVICES-SALARY & FRINCES APPRYD 0 0 0 0 0 0 0 22.00 0220 IAR SERVICES-CHIER PROMI OSTS APPRYD 0 0 0 0 0 0 0 0 0			0	1	0	C	0	l	•
22.00 02200 ARS SERVICES-OTHER PROX COSTS APPRVD 0 0 0 0 0 0 22.00			0		0	C	0	1	
23.00					0	(0		
INPATI ENT ROUTINE SERVICE COST CENTERS 0 3,606 0 0 6,912,964 30,00 310.00 300.00 AULTS & PEDIDITRIC S 0 0 3,606 0 0 6,912,964 30,00 310.00 330.00 300.00 AULTS & PEDIDITRIC S 0 0 0 0 0 0 0 32.00					0	_	_		
30.00 30000 ADULTS & PEDIATRICS 0 3,606 0 0 6,912,964 30.00 31.00	23.00				<u> </u>		0	0	23.00
31.00 03100 INTENSIVE CARE UNIT	30. 00		0	3.	606	C	0	6, 912, 964	30.00
32.00 03200 COROMARY CARE LINIT 0 0 0 0 0 0 0 32.00		1 1	0			C	0		1
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 34. 00	32.00	03200 CORONARY CARE UNIT	0		0	C	0	0	32. 00
40.00 0.4000 SUBPROVI DER - I PF	33.00	03300 BURN INTENSIVE CARE UNIT	0		0	C	0	0	33. 00
11. 00 04-100 SUBPROVI DER 1RF	34.00		0	1	0	C	0	0	34.00
42 00 04200 SUBPROVIDER		1 1	0		0	C	0		1
43.00 04300 NURSERY			0	1	0	C	0	l .	1
44 00 04400 SKILLED NURSING FACILITY			0		0	(0		1
45.00 04500 NURSI NG FACILITY		· ·			0	C	0	l	1
45. 01 04510 1045					0	(0		1
Accord Octobro Accord			-	l .	0	_	_	l	1
ANCILLARY SERVICE COST CENTERS 50.00 50.			-	l .	o				
51-00 05100 RECOVERY ROOM 0 0 0 0 0 565, 376 51, 00 52, 00 5200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 52, 00 52, 00 53, 00 05300 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS	_	'					
S2.00 05200 05200 05200 05200 05200 05200 0530	50.00		0	1,	313	C	0	12, 605, 028	50. 00
53.00 05300 ABSTHESI OLOGY 0 0 0 0 0 0 53.00			0	1	97	C	0	l	
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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS INDIANA UNIVERSITY HEALTH BEDFORD
Provider CCN: 151328 In Lieu of Form CMS-2552-10

				'		Date/lime Pre 5/28/2015 7:0 RESIDENTS	
		COOLAL CERVILOE	NONDUNCTOLAN	NUDGI NO GOLIOOL			
	Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	PRGM COSTS	
		(TIME	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		SPENT) 17.00	TI ME) 19. 00	TI ME) 20. 00	TI ME) 21.00	TI ME) 22. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	OO100 NEW CAP REL COSTS-BLDG & FIXT OO200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	5, 053					17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	C	i c			19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0			0		21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	0				0	22. 00
23. 00	I NPATIENT ROUTINE SERVICE COST CENTERS	0					23. 00
30.00	03000 ADULTS & PEDIATRICS	4, 265		C			30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	788				-	31. 00 32. 00
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41. 00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF	0			0	0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0		l c	0	0	42. 00
43. 00 44. 00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0		0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0			_	ő	45. 00
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46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0		C	0	0	46. 00
50.00	05000 OPERATING ROOM	0	C				50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0				0	51. 00 52. 00
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71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0	0	71. 00 72. 00
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88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C			0	88. 00 89. 00
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Health Financial Systems In Lieu of Form CMS-2552-10 INDIANA UNIVERSITY HEALTH BEDFORD COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151328 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm INTERNS & RESIDENTS SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER Cost Center Description Y & FRINGES PRGM COSTS **ANESTHETISTS** (ASSI GNED (ASSI GNED (ASSI GNED (TIME (ASSI GNED SPENT) TIME) TIME) TIME) TIME) 17.00 19.00 20.00 21.00 22.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 00000 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 0 99.00 99. 00 09900 CMHC 0 0 0 99. 10 09910 CORF 0 0 99. 10 0 o 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 106.00 0000 0 0 107.00 107. 00 10700 LIVER ACQUISITION 0 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION O 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 0 115.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 116. 00 11600 HOSPI CE 0 0 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 0 118.00 118.00 5,053 0 0 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 0 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 192. 01 19201 VACANT SPACE 0 0 192. 01 0 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194.00 07950 MARKETING/PUBLIC RELATIONS 0 0 0 194.00 0 0 0 194. 01 194. 01 07951 CLARIAN HOME CARE 0 0 194.02 07952 BLOOMNGTN AMBULANCE AND OCC MED 0 194. 02 0 0 0 200.00 Cross Foot Adjustments 200. 00

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Negative Cost Centers

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COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151328 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17. 00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 02300 PARAMED ED PRGM 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 000000000 31.00 32.00 03200 CORONARY CARE UNIT 32 00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 40.00 41 00 41 00 04200 SUBPROVI DER 42.00 42.00 04300 NURSERY 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 45.00 45.00 04500 NURSING FACILITY 0 45. 01 04510 | CF/MR 45.01 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 0 50 00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 51.00 00000000000 52 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 06000 LABORATORY 60.00 60.00 60.01 06001 BLOOD LABORATORY 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 000000000000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07400 RENAL DIALYSIS 74 00 74 00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 07697 CARDIAC REHABILITATION 0 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 88 00 0 88 00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0 09000 CLI NI C 90.00 90.00 90. 01 09001 CLINIC - DIABETES 90. 01 09100 EMERGENCY 91.00 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

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COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 151328	Peri od:	Worksheet B-1
			From 01/01/2014 To 12/31/2014	Date/Time Prepared:
			10 12/31/2014	5/28/2015 7: 02 pm
Cost Center Description	PARAMED ED			
p	PRGM			
	(ASSI GNED			
	TIME)			
	23.00			
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DIALYSIS	0			94. 00
95. 00 09500 AMBULANCE SERVICES	0			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o o			97. 00
99. 00 09900 CMHC	o o			99.00
99. 10 09910 CORF	0			99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	0			100.00
	0			101.00
101. 00 10100 HOME HEALTH AGENCY	U U			101.00
SPECIAL PURPOSE COST CENTERS	0			105.00
105. 00 10500 KI DNEY ACQUI SI TI ON				105.00
106. 00 10600 HEART ACQUISITION	0			106.00
107. 00 10700 LI VER ACQUI SI TI ON	0			107. 00
108. 00 10800 LUNG ACQUISITION	0			108. 00
109. 00 10900 PANCREAS ACQUISITION	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0			110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0			111. 00
113. 00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			115. 00
116. 00 11600 HOSPI CE	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0			118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
191. 00 19100 RESEARCH	0			191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			192. 00
192. 01 19201 VACANT SPACE	0			192. 01
193. 00 19300 NONPALD WORKERS	0			193. 00
194.00 07950 MARKETING/PUBLIC RELATIONS	O			194. 00
194. 01 07951 CLARI AN HOME CARE	O			194. 01
194.02 07952 BLOOMNGTN AMBULANCE AND OCC MED	o			194. 02
200.00 Cross Foot Adjustments				200. 00
201.00 Negative Cost Centers				201. 00
202.00 Cost to be allocated (per Wkst. B,	0			202. 00
Part I)				[232. 66
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000			203. 00
204.00 Cost to be allocated (per Wkst. B,	0.00000			204. 00
Part II)				204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000			205. 00
	3. 222300			
1 1	1			1

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 151328

					5/28/2015 7:0	2 pm
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	26) 1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	6, 351, 156		6, 351, 156	0	0	30. 00
31. 00 03100 INTENSIVE CARE UNIT	2, 283, 321		2, 283, 321	0	0	31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	32. 00 33. 00
34. 00 03300 BURN THTENSIVE CARE UNIT	0			0	0	34.00
40. 00 04000 SUBPROVI DER - PF	0		ĺ	0	Ö	40.00
41. 00 04100 SUBPROVI DER - I RF	0		0	0	0	41. 00
42. 00 04200 SUBPROVI DER	0		0	0	0	42. 00
43. 00 04300 NURSERY	0		0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0		0	0	0	44. 00 45. 00
45. 00 04500 NORST NG FACT ET 1				0	0	45. 00
46. 00 04600 OTHER LONG TERM CARE	0		ĺ	0	Ö	46. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 983, 549		2, 983, 549		0	50. 00
51. 00 05100 RECOVERY ROOM	158, 337		158, 337	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0		0	0	0	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	5, 258, 007		5, 258, 007	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0, 230, 007		0, 230, 007	0	0	55.00
56. 00 05600 RADI OI SOTOPE	279, 171		279, 171	0	0	56. 00
57.00 05700 CT SCAN	0		0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4 055 722		4 055 722	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	4, 955, 723		4, 955, 723	0	0	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	_	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1 700 742	0	1 700 743	0	0	65.00
67. 00 06700 OCCUPATIONAL THERAPY	1, 789, 763	0	1, 789, 763	0	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		٥	٥	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 656, 676		2, 656, 676	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 853, 650		1, 853, 650	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	89, 122 4, 456, 100		89, 122 4, 456, 100	0	0	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	4, 430, 100		4, 430, 100	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	77, 573		77, 573	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	1	ı	1			
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	88. 00
90. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00 90. 00
90. 01 09001 CLI NI C - DI ABETES	162, 718		162, 718	0	0	90. 01
91. 00 09100 EMERGENCY	5, 133, 576		5, 133, 576		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	893, 124		893, 124		0	92.00
OTHER REIMBURSABLE COST CENTERS	1	ı	1			
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	ł	0	0	0	94. 00 95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		ł		0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		ĺ	0	Ö	97. 00
99. 00 09900 CMHC	0		0		0	99. 00
99. 10 09910 CORF	0		0		0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0		0			100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0		0		0	101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0		T 0		0	105. 00
106. 00 10600 HEART ACQUISITION	0		ĺ			106. 00
107.00 10700 LIVER ACQUISITION	0		0		0	107. 00
108.00 10800 LUNG ACQUISITION	0		0			108. 00
109. 00 10900 PANCREAS ACQUISITION	0		0			109.00
110.00 11000 INTESTINAL ACQUISITION	0		0			110.00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE					0	111. 00 113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115. 00
				'		

