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This	h Financial Systems report is required by law (42 USC 1395g; 42	TU HEALTH GOSHEN	HOSPITAL	ant can noch	In Lie	of Form CMS-	2552-10
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	TAL AND HOSPITAL HEALTH CARE COMPLEX COST RE			CCN: 150026	Period:	Worksheet S	-0000
	ETTLEMENT SUMMARY	FORT CERTIFICATION	Frovider	CCN. 130020	From 01/01/2014 To 12/31/2014	Parts I-III Date/Time Pro	
PART	I - COST REPORT STATUS	norman and an artist of the state of the sta	• • • • • • • • • • • • • • • • • • • •		<u> </u>	5/29/2015 3:3	13. hii
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	Take the field of	PRIT RESOLUTI					
	CERTIFICATION BY OFFICER OR ADMI	NTSTRATOR OF PROVIDE	R(S)				
		The state of the s	(5)				
	I HEREBY CERTIFY that I have read the abo	ve certification st	atement and	that I have	examined the acco	ompanving	
	electronically filed or manually submitte	d cost report and t	he Balance S	heet and Sta	tement of Revenue	e and	
	Expenses prepared by IU HEALTH GOSHEN HOS	PITAL (150026) fo	r the cost r	eporting per	iod beginning 01,	/01/2014 and	
	ending 12/31/2014 and to the best of my k						
	complete and prepared from the books and						
	except as noted. I further certify that						
	health care services, and that the service laws and regulations.	es identified in th	is cost repo	irt were prov	ided in complianc	ie with such	
	rans and regulacions.		//	1			
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PART III - SETTLEMENT SUMMARY						***************************************
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2.00 Subprovider - IPF	0	o	0		0	2.00
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The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

Health Financia	al Syct	ome	IU HEALTH GOSHEN H	IUCDI TAI			In Lieu	u of Form (MC SEES 1	10
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This report is	requi i	red by Law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	ire to report can i	resul t	in all	interim	FORM APPR	OVED	
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HOSPITAL AND H	OSPI TAI	L HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provider CCN: 150	026	Peri od:		Worksheet	S	
AND SETTLEMENT SUMMARY								Parts I-I	ΙÍ	
AND SETTEEMENT	O O III III II	\(\)				To 12/	31/2014	Date/Time	Prepared:	:
								5/29/2015		
PART I - COST	REPORT	STATUS							•	
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use only	2. [] Manually submitted co	st report							
	3. [0	llf this is an amended	I report enter the number of	times the provid	er res	submitted	this co	ost report		
	4. [F] Medicare Utilization.	Enter "F" for full or "L"	for low.						
Contractor	5. ſ 1	1Cost Report Status	6. Date Received:		10. NF	PR Date:				_
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PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH GOSHEN HOSPITAL (150026) 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	2
Date	

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

	used in the prior cost reporting period? In column 2	<u>2, enter "Υ</u>	Tor yes o	r "N" for r	10.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
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24.00	If this provider is an IPPS hospital, enter the	1, 552	195	0	24	2, 359	166	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.							
25.00	If this provider is an IRF, enter the in-state	o	0	0	О (o		25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid						· '	
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	, , , , , , , , , , , , , , , , , , ,	'		1	'		'	'
	HMO paid and eligible but unpaid days in column 5.							

care or general surgery. (see instructions)

Health Financial Systems IU HEALTH GOSHEN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150026 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 3:16 pm Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 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. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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 direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col.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 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to

rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems IU HEALTH GOSHEN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150026 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 3:16 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in 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 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 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 Program Code Unwei ghted Unwei ghted Ratio (col. 3/ 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 0.00 0.00 0.000000 67.00 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 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? N Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 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 Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. 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) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPL	IU HEALTH GOS EX IDENTIFICATION DATA		CCN: 150026		i:	worksheet S	5-2
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1.00 <mark>lf this is a Medicare certified i</mark>	ntestinal transplant cent	er, enter the c	erti fi cati o	n			131.
date in column 1 and termination 2.00 ff this is a Medicare certified i	slet transplant center, e	nter the certifi	cation date	e			132.
in column 1 and termination date, 3.00 f this is a Medicare certified o			cation date	e			133.
in column 1 and termination date,	if applicable, in column	2.					
4.00 If this is an organ procurement of and termination date, if applicate		the OPO number i	n column 1				134.
All Providers							
0.00 Are there any related organization chapter 10? Enter "Y" for yes or				te	Υ	15H059	140.
are claimed, enter in column 2 th	<u>ne home office chain numbe</u>	r. (see instruct					\perp
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home office and enter the home of				rialic ai	ia addi c33	OI THE	
1.00 Name: IU HEALTH 2.00 Street: 65 @ 21ST STREET	Contractor's Name: W PO Box:	IPS	Contrac	ctor's N	umber: 0810	01	141. 142.
3. 00 Ci ty: INDI ANAPOLI S	•	N	Zip Cod	de:	4620)2	143.
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		Α?				Y	144.
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	claimed on Worksheet A, li		costs for i	npati ent	servi ces	l .	145.
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5.00 If costs for renal services are conly? Enter "Y" for yes or "N" for	claimed on Worksheet A, li or no. ogy changed from the previ	ne 74, are the o	t report?			N	
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5.00 If costs for renal services are conly? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolor Enter "Y" for yes or "N" for no inthe approval date (mm/dd/yyyy) in the approval date (mm/dd/yyyyy) in the approval date (mm/dd/yyyy) in the approval date (mm/dd/yyyyy) in the approval date (mm/dd/yyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyy	claimed on Worksheet A, lipr no. Dogy changed from the previncolumn 1. (See CMS Pub. a column 2. dical basis? Enter "Y" for of allocation? Enter "Y" for ied cost finding method? Dogstrian individual in the composition of the cost of	ously filed cos: 15-2, § 4020) I yes or "N" for or yes or "N" for Enter "Y" for ye Part A 1.00 In exemption from onent for Part A N N N N N N County	t report? f yes, ento no. or no. es or "N" fo Part B 2.00 m the appli and Part B N N N N N N S S S S S S S S S S S S S	er cation catio	1.00 N N N N N Title V 3.00 of the lowe 2 CFR \$413 N N N N N N CHARACTER STATES N N N N N CHARACTER STATES CBSA	N 2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	146. 147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
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Health Financial Systems	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	Worksheet S-2			
		From 01/01/2014		
		To 12/31/2014		
		Begi nni ng	5/29/2015 3:1	6 pm
	Endi ng			
	2.00			
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	12/31/2014	170. 00		
			1.00	
171.00 If line 167 is "Y", does this provider have Medicare cost plans reported on Wkst. S-3, (see instructions)	N	171. 00		

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:	IU HEALTH GOSHEN HOSPITAL STIONNAIRE Provider	CCN: 150026 P	eriod:	eu of Form CMS- Worksheet S-2	
,5, 1 IA	INSTITUTE HEALTH ONNE RETWOONSEMENT QUE.	5 Sinvance Trovider	F	rom 01/01/2014 o 12/31/2014	Part II Date/Time Pro	epared
				Y/N	5/29/2015 3: Date	17 pm
				1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	oonses. Enter N for all NO re	esponses. Enter	all dates in	the	
C	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation Has the provider changed ownership immediatel	ly prior to the beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of t	the change in column 2. (see	instructions)	5 1	\/ \/ \/	
			Y/N 1.00	2. 00	V/I 3. 00	+
	Has the provider terminated participation in yes, enter in column 2 the date of termination		N			2. (
Į,	voluntary or "I" for involuntary.					
	Is the provider involved in business transact contracts, with individuals or entities (e.g.		N			3. (
(or medical supply companies) that are related	d to the provider or its				
	officers, medical staff, management personnel of directors through ownership, control, or f					
	relationships? (see instructions)			_		
			Y/N 1.00	Type 2. 00	Date 3.00	+
	Financial Data and Reports					
	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for		Y	А		4. (
(or "R" for Reviewed. Submit complete copy or	enter date available in				
	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		N			5. (
	those on the filed financial statements? If y			V (A)		
				1. 00	Legal Oper. 2.00	
	Approved Educational Activities	12 (-1 2 16 ! - 11		N.	I	—
	Column 1: Are costs claimed for nursing scho the legal operator of the program?	bol? Column 2: If yes, is th	ne provider is	N		6. 0
	Are costs claimed for Allied Health Programs?		d d	Y		7.0
	Were nursing school and/or allied health prog cost reporting period? If yes, see instruction		a durring the	N		8.0
	Are costs claimed for Intern-Resident program yes, see instructions.	ms claimed on the current cos	st report? If	N		9.0
10. 00 Ñ	Was an Intern-Resident program been initiated	d or renewed in the current o	cost reporting	N		10.0
	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & R in an App	proved	N		11.0
	Teaching Program on Worksheet A? If yes, see)/ (N	
					1. 00	
	Bad Debts	d dahta2 lf was assinatrus	tiono		Υ	12.6
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb			t reporting	N N	12. 0 13. 0
	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co navmonts waived? It	Fyos soo inst	ructions	N	14.0
	Bed Complement	and/or co-payments warved? I	r yes, see rnst	ructions.	N N	14.0
15.00	Did total beds available change from the price	or cost reporting period? If	1	uctions. t A	N Part B	15.0
		Description	Y/N	Date	Y/N	
E	PS&R Data	0	1.00	2. 00	3. 00	
6.00	Was the cost report prepared using the PS&R		Y	04/20/2015	Y	16.0
	Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R					
ı	Report used in columns 2 and 4 .(see					
	instructions) Was the cost report prepared using the PS&R		N		N	17. (
ı	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)					1.0
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		N		N	18. 0
	claims that have been billed but are not					
	included on the PS&R Report used to file this cost report? If yes, see instructions.					
i			N		N	19. (
9. 00 I	If line 16 or 17 is yes, were adjustments					
19. 00 I						
9. 00 I	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		A1		A.I	20.0
9. 00 I	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N		N	20. (