Health Financial Systems	NDIANA UNIVERSIT	IDI ANA UNI VERSI TY HEALTH BEDFORD				In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN			Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 7:0	pared:			
			Title	e XVIII	Hospi tal	Cost			
					Costs				
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		ipy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs			
	1.00	2	2. 00	3. 00	4. 00	5. 00			
116. 00 11600 HOSPI CE	C				0	0	116. 00		
200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	39, 381, 566 893, 124 38, 488, 442		0	39, 381, 56 893, 12 38, 488, 44	4	0	200. 00 201. 00 202. 00		

Provider CCN: 151328

Peri od:

From 01/01/2014

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 212, 394 5, 212, 394 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 1,844,439 1, 844, 439 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34 00 40.00 04000 SUBPROVIDER - IPF 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 41.00 04200 SUBPROVI DER 42.00 42.00 0 04300 NURSERY 0 43.00 43.00 0 44.00 04400 SKILLED NURSING FACILITY 0 44.00 45.00 04500 NURSING FACILITY 0 45.00 0 04510 I CF/MR 0 45.01 45.01 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 595, 253 11, 008, 252 12, 603, 505 0. 236724 0.000000 50.00 05100 RECOVERY ROOM 0 280056 0.000000 51 00 75,666 489, 710 565, 376 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 34, 439, 252 36, 702, 804 0.000000 54.00 2, 263, 552 0.143259 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0.000000 55.00 56.00 05600 RADI OI SOTOPE 122, 282 1, 400, 945 1, 523, 227 0.183276 0.000000 56.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 000000 58 00 0 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0.000000 59.00 06000 LABORATORY 3, 942, 306 28, 505, 407 32, 447, 713 0. 152730 0.000000 60.00 60.00 60.01 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 0 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 0.000000 0.000000 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 0.000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0.000000 0.000000 63.00 64 00 06400 INTRAVENOUS THERAPY 0 0 0.000000 0 000000 64 00 06500 RESPIRATORY THERAPY 65.00 0.000000 0.000000 65.00 06600 PHYSI CAL THERAPY 371, 172 4, 030, 065 4, 401, 237 0.406650 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 68 00 0.000000 0.000000 68 00 1,665,034 8, 159, 506 0.270412 69.00 06900 ELECTROCARDI OLOGY 9, 824, 540 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 309, 773 3,074,499 4, 384, 272 0.422795 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72 00 45,686 319, 563 365, 249 0.244003 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 7, 724, 645 9, 911, 061 17, 635, 706 0. 252675 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0.000000 75.00 0 07697 CARDIAC REHABILITATION 76.97 0 366, 402 366, 402 0.211716 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 0 0 0.000000 90 00 09000 CLI NI C 0 0 0.000000 90 00 09001 CLINIC - DIABETES 4.568677 0.000000 90.01 35, 616 35, 616 90.01 91.00 09100 EMERGENCY 434, 970 10, 724, 636 11, 159, 606 0.460014 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 65, 955 1, 635, 378 1, 701, 333 0.524955 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0.000000 94.00 09500 AMBULANCE SERVICES 0 95.00 C 0 0.000000 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED Ω 0 0.000000 0.000000 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0.000000 97.00 97.00 99. 00 09900 CMHC 0 99.00 09910 CORF 0 0 99.10 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 C 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105.00 0 0 106.00 10600 HEART ACQUISITION 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116.00 11600 HOSPI CE 0 0 116. 00

Health Financial Systems	IDIANA UNIVERSITY HEALTH BEDFORD				In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi	Provider CCN: 151328		Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 7:02 pm	
			<u>Ti tle</u>	XVIII	Hospi tal	Cost		
			Charges					
Cost Center	Description	I npati ent	Outpati e	nt 7	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00		8. 00	9. 00	10.00	
200.00 Subtotal (se 201.00 Less Observa	e instructions) tion Beds	26, 673, 127	114, 100	, 292	140, 773, 4	19		200. 00 201. 00
202.00 Total (see i	nstructions)	26, 673, 127	114, 100	292	140, 773, 4	19		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/28/2015 7:02 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES INDIANA UNIVERSITY HEALTH BEDFORD
Provider CCN: 151328

		Title XVIII	Hospi tal	5/28/2015 /: 02 pm Cost
Cost Center Description	PPS Inpatient		, moopi tui	
·	Ratio			
LAIDATLENT POUTLAG CERVI OF COCT OFFITERS	11. 00			
30. 00 O3000 ADULTS & PEDIATRICS				30.00
31. 00 03100 NTENSI VE CARE UNI T				31.00
32.00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - I PF				40.00
41. 00 04100 SUBPROVI DER - 1 RF 42. 00 04200 SUBPROVI DER				41. 00 42. 00
43. 00 04300 NURSERY				43. 00
44. 00 04400 SKILLED NURSING FACILITY				44. 00
45.00 04500 NURSING FACILITY				45. 00
45. 01 04510 I CF/MR				45. 01
46. 00 04600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	0.000000			56.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000 0. 000000			57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	0.000000			63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000 0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000 0. 000000			71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS	1			00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				88. 00 89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 CLI NI C - DI ABETES	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS	0.000000			0,
94. 00 O9400 HOME PROGRAM DIALYSIS 95. 00 O9500 AMBULANCE SERVICES	0. 000000			94.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000 0. 000000			95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000			97.00
99. 00 09900 CMHC				99. 00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100. 00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUISITION				105.00
106. 00 10600 HEART ACQUISITION				105. 00 106. 00
107. 00 10700 LIVER ACQUISITION				107. 00
108. 00 10800 LUNG ACQUISITION				108.00
109.00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION				110.00
111. 00 11100 SLET ACQUISITION				111. 00
113. 00 11300 INTEREST EXPENSE				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE				115. 00 116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
<u> </u>				

Health Financial Systems	NDIANA UNIVERSITY HEA	ALTH BEDFORD	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151328	Peri od: From 01/01/2014	Worksheet C	
				Date/Time Pre 5/28/2015 7:0	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
202.00 Total (see instructions)					202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES INDIANA UNIVERSITY HEALTH BEDFORD Provi der CCN: 151328 Peri od: From 01/01/2014 To 12/31/2014 Hospi tal Costs Title XIX Cost

Cost Center Descrip	ti on	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	
NPATI ENT ROUTINE SERVICE	UNIT CARE UNIT I LI TY E	6, 351, 156 2, 283, 321 0 0 0 0 0 0 0 0 0		6, 351, 156 2, 283, 321 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	6, 351, 156 2, 283, 321 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 01 46. 00
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LAB 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI 55. 00 05500 RADI OLOGY-THERAPEUT 56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE 59. 00 05900 CARDI AC CATHETERI ZA	C IC IMAGING (MRI)	2, 983, 549 158, 337 0 0 5, 258, 007 0 279, 171 0 0		2, 983, 549 158, 337 0 0 5, 258, 007 0 279, 171 0 0	0 0 0 0 0 0 0	2, 983, 549 158, 337 0 0 5, 258, 007 279, 171 0 0	52. 00 53. 00 54. 00 55. 00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SE 62. 00 06200 WHOLE BLOOD & PACKE 63. 00 06300 BLOOD STORING, PROC 64. 00 06500 INTRAVENOUS THERAPY 66. 00 06500 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAP 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDIOLOGY	D RED BLOOD CELLS ESSING & TRANS.	4, 955, 723 0 0 0 0 0 0 1, 789, 763 0 2, 656, 676	0 0 0 0	4, 955, 723 0 0 0 0 0 0 1, 789, 763 0 2, 656, 676	0 0 0 0 0 0 0 0	4, 955, 723 0 0 0 0 0 0 1, 789, 763 0 0 2, 656, 676	60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
70. 00 07000 ELECTROENCEPHALOGRA 71. 00 07100 MEDI CAL SUPPLIES CH 72. 00 07200 IMPL. DEV. CHARGED 73. 00 07300 DRUGS CHARGED TO PA 74. 00 07400 RENAL DI ALYSIS 75. 00 07500 ASC (NON-DI STINCT P 76. 97 07697 CARDI AC REHABI LITAT OUTPATIENT SERVICE COST (ARGED TO PATLENTS TO PATLENT TLENTS ART) LON	0 1, 853, 650 89, 122 4, 456, 100 0 77, 573		0 1, 853, 650 89, 122 4, 456, 100 0 77, 573	0 0 0 0 0 0	0 1, 853, 650 89, 122 4, 456, 100 0 77, 573	72. 00 73. 00 74. 00 75. 00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED 90. 00 09000 CLINIC 90. 01 09001 CLINIC - DIABETES 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NO OTHER REIMBURSABLE COST (C	HEALTH CENTER ON-DISTINCT PART)	0 0 0 162, 718 5, 133, 576 893, 124		0 0 162, 718 5, 133, 576 893, 124	0 0 0 0	0 0 162, 718 5, 133, 576 893, 124	90. 01 91. 00
94. 00 09400 HOME PROGRAM DI ALYS 95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQU 97. 00 09700 DURABLE MEDI CAL EQU 99. 10 09910 CMHC 99. 10 09910 CORF 100. 00 10000 I &R SERVI CES-NOT AP 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENT	IP-RENTED IP-SOLD PRVD PRGM	0 0 0 0 0 0 0		0 0 0 0 0 0 0	0 0 0 0		94. 00 95. 00 96. 00 97. 00 99. 00 99. 10 100. 00 101. 00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION 109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION 111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW- 115. 00 11500 AMBULATORY SURGICAL	N I ON SNF	0 0 0 0 0 0		0 0 0 0 0 0		0 0 0 0 0	105. 00 106. 00 107. 00 108. 00 109. 00 110. 00 111. 00 113. 00 114. 00 115. 00

Health Fina	ncial Systems	INDIANA UNIVERSIT	IANA UNIVERSITY HEALTH BEDFORD In Lieu of Form					2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			Provi der		Peri od: From 01/01/2014	Worksheet C Part I	
						To 12/31/2014		
				Ti t	le XIX	Hospi tal	Cost	
						Costs		
	Cost Center Description	Total Cost	Ther	apy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,		Adj .		Di sal I owance		
		Part I, col.						
		26)						
		1.00		2.00	3.00	4. 00	5. 00	
116. 00 11600	0 HOSPI CE	C				0	0	116. 00
200. 00	Subtotal (see instructions)	39, 381, 566	,	0	39, 381, 56	6 0	39, 381, 566	200. 00
201.00	Less Observation Beds	893, 124			893, 12	4	893, 124	201.00
202. 00	Total (see instructions)	38, 488, 442		0	38, 488, 44	2 0	38, 488, 442	202. 00