Health Financial Systems	IU HEALTH GOSHEN H	OSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Pre 5/29/2015 3:1	pared:
			Pa	art A	Part B	
	Descriptio	n	Y/N	Date	Y/N	
	0		1.00	2. 00	3. 00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
					1. 00	

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS CAPITALS Related Cost						
		1. 00				
	PLTALS)					
	, , , , ,					
2.00 Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.			
3.00 Have changes occurred in the Medicare depreciation expense due to appraisals	s made during the cost	N	23.			
reporting period? If yes, see instructions.	3					
4.00 Were new leases and/or amendments to existing leases entered into during thi	s cost reporting period?	N	24.			
If yes, see instructions	. 31					
5.00 Have there been new capitalized leases entered into during the cost reporting	ng period? If yes, see	N	25.			
instructions.	3					
o.00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting	period? If yes, see	N	26.			
instructions.						
'.00 \mid Has the provider's capitalization policy changed during the cost reporting $\mathfrak p$	period? If yes, submit	N	27.			
copy.						
Interest Expense						
	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting					
period? If yes, see instructions.						
.00 Did the provider have a funded depreciation account and/or bond funds (Debt	Service Reserve Fund)	N	29			
treated as a funded depreciation account? If yes, see instructions						
.00 Has existing debt been replaced prior to its scheduled maturity with new det	ot? If yes, see	N	30			
instructions.	+2.16	N	31			
instructions. Purchased Services						
	through contractual	N.	32			
Have changes or new agreements occurred in patient care services furnished that arrangements with suppliers of services? If yes, see instructions.	.nrough contractual	N	32			
.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining	to competitive bidding? I	f N	33			
no, see instructions.	.o competitive brading: 1	' '	33			
Provi der-Based Physi ci ans						
.00 Are services furnished at the provider facility under an arrangement with pr	rovi der-based physici ans?	, у	34			
If yes, see instructions.	The second project of		-			
.00 Iffine 34 is yes, were there new agreements or amended existing agreements	with the provider-based	N	35			
physicians during the cost reporting period? If yes, see instructions.	·					
	Y/N	Date				
	1. 00	2. 00				
Home Office Costs						
00 Were home office costs claimed on the cost report?	Y		36			
00 If line 36 is yes, has a home office cost statement been prepared by the hor	me office? Y		37			
If yes, see instructions.						
00 If line 36 is yes , was the fiscal year end of the home office different from			38			
the provider? If yes, enter in column 2 the fiscal year end of the home offi						
00 If line 36 is yes, did the provider render services to other chain component	ts? If yes, N		39			
see instructions.						
00 If line 36 is yes, did the provider render services to the home office? If	yes, see N		40			
instructions.						
1.00		2.00	_			
		2. 00				
1.00	SHERA		11			
Cost Report Preparer Contact Information	SHEKA		41			
Cost Report Preparer Contact Information OD Enter the first name, last name and the title/position REX						
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,						
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			40			
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Output Cost Report Preparer Contact Information REX REX REX ERNST & YOUNG			42			
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report ERNST & YOUNG preparer.	DEV CHEDAGEV	COM	42			
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report ERNST & YOUNG	REX. SHERA@EY.	COM	42			