Provider CCN: 151328

Peri od:

From 01/01/2014

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 212, 394 5, 212, 394 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 1,844,439 1, 844, 439 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34 00 40.00 04000 SUBPROVIDER - IPF 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 41.00 04200 SUBPROVI DER 42.00 42.00 0 04300 NURSERY 0 43.00 43.00 0 44.00 04400 SKILLED NURSING FACILITY 0 44.00 45.00 04500 NURSING FACILITY 45.00 0 04510 I CF/MR 0 45.01 45.01 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 595, 253 11, 008, 252 12, 603, 505 0. 236724 0.000000 50.00 05100 RECOVERY ROOM 0 280056 0.000000 51 00 75,666 489, 710 565, 376 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 34, 439, 252 36, 702, 804 0.000000 54.00 2, 263, 552 0.143259 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0.000000 55.00 56.00 05600 RADI OI SOTOPE 122, 282 1, 400, 945 1, 523, 227 0.183276 0.000000 56.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 000000 58 00 0 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0.000000 59.00 06000 LABORATORY 3, 942, 306 28, 505, 407 32, 447, 713 0. 152730 0.000000 60.00 60.00 60.01 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 0 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 0.000000 0.000000 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 0.000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0.000000 0.000000 63.00 64 00 06400 INTRAVENOUS THERAPY 0 0 0.000000 0 000000 64 00 06500 RESPIRATORY THERAPY 65.00 0.000000 0.000000 65.00 06600 PHYSI CAL THERAPY 371, 172 4, 030, 065 4, 401, 237 0.406650 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 68 00 0.000000 0.000000 68 00 1,665,034 8, 159, 506 0.270412 69.00 06900 ELECTROCARDI OLOGY 9, 824, 540 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 309, 773 3,074,499 4, 384, 272 0.422795 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 45,686 319, 563 365, 249 0.244003 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 7, 724, 645 9, 911, 061 17, 635, 706 0. 252675 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0.000000 75.00 0 07697 CARDIAC REHABILITATION 76.97 0 366, 402 366, 402 0.211716 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0.000000 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0.000000 0.000000 89.00 0 0 90 00 09000 CLI NI C 0 0 0.000000 0.000000 90 00 09001 CLINIC - DIABETES 4.568677 0.000000 90.01 35, 616 35, 616 90.01 91.00 09100 EMERGENCY 434, 970 10, 724, 636 11, 159, 606 0.460014 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 65, 955 1, 635, 378 1, 701, 333 0.524955 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0.000000 94.00 09500 AMBULANCE SERVICES 0 0 95.00 C 0.000000 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED Ω 0 0.000000 0.000000 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0.000000 97.00 97.00 99. 00 09900 CMHC 0 99.00 09910 CORF 0 0 99.10 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 C 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105.00 0 0 106.00 10600 HEART ACQUISITION 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116.00 11600 HOSPI CE 0 0 116. 00

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFORD In Lie					u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Pro	vi der	CCN: 151328	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 7:0	
	Title XIX Hospital				Cost	52 piii	
		Charg	jes				
Cost Center Description	I npati ent	Outpati	i ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
	6. 00	7.00	0	8. 00	9. 00	10.00	
200.00 Subtotal (see instructions)	26, 673, 127	114, 10	00, 292	140, 773, 41	9		200. 00
201.00 Less Observation Beds							201.00
202.00 Total (see instructions)	26, 673, 127	114, 10	00, 292	140, 773, 41	9		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/28/2015 7:02 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES INDIANA UNIVERSITY HEALTH BEDFORD
Provider CCN: 151328

		Title XIX	Hospi tal	5/28/2015 /: 02 pm Cost
Cost Center Description	PPS Inpatient	THE MA	nospi tui	0031
	Ratio			
LAIDATI ENT. DOUTLING CERVI OF COCT. OFNITERS	11. 00			
30. 00 O3000 ADULTS & PEDIATRICS	T I			30.00
31. 00 03100 NTENSI VE CARE UNI T				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF				40. 00 41. 00
42. 00 04200 SUBPROVI DER 42. 00 04200 SUBPROVI DER				42.00
43. 00 04300 NURSERY				43. 00
44.00 04400 SKILLED NURSING FACILITY				44. 00
45.00 04500 NURSING FACILITY				45. 00
45. 01 04510 I CF/MR				45. 01
46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS				46. 00
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0. 000000 0. 000000			55. 00 56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000 0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64.00 06400 I NTRAVENOUS 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 69. 00 06900 ELECTROCARDI OLOGY	0. 000000 0. 000000			68. 00 69. 00
70. 00 07000 ELECTROCARD OLOGT	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00 07400 RENAL DIALYSIS	0.000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 97 07697 CARDIAC REHABILITATION	0. 000000 0. 000000			75. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	0.000000			70. 77
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 CLINIC - DIABETES	0.000000			90. 01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000 0. 000000			91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	3. 300000			72.00
94.00 O9400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 99. 00 09900 CMHC	0. 000000			97. 00 99. 00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON				105. 00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON				106. 00 107. 00
107.00 10700 EIVER ACQUISITION 108.00 10800 LUNG ACQUISITION				107.00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				110.00
111.00 11100 I SLET ACQUI SI TI ON				111. 00
113. 00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00 115. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
				•

Health Financial Systems IN	DIANA UNIVERSITY HEA	ALTH BEDFORD	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151328	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre	narodi
			10 12/31/2014	5/28/2015 7:0	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
202.00 Total (see instructions)					202. 00

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552							2552-10	
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Pro	vi der	CCN: 151328	Peri od:	Worksheet D	
						From 01/01/2014	Part II	
						To 12/31/2014	Date/Time Pre 5/28/2015 7:0	pared:
				Ti +I	e XVIII	Hospi tal	Cost	z piii
	Cost Center Description	Capi tal	Total Ch		Ratio of Cos		Capital Costs	
	oost content bosci i pti on	Related Cost				Program	(column 3 x	
		(from Wkst. B,			(col . 1 ÷ col		column 4)	
		Part II, col.	8)		2)	3-1		
		26)	ĺ					
		1.00	2.00)	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	299, 356	12, 60	3, 505	0. 0237	52 769, 579	18, 279	50.00
51.00	05100 RECOVERY ROOM	2, 700	56	5, 376	0.0047	76 32, 967	157	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0. 00000	00	0	52.00
53.00	05300 ANESTHESI OLOGY	0		0	0. 00000	00	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	341, 713	36, 70	2, 804	0.0093	1, 069, 354	9, 956	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0. 00000	00	0	55. 00
56.00	05600 RADI OI SOTOPE	3, 229	1, 52	23, 227	0. 0021	20 83, 951	178	56. 00
57.00	05700 CT SCAN	0	-	0	1		0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	1		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0. 00000		0	59. 00
60.00	06000 LABORATORY	154, 748	32, 44	7, 713	1		10, 623	60.00
60. 01	06001 BLOOD LABORATORY	0	,	0	0.0000		0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0. 00000	0 0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0. 00000		0	63. 00
64. 00	06400 NTRAVENOUS THERAPY	0		0	0.0000		o o	64.00
65. 00	06500 RESPI RATORY THERAPY	0		0	0.0000		o o	65. 00
66. 00	06600 PHYSI CAL THERAPY	92, 308	4 40)1, 237				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	72, 300	7, 40	, 1, 23, 0	0.0000		0,700	
68. 00	06800 SPEECH PATHOLOGY	0		0	0.0000		Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	143, 045	0.82	24, 540			16, 201	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	143,043	7, 02	.+, 5+0 N	0.0000		0	•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 327	4 38	34, 272	1			•
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 722	•	5, 249	1			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	77, 011		35, 247 35, 706			18, 378	1
74. 00	07400 RENAL DIALYSIS	77,011	•	,s, 700 0	i		10, 370	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	l .	0	i		0	
76. 97	07697 CARDIAC REHABILITATION	19, 533	l .	6, 402	1			
10. 71	OUTPATIENT SERVICE COST CENTERS	17, 333		00, 402	0.0333	10	0	70.77
88. 00	08800 RURAL HEALTH CLINIC	0		0	0.0000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ŀ	0	1		Ö	89. 00
90. 00	09000 CLINIC	0	ŀ	0	0.0000		0	90.00
90. 00	09001 CLINIC - DIABETES	10, 128	l .	616, 616			0	90.00
91. 00	09100 EMERGENCY	151, 560	•	59, 606	1			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	55, 058)1, 333			l	
72.00	OTHER REIMBURSABLE COST CENTERS	35,036	1,70	71, 333	0.0323	52 1, 150	37	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0		0	0.0000	00 0	0	94. 00
95.00	09500 AMBULANCE SERVICES			U	0.0000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED			^	0.0000	20	0	•
96. 00 97. 00	09700 DURABLE MEDICAL EQUIP-RENTED	0		0	0. 00000 0. 00000			
200.00		1, 385, 438	133, 71	U 4 504	1	10, 444, 013		1
200.00	p Total (Titles 30-177)	1, 303, 430	133,71	0, 500	"1	10, 444, 013	1 63, 301	₁ 200.00

| Period: | Worksheet D | From 01/01/2014 | Part IV | To | 12/31/2014 | Date/Time | Prepared: | 5/28/2015 | 7:02 | pm |
 Heal th Financial
 Systems
 INDIANA
 UNIVERSITY

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 Provi der CCN: 151328 THROUGH COSTS

						5/28/2015 7:0	2 pm
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursina School	Allied Healt	n All Other	Total Cost	
		Anesthetist	3		Medi cal	(sum of col 1	
		Cost			Education Cost		
		0031			Ludouti on oost	4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATING ROOM	0	0		0 0	0	50.00
			0		0 0	1	•
51.00	05100 RECOVERY ROOM	0	0		-	ľ	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	l ol	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	l ol	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY		0		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O			Ĭ	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
		0	0			· -	1
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	O	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		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	0	75. 00
	07697 CARDI AC REHABI LI TATI ON		0		0 0	1	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		l	<u> </u>		70.77
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	1 1	0	0		0 0	0	89. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				1
90.00	09000 CLINIC	0	0		0	0	90.00
90. 01	09001 CLINIC - DIABETES	0	0		0	0	90. 01
91. 00	09100 EMERGENCY	0	0		0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	O	0		0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	l o	0		0 0	0	97. 00
200.00		l ol	0		0 0	0	200.00
		-1		'	-	'	