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позет т	AL AND HOSPITAL HEALTH CARE RETWIDURSEMENT QUE.	STI ONNAL RE	Provider CCN. 1500	From O	1/01/2014	Part II Date/Time Pre 5/29/2015 3:1	pared:
		Part B					
		Date					
		4. 00					
	PS&R Data						
16. 00	Was the cost report prepared using the PS&R	04/20/2015					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						
17. 00	instructions)						17. 00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records						17.00
	for allocation? If either column 1 or 3 is						
	yes, enter the paid-through date in columns						
	2 and 4. (see instructions)						
18. 00	1						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						19. 00
	made to PS&R Report data for corrections of						
	other PS&R Report information? If yes, see						
20.00	instructions.						20. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe						20.00
	the other adjustments:						
21. 00	1						21. 00
21.00	provider's records? If yes, see						21.00
	instructions.						
			3. 00				
	Cost Report Preparer Contact Information						
41. 00			ED				41. 00
	held by the cost report preparer in columns 1	, 2, and 3,					
42.00	respectively.	- anant					42. 00
42. 00	Enter the employer/company name of the cost r preparer.	epoi t					42.00
43 00	Enter the telephone number and email address	of the cost					43. 00
45.00	report preparer in columns 1 and 2, respective						43.00
	1. Sport property in containing a drie 2, respective			II.			ı

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 Systems
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150026

					1	0 12/31/2014	5/29/2015 3:10	
							I/P Days / 0/P	Э ріп
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	'''	OI DOGS	Avai I abl e	oran nodi s	11 110 1	
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		111	40, 515		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						ol	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						o	6. 00
7. 00	Total Adults and Peds. (exclude observation			111	40, 515	0.00	o	7. 00
7.00	beds) (see instructions)				10,010	0.00	Ĭ	7.00
8.00	INTENSIVE CARE UNIT	31. 00		12	4, 380	0.00	0	8. 00
9. 00	CORONARY CARE UNIT				.,			9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					o	13. 00
14. 00	Total (see instructions)	43.00		123	44, 895	0.00	Ö	14. 00
15. 00	CAH visits			123	44, 073	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					O	23. 00
24. 00	HOSPI CE	116, 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30.00		O	٥			24. 10
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			123				27. 00
28. 00	Observation Bed Days			123			0	28. 00
29. 00	1						U	29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00								31. 00
31.00	Labor & delivery days (see instructions)			0	0			31.00
	Total ancillary labor & delivery room			Ü	١			32. 00 32. 01
32. 01	outpatient days (see instructions)							32. UT
33 00	LTCH non-covered days							33. 00
33.00	LIGHT HOT COVERED days		I		I	l		55.00

Health Financial Systems IU HEAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 150026 Period: Worksheet S-3 From 01/01/2014 Part I

				T	0 12/31/2014	Date/Time Prep 5/29/2015 3:10	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		Э рііі
	C	T: +1 - \/\/\	T: +1 - VIV	T-+-1 All	Tatal lataras	F 0	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	6, 966	1, 171	17, 443		101 00	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, 311	2, 585				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	6, 966	1, 171	17, 443			7. 00
8. 00	beds) (see instructions)	1, 085	0	2, 626			8. 00
9. 00	INTENSIVE CARE UNIT	1,085	٩	2, 020			9. 00
10.00	BURN INTENSIVE CARE UNIT						9. 00 10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		374	2, 315			13. 00
14. 00	Total (see instructions)	8, 051	1, 545	22, 384		986. 99	14. 00
15. 00	CAH visits	0,001	1, 510	22, 001	0.00	700. 77	15. 00
16. 00	SUBPROVI DER - I PF	Š.	Ĭ	ŭ			16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY	6, 391	o	9, 292	0.00	26. 44	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	0	0.00	13. 27	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	416			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0. 00	1, 026. 70	27. 00
28. 00	Observation Bed Days	_	342	2, 666			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
	Employee discount days (see instruction)			0			30. 00 31. 00
< 1 (1()	TEMPLOYEE OF SCOUNT DAVS - TRE			()			(1111)

31.00

32.00

32.01

33.00

300

166

31.00 Employee discount days - IRF

33.00 LTCH non-covered days

32.00

32.01

Labor & delivery days (see instructions)
Total ancillary labor & delivery room
outpatient days (see instructions)