Heal th	Financial Systems IND	I ANA UNIVERSIT	A HEALTH BEDLOF	₹D	In Lie	eu of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PAS	S Provi der		Period: From 01/01/2014 To 12/31/2014		nared:
					10 12/31/2014	5/28/2015 7:0	12 pm
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
	ANCHI LADV CEDVI CE COCT CENTEDO	6. 00	7. 00	8. 00	9. 00	10.00	
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0	12, 603, 505	0.00000	0. 000000	769, 579	50.00
51. 00	05100 RECOVERY ROOM	0				32, 967	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		I		0	1
53. 00	05300 ANESTHESI OLOGY	0		1		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		1	0.0000		1, 069, 354	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0.00000		0	55. 00
56. 00	05600 RADI OI SOTOPE	0	_			83, 951	
57. 00	05700 CT SCAN	0	1,020,227	0. 00000		00,701	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	l .		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	l .		Ō	
60. 00	06000 LABORATORY	0	32, 447, 713			2, 227, 439	
60. 01	06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0. 000000	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	0. 000000	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.00000	0. 000000	0	64. 00
65.00	06500 RESPIRATORY THERAPY	0	0	0.00000	0. 000000	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	4, 401, 237	0.00000	0. 000000	190, 063	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0. 000000	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0.00000	0. 000000	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	9, 824, 540			1, 112, 711	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,001,2,2			721, 775	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0				15, 835	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1 17 000, 700			4, 208, 477	
74.00	07400 RENAL DIALYSIS	0	_			0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	_	0.00000		0	75. 00
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	366, 402	0.00000	0.000000	0	76. 97
88. 00	08800 RURAL HEALTH CLINIC	1 0	0	0.00000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		-	l .		0	89. 00
90.00	09000 CLINIC	0		1		0	90.00
90. 00	09001 CLINIC - DIABETES		1	1		0	90.00
91. 00	09100 EMERGENCY	0					
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					
72.00	OTHER REIMBURSABLE COST CENTERS		1,701,000	0.0000	0.00000	1, 100	72.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0. 000000	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0. 000000	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.00000	0. 000000	0	97. 00
200.00	Total (lines 50-199)	0	133, 716, 586	,		10, 444, 013	200.00

| Period: | Worksheet D | From 01/01/2014 | Part IV | To | 12/31/2014 | Date/Time | Prepared: | 5/28/2015 | 7:02 | pm | THROUGH COSTS

						5/28/2015 7: 0	2 pm
				e XVIII	Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	n		
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0)	0		50.00
51.00	05100 RECOVERY ROOM	0	0)	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0		52.00
53.00	05300 ANESTHESI OLOGY	o	0	1	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0	1	0		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0)	0		55. 00
56.00	05600 RADI OI SOTOPE	o	0)	0		56. 00
57.00	05700 CT SCAN	ol	0)	0		57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0	,	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	,	0		59.00
60.00	06000 LABORATORY	0	0	,	0		60.00
60. 01	06001 BLOOD LABORATORY	0	0	,	0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	,	0		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY		Ö		0		64.00
65. 00	06500 RESPI RATORY THERAPY		Ö		0		65. 00
66. 00	06600 PHYSI CAL THERAPY		Ö		0		66.00
67. 00	06700 OCCUPATI ONAL THERAPY		Ö		0		67. 00
68. 00	06800 SPEECH PATHOLOGY		0		0		68. 00
69. 00	06900 ELECTROCARDI OLOGY		0		0		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0		0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT		0		0		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		0		73.00
74. 00	07400 RENAL DIALYSIS		0		0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0		0		75.00
76. 97	07697 CARDIAC REHABILITATION		0	1	0		76. 97
10. 71	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	O .		10.71
88. 00	08800 RURAL HEALTH CLINIC		0	1	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	1	0		89. 00
90. 00	09000 CLINIC		0		0		90.00
90. 00	09001 CLINIC - DIABETES	0	0		0		90.00
91. 00	09100 EMERGENCY		0		0		91.00
91.00	I I	0	0	1	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	ı U	U	"	U _I		72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		O		94. 00
95.00	09500 AMBULANCE SERVICES	١	U	1	٥		95.00
	I I		_	J			•
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0		96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0]	0		97. 00
200.00	Total (lines 50-199)	ا	0	1	0		200. 00

Health Financial Systems IND	IANA UNIVERSIT	Y HEAL	_TH_BEDFOR	RD	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/28/2015 7:0	pared:
			Ti tl	e XVIII	Hospi tal	Cost	
				Charges		Costs	
Cost Center Description	Cost to Charge	PPS R	ei mbursed	Cost	Cost	PPS Services	
	Ratio From	Servi	ces (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	i	nst.)	Servi ces	Services Not		
	Part I, col. 9			Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
ANOULL ADV. CEDVICE COCT. CENTERS	1. 00		2. 00	3. 00	4. 00	5. 00	

				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(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	
	ANGLI LADV. CEDVI CE COCT. CENTEDO	1.00	2.00	3.00	4.00	3.00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.227724	1 0	2 024 224			FO 00
	05000 OPERATI NG ROOM	0. 236724	 	_,,	0	1	
	05100 RECOVERY ROOM	0. 280056	1			-	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 143259	0	12, 291, 153	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	l 0	0	0	55. 00
56. 00	05600 RADI 0I S0T0PE	0. 183276	1	665, 832	0	0	56. 00
	05700 CT SCAN	0. 000000	1	000,002	0	٥	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1		0	0	58. 00
				1	0	0	
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	ł .	1	0	0	59. 00
	06000 LABORATORY	0. 152730		11, 792, 953	8, 516	0	60.00
	06001 BLOOD LABORATORY	0. 000000		0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000)	0	0		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63. 00
	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
	06500 RESPI RATORY THERAPY	0. 000000	l e	ا ا	0	Ō	65. 00
	06600 PHYSI CAL THERAPY	0. 406650		1, 188, 384	0	o o	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	ł	1	0	0	67. 00
		1	1	1	0	0	
	06800 SPEECH PATHOLOGY	0. 000000	•	-	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0. 270412	1	2, 851, 055	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000		0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 422795	•	799, 278	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 244003	0	44, 915	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 252675	0	3, 463, 378	42, 595	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0	0	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	l 0	0	0	75. 00
	07697 CARDI AC REHABI LI TATI ON	0. 211716	1		0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			,	_		1
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	1			0	89. 00
	l l		1		0	ľ	1
	09000 CLI NI C	0. 000000	1	-	0	1	90.00
	09001 CLINIC - DIABETES	4. 568677	1			0	90. 01
	09100 EMERGENCY	0. 460014					91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 524955	0	921, 641	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000)	0			94.00
95.00	09500 AMBULANCE SERVICES	0. 000000)	0			95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000		0	0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	ł	0	0	0	97. 00
200.00	Subtotal (see instructions)	3. 000000	0	40, 761, 359	51, 111		200.00
201.00	Less PBP Clinic Lab. Services-Program			10, 701, 007	0.,111		201.00
201.00	Only Charges						201.00
202. 00			0	40, 761, 359	51, 111	0	202. 00
202.00		I	1	1 40, 701, 337	J 1, 111	ı	1202.00

200.00

201.00

202. 00

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151328 Peri od: Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 691, 549 0 50.00 51.00 05100 RECOVERY ROOM 27,640 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 760, 818 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 56.00 122, 031 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 59 00 0 Ω 60.00 06000 LABORATORY 1,801,138 1, 301 60.00 60.01 06001 BLOOD LABORATORY 60.01 C 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 0 06600 PHYSI CAL THERAPY 483, 256 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 770, 959 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 337, 931 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 10, 959 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 875, 109 10, 763 73.00 74.00 07400 RENAL DIALYSIS C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 07697 CARDIAC REHABILITATION 76. 97 41, 747 0 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 89.00 09000 CLI NI C 90.00 90.00 0 0 09001 CLINIC - DIABETES 90.01 63,834 0 90.01 91.00 09100 EMERGENCY 1, 615, 380 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 483, 820 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00

9, 086, 171

9, 086, 171

12,064

12, 064

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der		Peri od:	Worksheet D	2002 10
				F	rom 01/01/2014	Part V	
			Component	CCN: 15Z328 T	o 12/31/2014	Date/Time Pre 5/28/2015 7:0	pared:
			T; +1	e XVIII S			2 pm
			11 (1		wing Beds - SNF		
	Coot Contor Decement on	Coot to Charge	DDC Doimburgood	Charges	Coot	Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From Worksheet C,	Services (see	Reimbursed Services	Reimbursed Services Not	(see inst.)	
		Part I, col. 9	inst.)	Subject To	Subject To		
		Part I, Cor. 9		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATING ROOM	0. 236724	. 0		0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 280056			_	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	1		1	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000				0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 143259		_	_	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000		_	1	0	55.00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0. 183276	1		<u> </u>	0	56.00
				1	<u> </u>	-	1
57. 00	05700 CT SCAN	0. 000000			_	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	1		0	0	59.00
60.00	06000 LABORATORY	0. 152730			_	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000		C	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0	_	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1	1	1	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		C	_	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	1	C	_	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000			1	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 406650	1	C	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000		C	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	C	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 270412	. 0	C	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	C	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 422795	0	C	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 244003	0	C	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 252675	0	C	0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0	C	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	C	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 211716	0	l c	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						1
88.00	08800 RURAL HEALTH CLINIC	0. 000000)			0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	0. 000000	0		0	0	90.00
90. 01	09001 CLINIC - DIABETES	4. 568677			0	0	90. 01
91. 00	09100 EMERGENCY	0. 460014	1		0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 524955	1			0	1
	OTHER REIMBURSABLE COST CENTERS						1
94.00		0. 000000					94. 00
95. 00	09500 AMBULANCE SERVI CES	0. 000000	1	ĺ			95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000		1		0	
97. 00		0. 000000		ا	ol ol	0	1
200.00			Ö	ا ا	ด	-	200. 00
201.00		1		ĺ	n n	ū	201. 00
	Only Charges						

0 202. 00

202.00

Only Charges Net Charges (line 200 +/- line 201)

Title XVIII Swing Beds - SNF Cost	
Costs	
Cost Center Description Cost Cost	
Rei mbursed Rei mbursed	
Services Services Not	
Subject To Subject To	
Ded. & Coi ns. Ded. & Coi ns.	
(see inst.) (see inst.)	
6.00 7.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0 0	50.00
51. 00 05100 RECOVERY ROOM 0 0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0	52.00
53. 00 05300 ANESTHESI OLOGY	53. 00
	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C O O	55. 00
56. 00 05600 RADI 01 SOTOPE 0 0	56. 00
57. 00 05700 CT SCAN 0 0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0	59. 00
60. 00 06000 LABORATORY 0 0	60.00
60. 01 06001 BLOOD LABORATORY 0 0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	63.00
64. 00 06400 INTRAVENOUS THERAPY 0 0	64.00
65. 00 06500 RESPI RATORY THERAPY 0 0	65. 00
66. 00 066000 PHYSI CAL THERAPY 0 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0	67. 00
68. 00 06800 SPEECH PATHOLOGY 0 0	
	68. 00
	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0	70.00
71. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O O	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0	72. 00
73.00 OT300 DRUGS CHARGED TO PATIENTS O O	73. 00
74. 00 07400 RENAL DI ALYSI S 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 CLI NI C 0 0	90.00
90. 01 09001 CLI NI C - DI ABETES 0 0	90. 01
91. 00 09100 EMERGENCY 0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0	92. 00
OTHER REIMBURSABLE COST CENTERS	1 /2:00
94. 00 09400 HOME PROGRAM DI ALYSIS 0 0	94. 00
95. 00 09500 AMBULANCE SERVI CES 0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0	96.00
	1
	97. 00
200.00 Subtotal (see instructions) 0 0	200.00
201.00 Less PBP Clinic Lab. Services-Program 0	201. 00
Only Charges	202 00
202.00 Net Charges (line 200 +/- line 201) 0 0	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151328 Peri od: Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/28/2015 7:02 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 381, 036 0 50.00 51.00 05100 RECOVERY ROOM 27,014 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 0 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 702, 049 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 23, 691 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 59 00 0 0 60.00 06000 LABORATORY 468, 676 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 366, 782 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 273, 273 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 182, 204 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 7, 408 0 72.00 07300 DRUGS CHARGED TO PATIENTS 382, 794 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 07697 CARDIAC REHABILITATION 76. 97 0 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 89.00 09000 CLI NI C 90.00 90.00 0 0 09001 CLINIC - DIABETES 90.01 15, 351 0 90.01 91.00 09100 EMERGENCY 1,016,236 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 93, 294 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 200.00 Subtotal (see instructions) 3, 939, 808 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges Net Charges (line 200 +/- line 201) 202. 00 202.00 3, 939, 808 0

leal th	Financial Systems	INDIANA UNIVERSITY HE	ALTH BEDFORD	In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 151328	Peri od:	Worksheet D-1		
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 7:02	te/Time Prepared:	
			Title XVIII	Hospi tal	Cost		
	Cost Center Description						
					1. 00		
	PART I - ALL PROVIDER COMPONENTS					ļ	
1. 00	INPATIENT DAYS Inpatient days (including private r	com days and swing had days	ovel udi na nowborn)		4, 956	1.00	
2. 00	Inpatient days (including private i				4, 282		
2. 00 3. 00	Private room days (excluding swing-			ivata room dave	4, 202		
5. 00	do not complete this line.	bed and observation bed days	s). If you have only pr	i vate i oolii days,	U	3.0	
1. 00	Semi-private room days (excluding s	wing had and observation had	4 days)		3, 591	4.0	
5. 00	Total swing-bed SNF type inpatient			r 21 of the cost	627		
5. 00	reporting period	days (frictually private roof	ii days) tili odgir beceilibe	i 31 of the cost	027	3.0	
5. 00	Total swing-bed SNF type inpatient	days (including private room	days) after December	31 of the cost	0	6.0	
. 00	reporting period (if calendar year,		days) at tel becember	or the cost	U	0.0	
7. 00	Total swing-bed NF type inpatient d		days) through December	31 of the cost	47	7.0	
. 00	reporting period	ays (Theraaring private room	days) thi dagir becomber	01 01 1110 0031	17	,. 0	
3. 00	Total swing-bed NF type inpatient d	lays (including private room	days) after December 3	1 of the cost	0	8.0	
. 00	reporting period (if calendar year,		days) arter becomber o	Tor the cost	o l	0.0	
9. 00	Total inpatient days including priv		the Program (excluding	swing-bed and	2, 311	9.0	
. 00	newborn days)	are reem days approache to	the regram (exertaining	oming bod and	2,0	'' "	
10.00	Swing-bed SNF type inpatient days a	pplicable to title XVIII onl	y (including private r	oom days)	627	10.0	
	through December 31 of the cost reporting period (see instructions)						
11.00	Swing-bed SNF type inpatient days a			oom days) after	0	11.0	
	December 31 of the cost reporting p	eriod (if calendar year, en	ter 0 on this line)				
12.00	Swing-bed NF type inpatient days ap	plicable to titles V or XIX	only (including private	e room days)	0	12.0	
	through December 31 of the cost rep						
13.00	Swing-bed NF type inpatient days ap				0	13.0	
	after December 31 of the cost repor				_	l	
	Medically necessary private room da		(excluding swing-bed	days)	0		
	Total nursery days (title V or XIX	onl y)			0		
6. 00	Nursery days (title V or XIX only)				0	16.0	
7 00	SWING BED ADJUSTMENT		+b	C 111		17.0	
7. 00	Medicare rate for swing-bed SNF ser	vices applicable to services	s through December 31 o	r the cost		17. C	
18. 00	reporting period Medicare rate for swing-bed SNF ser	vices applicable to service	after December 21 of	the cost		18. C	
6.00	reporting period	vices applicable to services	s arter becember 31 or	the cost		10.0	
9. 00	Medicald rate for swing-bed NF serv	icas annlicable to services	through December 31 of	the cost	132. 15	10 0	
7. 00	reporting period	rees approcable to services	till odgil becember 31 of	the cost	132. 13	' /. 0	
20. 00	Medicaid rate for swing-bed NF serv	ices applicable to services	after December 31 of t	he cost	0 00	20. C	
	reporting period						
1.00	Total general inpatient routine ser	vice cost (see instructions))		6, 351, 156	21. C	
2. 00	Swing-bed cost applicable to SNF ty			ing period (line	0	22.0	
	5 x line 17)		·				
3.00	Swing-bed cost applicable to SNF ty	pe services after December 3	31 of the cost reporting	g period (line 6	0	23.0	
	x line 18)						
4. 00	Swing-bed cost applicable to NF typ	e services through December	31 of the cost reporti	ng period (line	6, 211	24.0	
	7 x line 19)						
5. 00	Swing-bed cost applicable to NF typ	e services after December 3°	l of the cost reporting	period (line 8	0	25.0	
	x line 20)						
/ 00	Total swing-bed cost (see instructi	ons)			816, 615	26. C	
	General inpatient routine service c			l de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	5, 534, 541		

	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 311	9. 00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	627	10. 00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only)	0	15. 00 16. 00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17.00			17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
10.00	reporting period		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	132. 15	19. 00
17.00	reporting period	132. 13	19.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	6, 351, 156	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)	_	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	o	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	6, 211	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	816, 615	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 534, 541	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	_	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)		32. 00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00 36. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	5, 534, 541	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5, 534, 541	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 292. 51	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 986, 991	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	2, 700, 771	40. 00
41. 00		2, 986, 991	
11.00	Totalg. a general ripation routine service sest (Time 97 + Time 40)	2, 700, 771	11.00

	Financial Systems IND ATION OF INPATIENT OPERATING COST	IANA UNIVERSIT			RD CCN: 151328	In Lie	eu of Form CMS- Worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		P	ovi aer	CCN: 151328	From 01/01/2014		
						To 12/31/2014	Date/Time Pre 5/28/2015 7:0	pared: 2 pm
	Cost Contar Deceription	Total	To:		e XVIII	Hospital Program Days	Cost	
	Cost Center Description	Total Inpatient Cost	To [.] Inpatie		Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		•			col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00		00 C	3.00	4.00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units							
43. 00 44. 00	INTENSIVE CARE UNIT	2, 283, 321 0		788 C				1
45. 00	BURN INTENSIVE CARE UNIT	0		C	1			
46. 00	SURGICAL INTENSIVE CARE UNIT	0		C	0.	00	0	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47. 00
	·	-					1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				ne)		2, 456, 304 6, 950, 057	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 40) (Sec 1113	tructro	0115)		0, 430, 037	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	servi ce	s (from	n Wkst. D, su	m of Parts I and	0	50. 00
51. 00		atient ancillar	v servi	ces (fr	om Wkst. D.	sum of Parts II	0	51.00
	and IV)		,					
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		l ated	non-nhy	eician anest	hetist and	0	
33.00	medical education costs (line 49 minus line		erateu,	non-pny	isi ci ali allest	netrat, and] 33. 00
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION							F4 00
	Program discharges Target amount per discharge						0.00	
56.00	.00 Target amount (line 54 x line 55)							56. 00 57. 00
57. 00 58. 00								
59. 00								
60. 00	market basket							60.00
61. 00								61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							63.00	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31	of the	cost report	ing period (See	810, 404	64. 00
	instructions)(title XVIII only)	Ü			•		010, 101	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 c	f the c	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus	line 6	5)(title XVI	II only). For	810, 404	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through	. Docomb	or 21 c	of the cost r	operting period	0	67. 00
07.00	(line 12 x line 19)	e costs till ougi	i beceill	ei 31 C	i the cost i	eportring perrod		07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	December	31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ((line 67	+ line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND I	CF/MR C	NLY			1
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,			,			70.00
72. 00	Program routine service cost (line 9 x line	71)			,			72. 00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv							73.00
75. 00	Capital -related cost allocated to inpatient	•				Part II, column		75. 00
7/ 00	26, line 45)	no 2)						74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *						76. 00 77. 00
	Inpatient routine service cost (line 74 minu	,						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces				*.	nus line 79)		79.00
81. 00								81.00
82. 00 83. 00								82.00
83.00	Program inpatient ancillary services (see in		13)					83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructio		5)				85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 8	5)				86. 00
87. 00	Total observation bed days (see instructions)					691	
88.00	Adjusted general inpatient routine cost per of the servation had cost (line 27 x line 28) (see	•)			1, 292. 51	
07. UU	Observation bed cost (line 87 x line 88) (se	= IIISTI UCTI OIIS)	1				893, 124	1 09.00