				To	12/31/2014	Date/Time Prep 5/29/2015 3:10	
		Full Time Equivalents	<u> </u>	Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	44.00	Pati ents	
1 00		11.00	12.00	13.00	14.00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		C	1, 946	1, 337	7, 011	1. 00
2.00	HMO and other (see instructions)			0	0		2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0. 00	C	1, 946	1, 337	7, 011	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0.00					21. 00
22. 00 23. 00	HOME HEALTH AGENCY	0. 00					22. 00 23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance 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)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions) LTCH non-covered days						33. 00
33.00	Eron non-covered days			1	I		33.00

					T	o 12/31/2014	Date/Time Pre 5/29/2015 3:1	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	COI. 5)	
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							4
1. 00	SALARIES Total salaries (see	200. 00	61, 801, 197	0	61, 801, 197	2, 141, 402. 00	28. 86	1.00
	instructions)				, ,			
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3.00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3.00
	В							
4.00	Physician-Part A - Administrative		1, 264, 350	0	1, 264, 350	8, 776. 75	144. 06	4.00
4. 01	Physicians - Part A - Teaching		0	0	0	0. 00	0.00	4. 01
5.00	Physician-Part B		6, 809, 577	0	6, 809, 577	27, 943. 00		
6. 00 7. 00	Non-physician-Part B Interns & residents (in an	21. 00	0	0	0	0. 00 0. 00		
7.00	approved program)	21.00	O		0	0.00	0.00	7.00
7. 01	Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		4, 765, 709	685, 066	5, 450, 775	199, 438. 00	27. 33	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		1, 303	0	1, 303	30. 16	43. 20	11. 00
12. 00	Contract Labor: Top Level		796, 675	0	796, 675	8, 158. 91	97. 64	12.00
	management and other							
	management and administrative services							
13. 00	Contract Labor: Physician-Part		423, 427	0	423, 427	1, 990. 00	212. 78	13. 00
14.00	A - Administrative		4 127 400	0	4 127 400	77 470 00	F2 2/	14 00
14. 00	Home office salaries & wage-related costs		4, 126, 498	0	4, 126, 498	77, 478. 00	53. 20	14. 00
15. 00	Home office: Physician Part A		0	0	0	0. 00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0.00	16. 00
	Physicians Part A - Teaching							_
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		16, 733, 348	0	16, 733, 348			17. 00
	instructions)		10, 700, 010		10, 700, 010			
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		1, 628, 753	0	1, 628, 753			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
	В			_				
22. 00	Physician Part A - Administrative		432, 111	O	432, 111			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		2, 327, 275	0	2, 327, 275			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00 25. 00
	approved program)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	<u>S</u> 4. 00	576, 710	0	576, 710	20, 128. 00	28. 65	26. 00
27. 00	Administrative & General	5. 00	10, 725, 239		10, 040, 173	·		
28. 00	Administrative & General under		0	0	0	0. 00	0. 00	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	29.00
30.00	Operation of Plant	7. 00	799, 437	0	799, 437			
31. 00	Laundry & Linen Service	8. 00	33, 247	0	33, 247	2, 949. 00	11. 27	
32.00	Housekeepi ng	9. 00	958, 903 0		958, 903 0			
33. 00	Housekeeping under contract (see instructions)		0	0	U	0. 00	0. 00	33.00
34.00	Di etary	10. 00	641, 570	-455, 584	185, 986			
35. 00	Di etary under contract (see instructions)		0	0	0	0. 00	0. 00	35. 00
36. 00	Cafeteri a	11. 00	0	455, 584	455, 584	39, 869. 00		
37. 00	Maintenance of Personnel	12.00	0	0	0	0.00		37.00
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	1, 364, 021 204, 792		1, 364, 021 204, 792			38.00
40. 00	1 3	15. 00	1, 464, 403		·			40.00
	·							

Health Financial Systems		IU HEALTH GOS	HEN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der CCN: 150026		Peri od:	Worksheet S-3	
					From 01/01/2014		
				7	Γo 12/31/2014		
						5/29/2015 3:1	6 pm
	Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	1, 384, 750	0	1, 384, 750	60, 032. 00	23. 07	41. 00
Records Li brary							
42.00 Social Service	17. 00	510, 563	0	510, 563	20, 556. 00	24. 84	42.00
43.00 Other General Service	18. 00	0	0	(0.00	0.00	43. 00