Health Financial Systems IND	Y HEALTH BEDFOR	RD.	In Lie	eu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
			From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 7:03		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	341, 182	5, 534, 541	0. 06164	6 893, 124	55, 058	90. 00
91.00 Nursing School cost	0	5, 534, 541	0.00000	893, 124	0	91.00
92.00 Allied health cost	0	5, 534, 541	0.00000	893, 124	0	92.00
93.00 All other Medical Education	0	5, 534, 541	0. 000000	893, 124	0	93. 00

Health Financial Systems INDIANA UNIVERSITY HEA	LTH BEDFO	RD	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151328	Peri od:	Worksheet D-3	
			From 01/01/2014	Data /Tima Daa	narad.
			To 12/31/2014	Date/Time Pre 5/28/2015 7:0	
	Ti tl	e XVIII	Hospi tal	Cost	2 p
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			ŭ .	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			3, 205, 381		30. 00
31. 00 03100 I NTENSI VE CARE UNI T			1, 226, 844		31. 00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43. 00
50. 00 05000 OPERATING ROOM		0. 23672	769, 579	182, 178	50.00
51. 00 05100 RECOVERY ROOM		0. 28005		9, 233	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 00000		7, 233	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000		Ö	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14325		153, 195	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C		0.00000		0	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 18327		15, 386	56. 00
57. 00 05700 CT SCAN		0.00000		0	57. 00
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)		0.00000		Ō	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60. 00 06000 LABORATORY		0. 15273		340, 197	60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0.00000	0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 40665	0 190, 063	77, 289	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 27041		300, 890	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 42279		l	71. 00
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENT		0. 24400			72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 25267		1, 063, 377	73. 00
74. 00 07400 RENAL DI ALYSI S		0.00000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000		0	75.00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 21171	0 0	0	76. 97
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C		0.00000	in	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLINI C		0.00000		0	90.00
90. 01 09001 CLINI C - DI ABETES		4. 56867		0	90. 01
91. 00 09100 EMERGENCY		0. 46001			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 52495			92. 00
OTHER REIMBURSABLE COST CENTERS		0.02170	-, 1, 130	1 307	1 00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0.0000		, and the second	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 00000	0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		ő	97. 00
200.00 Total (sum of lines 50-94 and 96-98)			10, 444, 013		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)	•		10, 444, 013		202. 00

Health Financial Systems Indiana University Hea		1000 0		u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15		eriod: rom 01/01/2014	Worksheet D-3	
	Component CCN: 15		o 12/31/2014	Date/Time Pre	nared:
	Component Con. 10		0 12/01/2011	5/28/2015 7:0	
	Title XVIII	Sı	wing Beds - SNF		
Cost Center Description		of Cost		Inpati ent	
	To Ch		Program	Program Costs	
		J	Charges	(col. 1 x col.	
			3	2)	
	1.	00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>.</u>				
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS			l .		
50. 00 05000 OPERATI NG ROOM	0	. 236724	0	0	50.00
51. 00 05100 RECOVERY ROOM		. 280056		Ō	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		. 000000		0	52.00
53. 00 05300 ANESTHESI OLOGY		. 000000		Ö	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		. 143259		5, 637	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		. 000000		0,007	55. 00
56. 00 05600 RADI 0I SOTOPE		. 183276		879	56.00
57. 00 05700 CT SCAN		. 000000		0	57.00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)		. 000000		Ö	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		. 000000		0	59.00
60. 00 06000 LABORATORY		. 152730		29, 575	60.00
60. 01 06000 EABORATORY		. 000000		29, 3/3	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		. 000000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		. 000000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		. 000000		0	63.00
64. 00 06400 INTRAVENOUS THERAPY				0	64.00
65. 00 06500 RESPI RATORY THERAPY		. 000000		0	65.00
		. 000000		_	1
66. 00 06600 PHYSI CAL THERAPY		. 406650		49, 899	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	ı	. 000000		0	67.00
68. 00 06800 SPEECH PATHOLOGY		. 000000		10.353	68. 00
69. 00 06900 ELECTROCARDI OLOGY		. 270412		18, 352	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		. 000000		0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		. 422795		38, 078	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		. 244003		0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		. 252675		211, 179	73.00
74. 00 07400 RENAL DI ALYSI S		. 000000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		. 000000		0	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		. 211716	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			T		
88. 00 08800 RURAL HEALTH CLINIC		. 000000		0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		. 000000		0	89. 00
90. 00 09000 CLI NI C		. 000000		0	90.00
90. 01 09001 CLI NI C - DI ABETES		. 568677		_	90. 01
91. 00 09100 EMERGENCY		. 460014			91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	. 524955	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DI ALYSI S	0	. 000000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED		. 000000		0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	. 000000	0	0	97. 00
200.00 Total (sum of lines 50-94 and 96-98)			1, 354, 201	353, 599	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			1, 354, 201		202. 00

Health Financial Systems INDIANA UNIVERSITY HEAL	_TH BEDFOR	RD		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 1513	28 F	Peri od:	Worksheet D-3	
	_			rom 01/01/2014		
	Component	t CCN: 15Z	328 I	To 12/31/2014		
	T: +	la VIV	-	ui na Dodo CNE	5/28/2015 7:0	2 piii
Coat Contan Bassarintian	11 (le XIX		wing Beds - SNF	1'	
Cost Center Description		Ratio of To Char			Inpatient	
		10 Chai	ges	Program	Program Costs (col. 1 x col.	
				Charges	2)	
		1.00	`	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	,	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1		0		30.00
						31.00
					•	1
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT					ł	32.00
				0		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T				0		34.00
40. 00 04000 SUBPROVI DER - 1 PF				0		40.00
41. 00 04100 SUBPROVI DER - I RF				0	•	41.00
42. 00 04200 SUBPROVI DER				0		42.00
43. 00 04300 NURSERY		<u> </u>		0		43. 00
ANCILLARY SERVICE COST CENTERS		1 0	201701	1	1 0	F0 00
50. 00 05000 OPERATI NG ROOM		1	236724			
51. 00 05100 RECOVERY ROOM		1	280056			
52. 00 O5200 DELIVERY ROOM & LABOR ROOM		1	000000			
53. 00 05300 ANESTHESI OLOGY		1	000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		1	143259			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C		1	000000			55. 00
56. 00 05600 RADI OI SOTOPE		1	183276			56. 00
57. 00 05700 CT SCAN		1	000000			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		1	000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		1	000000			59. 00
60. 00 06000 LABORATORY		1	152730			60. 00
60. 01 06001 BL00D LABORATORY		1	000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		1	000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1	000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		1	000000			63. 00
64.00 06400 I NTRAVENOUS THERAPY		1	000000			64. 00
65. 00 06500 RESPI RATORY THERAPY		1	000000			65. 00
66. 00 O6600 PHYSI CAL THERAPY		0.4	106650			66. 00
67. 00 06700 0CCUPATI ONAL THERAPY		1	000000			67. 00
68. 00 06800 SPEECH PATHOLOGY		1	000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY		1	270412			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		1	000000		1	70. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1	122795		0	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT		1	244003			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		1	252675		1	73. 00
74. 00 07400 RENAL DI ALYSI S		1	000000			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0.0	000000			
76. 97 O7697 CARDI AC REHABI LI TATI ON		0.2	<u> 211716</u>	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC		1	000000			
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER			000000		1	
90. 00 09000 CLI NI C			000000			
90. 01 09001 CLINIC - DIABETES		1	568677			90. 01
91. 00 09100 EMERGENCY		1	460014			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0.5	524955	5 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS		0.0	000000	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED			000000		0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0	000000	0		
200.00 Total (sum of lines 50-94 and 96-98)				0	0	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)				0		202. 00

Health Financial Systems	INDIANA UNIVERSITY HEA	ALTH BEDFORD	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151328	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 7:02 pm
•		Ti tla YVIII	Hospi tal	Cost

PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00				To 12/31/2014	Date/Time Pre 5/28/2015 7:0	
Next St MEDICAL AND OTHER HEALTH SERVICES 9,908,235 1.1			Title XVIII	Hospi tal		
Next St MEDICAL AND OTHER HEALTH SERVICES 9,908,235 1.1					1.00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
PRS payments 0 0 0 0 0 0 0 0 0	1.00				9, 098, 235	1.00
0		· · · · · · · · · · · · · · · · · · ·				2. 00
Enter the finespit all specific payment to cost ratio (see instructions) 0.000 5					-	
Line 2 times line 5			i one)			
2.00 Sum of Tine 3 plus line 4 divided by line 6 0.00 7.			1 0113)		l	ı
0					0.00	•
10.00 Organ acquisitions 9, 098,235 11.						
1.00 Total cost (sum of lines 1 and 10) (see instructions) 9,099,235 11.			, col. 13, line 200		1	9.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Cost or Charges					1	10.00
Reasonable charges	11.00				9, 046, 233	11.00
13.00 Organ acquistion charges (from Wist. D-4, Pt. III., line 69, col. 4) 0 13.						
14. 00 Total reasonable charges (sum of lines 12 and 13) 0 14.					l	•
Customary_charges			I. 4)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.	14.00					14.00
had such payment been made in accordance with 42 CFR \$413.13(e)	15. 00		yment for services on	a charge basis	0	15. 00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18. 18. 19. 1	16.00	· ·	payment for services o	on a chargebasis	0	16. 00
18.00 Total customary charges (see Instructions) 0 18. 0 19. 0	47.00	' '			0 000000	47.00
19. 0 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 19. instructions) 20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. instructions) 21. 00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 9, 189, 217 21. 21. 22. 23. 00 Cost of physici and residents (see instructions) 0 22. 23. 00 Cost of physici and services in a teaching hospital (see instructions) 0 23. 24. 24. 25. 26.					1	1
Instructions		,	if line 18 exceeds Li	ne 11) (see		19.00
Instructions 9,189,217 21.				, (
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 9,189,217 21.00 22.00 23.00 2	20. 00		if line 11 exceeds li	ne 18) (see	0	20. 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.	21. 00		instructions)		9, 189, 217	21. 00
24.0 Total prospective payment (sum of lines 3, 4, 8 and 9) 24.0 COMPUTATION OF REIMBURSEMENT SETTLEMENT		· · · · · · · · · · · · · · · · · · ·				
COMPUTATION OF RELIMBÜRSEMENT SETTLEMENT 25.00 Deductibles and coinsurance (for CAH, see instructions) 6.0,694 25.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 6.054,543 26.00 CAH, see instructions) 6.054,543 26.00 CAH, see instructions) 7.00 27.00 27.00 28.00 29.			ctions)			
25.00 Deductibles and coinsurance (for CAH, see instructions) 60,694 25.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 6,054,543 26.00 CAH, see instructions) 6,054,543 26.00 CAH, see instructions) 7,000 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.0	24.00				0	24. 00
27.00 Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions) 3,073,980 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 29.00	25. 00				60, 694	25. 00
CAH, see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 1, 997 31.03 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.01 34.00 Allowable bad debts (see instructions) 427, 868 34.01 35.00 Adjusted reimbursable bad debts (see instructions) 30.01 30.01 30.01 30.01 30.00 Subtotal (see instructions) 30.01 30.01 30.00 Subtotal (see instructions) 30.01	26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions))	6, 054, 543	26. 00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 29.0 2	27. 00		us the sum of lines 22	2 and 23} (for	3, 073, 980	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.03 3.00 3.00 Subtotal (sum of lines 27 through 29) 3.073,980 30.1 31.00 Primary payer payments 1,997 31.3 3.00 Subtotal (line 30 minus line 31) 3.071,983 32.00 Subtotal (line 30 minus line 31) 3.071,983 32.00 Subtotal (line 30 minus line 31) 3.001,983 32.00 33.00 Composite rate ESRD (From Wkst. I-5, line 11) 0 33.01 33.00	28 00		a 50)		0	28. 00
30.00 Subtotal (sum of lines 27 through 29) 3,073,980 30.01 31.00 Primary payer payments 1,997 31.00 32.00		, , ,	e 30)		1	ı
32.00 Subtotal (line 30 minus line 31) 3,071,983 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 33.00 33.00 Allowable bad debts (see instructions) 427,868 34.00 34.00 Allowable bad debts (see instructions) 325,180 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 325,180 35.00 37.00 Subtotal (see instructions) 3,397,163 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.00 39.00 39.00 Sequestration adjustment (see instructions) 0 39.00 39.00 39.00 Sequestration adjustment (see instructions) 0 39.00		,			3, 073, 980	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Prioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or subtotal (see instructions) 39.90 Subtotal (see instructions) 39.91 Sequestration adjustment (see instructions) 30.00 Subtotal (see instructions) 30.00 Sequestration adjustment (see instructions) 30.00 Sequestration adjustment (see instructions) 30.00 Sequestration adjustment (see instructions) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 Sil5. 2 30.00 To BE COMPLETED BY CONTRACTOR 30.00 Outlier reconciliation adjustment amount (see instructions) 30.00 Outlier reconciliation adjustment amount (see instructions) 30.00 Outlier reconciliation adjustment amount (see instructions)					1	1
33. 00 Composite rate ESRD (from Wkst. I-5, line 11) 34. 00 Allowable bad debts (see instructions) 35. 00 Adjusted reimbursable bad debts (see instructions) 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 Silb. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 0 90. 00 Original outlier amount (see instructions) 0 91. 00	32. 00		2)		3, 071, 983	32. 00
34. 00 Allowable bad debts (see instructions) 427, 868 34. 03. 03. 03. 04. 03. 04. 04. 04. 04. 04. 04. 05. 05. 04. 04. 04. 04. 04. 04. 04. 04. 04. 04	33 00		5)		0	33. 00
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 50 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628,398 (some points) 44.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions)						
37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 9 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 44. 00 Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 Outlier reconciliation adjustment amount (see instructions) 93. 37. 163 93. 38. 00 93. 39. 39. 39. 39. 39. 39. 39. 39. 39.					325, 180	35. 00
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 41.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions)		,	ctions)		l	1
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 44.00 Since the contractors of		,				
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.90 Subtotal (see instructions) 39.91 Augustration adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment (see instructions) 39.90 To sequestration adjustment (see instructions) 39.90 To sequestration adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment (see instructions) 39.90 To sequestration adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment adjustment (see instructions) 39.90 To sequestration adjustment (see instructions) 39.90 To sequestration adjustment (see in					l	1
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 39. 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 44. 05 115. 2 70 BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 01 Outlier reconciliation adjustment amount (see instructions) 93. 39. 40. 020, 39.					l	39. 50
40.00 Subtotal (see instructions) 3, 397, 163 40.01 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments Tentative settlement (for contractors use only) 42.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 44.00	39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	ctions)	0	39. 98
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 41.00 Silfs. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions)						39. 99
41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions)		· · · · · · · · · · · · · · · · · · ·			1	1
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions)		i i				
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 628, 398 5115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 90.00 91.00 91.00 92.00 93.00 94.00 95.00 96.00 97.00					1	1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions)	43.00				-400, 367	43. 00
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions)	44. 00		e with CMS Pub. 15-2,	chapter 1,	628, 398	44. 00
90.00 Original outlier amount (see instructions) 0 90.0 Outlier reconciliation adjustment amount (see instructions) 0 91.0						
91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.0	90. 00				0	90. 00
92.00 The rate used to calculate the Time Value of Money					1	1
	92. 00	The rate used to calculate the Time Value of Money			l	1
		· ·			1	•
94.00 Total (sum of lines 91 and 93) 0 94.0	94. UU	Liorai (2011 OI IIII62 AT 9110 A2)			ı	94. 00

Part I

Peri od:

From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm Title XVIII Hospi tal Cost Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 5, 851, 646 3, 729, 587 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 08/20/2014 869, 900 0 3.01 3.02 0 3.02 3.03 3.03 0 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 3.54 \cap 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 869, 900 Ω 3.99 3.50-3.98) 3, 729, 587 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 6, 721, 546 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 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 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 0 6.01 400, 367 6 02 SETTLEMENT TO PROGRAM 451, 326 6.02 7.00 Total Medicare program liability (see instructions) 6, 270, 220 3, 329, 220 7.00 Contractor NPR Date (Mo/Day/Yr) Number

0

1 00

2 00

8.00

8.00 Name of Contractor

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 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/28/2015 7:0	2 pm
				ving Beds - SNF		
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 043, 651		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	·	'	Į.		
3.01	ADJUSTMENTS TO PROVIDER	08/20/2014	59, 700		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program	ı	1		1	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3. 52 3. 53			0		0	3. 52 3. 53
3. 54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		59, 700		0	3. 99
3. 77	3. 50-3. 98)		37, 700			3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 103, 351		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	Г	1		1	
5.00	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. 01
5. 02	TERMINE TO TROTTSER		l ő		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
6.00	the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		38, 277		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 141, 628		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor		0	1. 00	2. 00	0.00
8. 00	Name of Contractor	l			l	8. 00

Heal th	Financial Systems INDIANA UNIVERSITY HE	FALTH REDEORD	Inlie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 151328	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II	pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	1, 133	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	-12		2, 831	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			368	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	·12		4, 379	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			140, 773, 419	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		2, 311, 074	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of celline 168	ertified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Seguestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00
31.00	Other Adjustment (specify)			0	31. 00
22 00	Palance due provider (Line 9 (or Line 10) minus Line 30 and Li	no 21) (soo instruction	6)	0	22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 32.00

Health Financial Systems	INDIANA UNIVERSITY HE	ALTH BEDFORD	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 151328	Peri od:	Worksheet E-2
			From 01/01/2014	
		Component CCN: 15Z328	To 12/31/2014	Date/Time Prepared:
				5/28/2015 7:02 nm

	Co	omponent CCN: 15Z328	To 12/31/2014	Date/Time Prep 5/28/2015 7:03	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		818, 508	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, ar		357, 135	0	3. 00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructi				
4.00	Per diem cost for interns and residents not in approved teaching p	orogram (see		0. 00	4. 00
	instructions)				
5.00	Program days		627	0	5. 00
6.00	Interns and residents not in approved teaching program (see instru			0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 175, 643	0	
9.00	Primary payer payments (see instructions)		0	0	
10. 00	Subtotal (line 8 minus line 9)		1, 175, 643	0	
11. 00	Deductibles billed to program patients (exclude amounts applicable	e to physician	0	0	11. 00
	professional services)				
12. 00	Subtotal (line 10 minus line 11)		1, 175, 643	0	
13. 00	Coinsurance billed to program patients (from provider records) (ex	clude coinsurance	11, 096	0	13. 00
44.00	for physician professional services)			0	44.00
	80% of Part B costs (line 12 x 80%)		4 4 4 5 4 7	0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1, 164, 547	0	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
	410A RURAL DEMONSTRATION PROJECT		0	0	16. 55
	Allowable bad debts (see instructions)		584	0	
	Adjusted reimbursable bad debts (see instructions)	>	380	0	17. 01
	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)	0 4 4 4 007	0	18.00
	Total (see instructions)		1, 164, 927	0	19.00
19. 01	Sequestration adjustment (see instructions)		23, 299	0	19. 01
	Interim payments		1, 103, 351	0	20.00
	Tentative settlement (for contractor use only)	141	00 077	0	21. 00
	Balance due provider/program (line 19 minus lines 19.01, 20, and 2		38, 277	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance w §115.2	II TH CMS Pub. 15-2,	79, 959	0	23. 00
	13110.2		_ i I		1

Health Financial Systems	INDIANA UNIVERSITY HEA	LTH BEDFORD	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provi der CCN: 151328	From 01/01/2014	Worksheet E-2
		Component CCN: 15Z328	To 12/31/2014	Date/lime Prepared: 5/28/2015 7:02 pm

	Col	mponent CCN: 15Z328	10 12/31/2014	5/28/2015 7:0	
		Title XIX	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and	d sum of Wkst. D,	0		3. 00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instruction				
4.00	Per diem cost for interns and residents not in approved teaching pr	rogram (see	0.00		4. 00
	instructions)				
5.00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see instruc		0		6. 00
7.00	Utilization review - physician compensation - SNF optional method of	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8. 00
9.00	Primary payer payments (see instructions)		0		9. 00
	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	to physician	0		11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		0		12.00
13. 00	Coinsurance billed to program patients (from provider records) (exc	clude coinsurance	0		13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		0		14. 00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0		15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
	Pioneer ACO demonstration payment adjustment (see instructions)		0		16. 50
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0		17. 00
	Adjusted reimbursable bad debts (see instructions)		0		17. 01
	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)	0		18. 00
	Total (see instructions)		0		19. 00
	Sequestration adjustment (see instructions)		0		19. 01
	Interim payments		0		20. 00
	Tentative settlement (for contractor use only)		0		21. 00
	Balance due provider/program (line 19 minus lines 19.01, 20, and 2		0		22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	0		23. 00
	§115. 2				