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HOSPI T	TAL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014	Worksheet S-3 Part III	
						To 12/31/2014		oared:
							5/29/2015 3:1	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		54, 991, 620	0	54, 991, 62	0 2, 113, 459. 00	26. 02	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 765, 709	685, 066	5, 450, 77	5 199, 438. 00	27. 33	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		50, 225, 911	-685, 066	49, 540, 84	5 1, 914, 021. 00	25. 88	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		5, 347, 903	0	5, 347, 90	3 87, 657. 07	61. 01	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		17, 165, 459	0	17, 165, 45	9 0.00	34. 65	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		72, 739, 273	-685, 066	72, 054, 20	7 2, 001, 678. 07	36. 00	6.00
7.00	Total overhead cost (see		18, 663, 635	-685, 066	17, 978, 56	9 681, 673. 00	26. 37	7. 00
	instructions)							

Health Financial Systems	IU HEALTH GOSHEN HOS	In Lieu of Form CMS-2552-10			
HOSPITAL WAGE RELATED COSTS	P	Provi der CCN: 150026		Worksheet S-3	
			From 01/01/2014	Part IV Date/Time Prepared:	

	To 12/31/2014	Date/Time Prep 5/29/2015 3:10	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 450, 803	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 454, 478	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	13, 461, 348	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	362, 741	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	191, 989	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	182, 586	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	-1, 252	14.00
15. 00		256, 574	15.00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumul ative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	0	17. 00
18. 00	Medicare Taxes - Employers Portion Only	3, 553, 471	18.00
19. 00	Unempl oyment Insurance	37, 273	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	41, 324	22. 00
23.00	Tuition Reimbursement	130, 152	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21, 121, 487	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Heal th	Financial Systems	IU HEALTH GOSHEN F	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150026	Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Pre 5/29/2015 3:1	pared:
	Cost Center Description				Contract Labor	Benefit Cost	
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost	C					
	Hospital and Hospital -Based Component Identi						
1.00	Total facility's contract labor and benefit	cost			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovi der - IPF						3.00
4.00	Subprovi der - IRF						4.00
5.00	Subprovi der - (0ther)				0	0	
6.00	Swing Beds - SNF				0	0	
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospi tal -Based SNF						8.00
9.00	Hospi tal -Based NF						9. 00 10. 00
10. 00 11. 00	Hospi tal Based OLTC				0	0	
	Hospi tal -Based HHA				0	U	11. 00 12. 00
12.00	Separately Certified ASC				0	0	
13.00	Hospi tal -Based Hospi ce				0	0	13. 00 14. 00
14. 00	Hospital Based Health Clinic RHC						
15. 00	Hospital Based Health Clinic FQHC						15. 00 16. 00
16. 00	Hospi tal -Based-CMHC						
17. 00	Renal Dialysis				0	_	17. 00
18. 00	Other				0	0	18. 00

Heal th	Financial Systems	IU HEALTH GOSI	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	JEALTH AGENCY STATISTICAL DATA	TO HENEMI GOO.	Provi der	CCN: 150026 t CCN: 157174	Period: From 01/01/2014 To 12/31/2014	Worksheet S-4 Date/Time Pre	pared:
					Home Health	5/29/2015 3:1 PPS	/ pm
					Agency I		
						00	
0. 00	County	Title V	Title XVIII	Title XIX	ELKHART Other	Total	0.00
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	Ιο	1, 147		13 54	1, 214	1.00
2. 00	Unduplicated Census Count (see instructions)	0. 00		32. (00 129.00	632.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
)	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		J	1.00	2.00	3.00	
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. (0. 00 1. 00	3. 00 4. 00
5. 00	Other Administrative Personnel			5. 3		5. 29	
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			7. ! 5. °		7. 59 5. 91	6. 00 7. 00
8. 00	Physical Therapy Service			2. (2. 63	
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. (0. 00 1. 15	
11. 00	Occupational Therapy Supervisor			0.0			
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.0		0. 37 0. 00	
14. 00	Medical Social Service			0.0		0. 95	
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. (0. 00 1. 55	
17. 00	Home Health Aide Supervisor			0.0			
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where				2		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			22140			20. 00
	during this cost reporting period (line 20 contains the first code).						
20. 01		5.11.5		99915			20. 01
			oisodes With Outliers	 LUPA Episode	es PEP Only	Total (cols.	
		Outliers		·	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1. 00	2. 00	3.00	4. 00	5. 00	
21.00	Skilled Nursing Visits	3, 217			42 65	3, 537	
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	446, 403 1, 143		1	05 8, 835 25 8	483, 603 1, 191	1
24.00	Physical Therapy Visit Charges	187, 680		1	.1	195, 160	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	70, 210		1	4 3 80 510	445 73, 780	
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	81		1	0 1 0 180	94 16, 920	1
29. 00		14, 580 83		1	2 12	97	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	17, 845 1, 016		1	30 2, 580 5 6	20, 855 1, 027	
32. 00	Home Health Aide Visit Charges	78, 640		1	20 480	79, 440	
33. 00	Total visits (sum of lines 21, 23, 25, 27, 20, and 21)	5, 964	54	2	78 95	6, 391	33. 00
34. 00	29, and 31) Other Charges	0	C	,	0 0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	815, 358	8, 950	31, 50	13, 945	869, 758	35. 00
36. 00	Total Number of Episodes (standard/non	379			72 6	457	36. 00
37. 00	Outlier) Total Number of Outlier Episodes	00.055	1		1	2	37. 00
38. UU	Total Non-Routine Medical Supply Charges	82, 330	222	7, 0	79 1, 238	J 90, 869	38. 00

Heal th	Financial Systems IU HEALTH GOSHEN HO	SPI TAI		In lie	eu of Form CMS-2	2552-10			
			CCN: 150026	Peri od:	Worksheet S-10				
	THE STREET FIRST THE STREET STREET STREET		3011. 100020	From 01/01/2014					
				To 12/31/2014					
					5/29/2015 3:1	/ pm			
					1. 00				
	Uncompensated and indigent care cost computation								
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 column	1 8)	0. 299289	1. 00			
	Medicaid (see instructions for each line) Net revenue from Medicaid 7,637,427								
2.00									
3. 00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 00			
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental		from Medicaio	1?	Υ	4. 00			
5.00	If line 4 is "no", then enter DSH or supplemental payments from I	Medicaid			0	5. 00			
6.00	Medi cai d charges				44, 348, 720				
7.00	Medicaid cost (line 1 times line 6)		6 !!.	0 1 5 . 5	13, 273, 084	7. 00			
8. 00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	ine / min	us sum of iii	ies 2 and 5; if	5, 635, 657	8. 00			
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for a	ach line)						
9. 00	Net revenue from stand-allone SCHIP	5113 101 6	acii i i iie)		0	9. 00			
10. 00	Stand-alone SCHIP charges				l ől	10.00			
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				o o				
12. 00	Difference between net revenue and costs for stand-alone SCHIP (line 11 m	inus line 9:	if < zero then	0	12. 00			
	enter zero)								
	Other state or local government indigent care program (see instru	uctions f	or each line)						
13.00	Net revenue from state or local indigent care program (Not inclu	ded on li	nes 2, 5 or 9	9)	0	13.00			
14.00	Charges for patients covered under state or local indigent care	program (Not included	in lines 6 or	0	14.00			
	10)								
15. 00	State or local indigent care program cost (line 1 times line 14)				0				
16. 00	Difference between net revenue and costs for state or local indi	gent care	program (lir	ne 15 minus line	0	16. 00			
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)								
17. 00	Private grants, donations, or endowment income restricted to fundament	ding char	ity care		0	17. 00			
18. 00	Government grants, appropriations or transfers for support of hos				l ől	18. 00			
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local			ns (sum of lines	5, 635, 657				
17.00	8, 12 and 16)	rnar gerre	care progra	is (sum or rrries	0,000,007	17.00			
			Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col . 2)				
			1. 00	2. 00	3. 00				
20. 00	Total initial obligation of patients approved for charity care (6, 323, 50	2, 391, 896	8, 715, 405	20. 00			
21. 00	charges excluding non-reimbursable cost centers) for the entire cost of initial obligation of patients approved for charity care		1 000 5	715 040	2 400 425	21. 00			
21.00	times line 20)	(Tine i	1, 892, 5!	715, 868	2, 608, 425	21.00			
22. 00	Partial payment by patients approved for charity care		94, 7:	0	94, 729	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)		1, 797, 8:						
20.00	poset of sharrey sars (fine 21 minus fine 22)		1,777,70	7 107 000	2/010/070	20.00			
					1. 00				
24. 00	Does the amount in line 20 column 2 include charges for patient		nd a Length o	of stay limit	N	24. 00			
25 22	imposed on patients covered by Medicaid or other indigent care p		ogramia i a	h of oter limit		25 22			
25. 00	If line 24 is "yes," charges for patient days beyond an indigen			in or stay limit	0	25. 00			
26. 00 27. 00	Total bad debt expense for the entire hospital complex (see inst				24, 170, 828				
28.00	Medicare bad debts for the entire hospital complex (see instruct Non-Medicare and non-reimbursable Medicare bad debt expense (lin	,	s lino 27\		125, 168 24, 045, 660				
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (Trib		,	28)	7, 196, 602				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	ise (IIIIe	i times till	, 20)	9, 710, 298				
	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			15, 345, 955				
51.00	1.0 ca. a.i. o. ia. ood and anoomponoacod out o cool (11110-17 pras 1111	c 50,			10,010,700	31.00			