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFORD	In Lie	eu of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151328	From 01/01/2014	Worksheet E-3 Part V Date/Time Prep 5/28/2015 7:02	pared:
	Title XVIII	Hospi tal	Cost	
			1. 00	
PART V - CALCULATION OF REIMBURSEMENT SE	ETTLEMENT FOR MEDICARE PART A SERVICES - COS	T REIMBURSEMENT		
4 00	-		/ 050 053	1

	Title XVIII Hospital	Cost	
	AND A CALCILIATION OF DELINDIPPENENT CETTLEMENT FOR MEDICADE DADT A CEDIMICEC COST DELINDIPPENENT	1.00	
1. 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT Inpatient services	6, 950, 057	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instructions)	0, 950, 057	
3.00	Organ acqui si ti on		
4.00	Subtotal (sum of lines 1 through 3)	6, 950, 057	1
5. 00	Primary payer payments	12, 248	
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)	7, 007, 310	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES	7,007,310	0.00
	Reasonable charges		
7.00	Routi ne servi ce charges	0	7.00
8.00	Ancillary service charges	O	
9.00	Organ acquisition charges, net of revenue	C	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	S 0	11. 00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge bas	si s 0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	
14.00	Total customary charges (see instructions)	0	
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	15.00
	instructions)	_	
16. 00		0	16. 00
17 00	instructions)		17 00
17.00	Cost of physicians' services in a teaching hospital (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	17. 00
18. 00	Direct graduate medical education payments (from Worksheet E-4, line 49)		18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	7, 007, 310	
20. 00	Deducti bl es (exclude professional component)	604, 192	
21. 00	Excess reasonable cost (from line 16)	001,172	
22. 00	Subtotal (line 19 minus line 20 and 21)	6, 403, 118	
23. 00	Coinsurance	22, 800	
24. 00	Subtotal (line 22 minus line 23)	6, 380, 318	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23, 508	
26. 00	Adjusted reimbursable bad debts (see instructions)	17, 866	26.00
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8, 391	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	6, 398, 184	28.00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29. 99	Recovery of Accelerated Depreciation	0	29. 99
30. 00	Subtotal (see instructions)	6, 398, 184	30.00
30. 01	Sequestration adjustment (see instructions)	127, 964	
31. 00		6, 721, 546	
32.00	·	0	
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-451, 326	
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	478, 506	34. 00
	§115. 2		

Health Financial Systems INDIANA UNIVERSITY HEALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 151328

Peri od: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared:

			'	0 12/31/2014	5/28/2015 7:0	
	· · · · · · · · · · · · · · · · · · ·	General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	CURRENT ACCETC	1. 00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	20, 683, 611	1 0		0	1.00
2. 00	Temporary investments	20, 063, 011		0	0	2.00
3. 00	Notes receivable			-	0	3.00
4. 00	Accounts receivable	6, 367, 575	1	o	0	4. 00
5.00	Other recei vable	478, 862		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	369, 709	0	0	0	7. 00
8.00	Prepai d expenses	388, 767	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9. 00
10. 00	Due from other funds	0	0		0	10.00
11. 00	Total current assets (sum of lines 1-10)	28, 288, 524	. 0	0	0	11. 00
40.00	FI XED ASSETS					
12. 00	Land	931, 334		-	0	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	1, 174, 400 -866, 298	1	-	0	13. 00 14. 00
15. 00	Buildings	14, 290, 100		0	0	15.00
16. 00	Accumulated depreciation	-8, 202, 252		0	0	16.00
17. 00	Leasehold improvements	3, 582, 066	1	0	0	17. 00
18. 00	Accumulated depreciation	-2, 350, 728	1	0	0	18. 00
19.00	Fi xed equipment	1, 863, 226	1	0	0	19.00
20.00	Accumulated depreciation	-1, 779, 720	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	18, 960, 902		0	0	23. 00
24. 00	Accumulated depreciation	-16, 089, 045	1	0	0	24. 00
25. 00	Mi nor equi pment depreci able	0	0	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	1, 845, 472	2	0	0	27. 00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable			0	0	28. 00 29. 00
30. 00	Total fixed assets (sum of lines 12-29)	13, 359, 457	1	_	0	30.00
30.00	OTHER ASSETS	15, 557, 457		<u> </u>	U	30.00
31. 00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	3, 634, 035	0	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	3, 634, 035	0	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	45, 282, 016	0	0	0	36. 00
	CURRENT LIABILITIES	1		1		
37. 00	Accounts payable	1, 520, 927	1	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 791, 389	1	0	0	38. 00
39. 00	Payroll taxes payable	070.047	0	0	0	39.00
40. 00	Notes and Loans payable (short term)	978, 067		0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments	0		U	U	41. 00 42. 00
43. 00	Due to other funds	3, 969, 868		0	0	43.00
44. 00	Other current liabilities	3, 707, 000		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	8, 260, 251	1			
	LONG TERM LIABILITIES		-	-1		
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47. 00
48.00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	78, 743	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	78, 743		0	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	8, 338, 994	0	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	36, 943, 022				52.00
53. 00	Specific purpose fund		0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance Plant fund balance - invested in plant			U	0	56.00
57. 00 58. 00	Plant fund balance - reserve for plant improvement,		1		0	57. 00 58. 00
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	36, 943, 022	2	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	45, 282, 016		o	0	60.00
	59)		[
				·		

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 151328 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 7:02 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 29, 595, 236 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 12, 203, 654 2.00 3.00 Total (sum of line 1 and line 2) 41, 798, 890 0 3.00 4.00 0 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 41, 798, 890 11.00 0 11.00 4, 855, 868 12.00 CAPITAL TRANSFER INTERCOMPANY 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 4, 855, 868 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 36, 943, 022 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 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 11.00 12.00 CAPITAL TRANSFER INTERCOMPANY 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0

0

0

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

			-	Го 12/31/2014	Date/Time Pre 5/28/2015 7:0	
	Cost Center Description		Inpati ent	Outpati ent	Total	2 piii
	oost ochter beschiptron		1. 00	2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		5, 212, 39	4	5, 212, 394	1.00
2.00	SUBPROVI DER - I PF				0	2. 00
3.00	SUBPROVI DER - I RF				0	3. 00
4.00	SUBPROVI DER				0	4. 00
5.00	Swing bed - SNF				0	5. 00
6.00	Swing bed - NF				0	6.00
7.00	SKILLED NURSING FACILITY		(o l	0	7. 00
8.00	NURSING FACILITY		(o l	0	8. 00
8.01	I CF/MR		(o l	0	8. 01
9.00	OTHER LONG TERM CARE		(o l	0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		5, 212, 39	4	5, 212, 394	10. 00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		1, 844, 43	9	1, 844, 439	11. 00
12.00	CORONARY CARE UNIT		()	0	12. 00
13.00	BURN INTENSIVE CARE UNIT		()	0	13. 00
14.00	SURGICAL INTENSIVE CARE UNIT		()	0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16.00	Total intensive care type inpatient hospital services (sum of li	ines	1, 844, 43	9	1, 844, 439	16. 00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		7, 056, 83	3	7, 056, 833	17. 00
18.00	Ancillary services		19, 115, 36		120, 820, 791	18. 00
19.00	Outpati ent servi ces		500, 92	12, 395, 629	12, 896, 554	19. 00
20.00	RURAL HEALTH CLINIC		(0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		(0	0	21. 00
22. 00	HOME HEALTH AGENCY			0	0	22. 00
23. 00	AMBULANCE SERVI CES		(0	0	23. 00
24.00	CMHC			0	0	24. 00
24. 10	CORF		(0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		(0	0	25. 00
26. 00	HOSPI CE		(0	0	26. 00
27. 00	PHYSI CI AN PRI VATE			2, 075, 827	2, 075, 827	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst.	26, 673, 12	116, 176, 879	142, 850, 005	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			41, 365, 599		29. 00
30. 00	ADD (SPECIFY)					30. 00
31. 00						31.00
32. 00						32. 00
33. 00						33. 00
34.00						34. 00
35. 00			(] _		35. 00
36. 00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)			0		37. 00
38. 00)		38. 00
39. 00						39. 00
40.00			(40.00
41. 00	T + 1 + 1 + 1		(ا_ ا		41.00
42. 00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		41, 365, 599		43. 00
	to Wkst. G-3, line 4)	ı		1		I

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10							
STATEMENT OF REVENUES AND EXPENSES Provi der CCN: 151328 Peri od:			Worksheet G-3				
STATE	ENT OF REVENUES AND EXICUSES	110VI del CON. 131320	From 01/01/2014 To 12/31/2014				
			10 12/01/2011	5/28/2015 7: 02 pm			
				1. 00			
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			142, 850, 005	1. 00		
2.00	Less contractual allowances and discounts on patients' accounts	90, 564, 971	2. 00				
3.00	Net patient revenues (line 1 minus line 2)	52, 285, 034	3. 00				
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		41, 365, 599			
5.00	Net income from service to patients (line 3 minus line 4)			10, 919, 435	5. 00		
	OTHER INCOME			41, 181			
6.00	00 Contributions, donations, bequests, etc				6. 00		
7.00	00 Income from investments				7. 00		
8.00	00 Revenues from telephone and other miscellaneous communication services				8. 00		
9.00	00 Revenue from television and radio service				9. 00		
10.00	Purchase di scounts			1, 220	10.00		
11.00	.00 Rebates and refunds of expenses				11. 00		
12.00	00 Parking lot receipts				12. 00		
13.00	Revenue from Laundry and Linen service			0	13. 00		
14.00	00 Revenue from meals sold to employees and guests				14. 00		
15.00	00 Revenue from rental of living quarters				15. 00		
16.00	Revenue from sale of medical and surgical supplies to other than patients				16. 00		
17.00	10 Revenue from sale of drugs to other than patients				17. 00		
18.00	00 Revenue from sale of medical records and abstracts				18. 00		
19. 00	.00 Tuition (fees, sale of textbooks, uniforms, etc.)				19. 00		
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00		
21.00	Rental of vending machines			0	21. 00		
22. 00	Rental of hospital space			945, 961	22. 00		
23.00	Governmental appropriations			160, 803	23. 00		
24. 00	OTHER MISCELL NONOPERATING REV			45, 571	24. 00		

1, 284, 219

12, 203, 654

0 27.00

12, 203, 654 29. 00

25. 00 26. 00

28.00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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

27. 00 OTHER EXPENSES (SPECIFY)