Heal th	Financial Systems	IU HEALTH GOSHE	EN HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	narod:
					10 12/31/2014	5/29/2015 3:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		10, 856, 835	10, 856, 83	5 -5, 484, 335	5, 372, 500	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	., ,	6, 012, 485		2. 00
3.00	00300 OTHER CAP REL COSTS		0	(0 0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	576, 710	18, 979, 815	19, 556, 52		19, 793, 602	4. 00
5. 01	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	857, 891	1, 181, 941	2, 039, 83		2, 039, 766	
5. 02	00540 OTHER ADMINISTRATIVE & GENERAL	9, 867, 348	29, 043, 382	38, 910, 73	295, 717	39, 206, 447	5. 02
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	799, 437	2, 301, 235	3, 100, 67	2 0	0 3, 100, 672	
8. 00	00800 LAUNDRY & LINEN SERVICE	33, 247	434, 477	467, 72		467, 724	8.00
9. 00	00900 HOUSEKEEPI NG	958, 903	394, 222	1, 353, 12		1, 352, 928	
10.00	01000 DI ETARY	641, 570	940, 943	1, 582, 51			
11. 00	01100 CAFETERI A	0	0	(1, 123, 755	1, 123, 755	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 364, 021	246, 158	1, 610, 17			
14.00	01400 CENTRAL SERVICES & SUPPLY	204, 792	295, 732	500, 52		494, 887	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 464, 403	8, 661, 969				1
17. 00	01700 SOCIAL SERVICE	1, 384, 750 510, 563	1, 449, 881 20, 468	2, 834, 63 531, 03		2, 834, 625 531, 019	
23. 00	02301 ALLI ED HEALTH	0	20, 400		206, 639		
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-1				
30.00	03000 ADULTS & PEDIATRICS	5, 906, 373	737, 210	6, 643, 58	3 792, 332	7, 435, 915	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 590, 108	324, 812				
43.00	04300 NURSERY	2, 450, 425	453, 936	2, 904, 36	1 -2, 641, 858	262, 503	43. 00
	ANCILLARY SERVICE COST CENTERS	0.050 (47	40.007.400	44.407.04	7 470 054	7 000 000	
50.00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	3, 850, 617	10, 336, 432			7, 008, 998	
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	451, 240	102, 089	553, 32	9 -76, 953 0 1, 406, 544	476, 376 1, 406, 544	
53. 00	05300 ANESTHESI OLOGY		Ö		0 1, 400, 544	0	1
53. 01	05301 PAIN MANAGEMENT	830, 740	919, 733	1, 750, 47	3 -228	1, 750, 245	
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 308, 579	23, 059, 081	36, 367, 66	14, 559, 902	21, 807, 758	
55.00	05500 RADI OLOGY-THERAPEUTI C	263, 292	33, 234	296, 52	6 -1, 241	295, 285	
56. 00	05600 RADI OI SOTOPE	0	0		0		
56. 01	05601 CARDI AC CATH LAB	849, 821	3, 080, 538	3, 930, 35			
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 661, 480 1, 061, 632	3, 470, 769 207, 926	6, 132, 24 1, 269, 55			
66. 00	06600 PHYSI CAL THERAPY	1, 726, 185	374, 926	2, 101, 11			
67. 00	06700 OCCUPATI ONAL THERAPY	461, 078	12, 547	473, 62			
68. 00	06800 SPEECH PATHOLOGY	303, 531	10, 844				
69. 00	06900 ELECTROCARDI OLOGY	-861	89, 810	88, 94		88, 645	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 6, 797, 822	6, 797, 822	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		5, 700, 893		
73. 00	O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	U U	υ		22, 007, 069	22, 007, 069	73.00
90. 00	09000 CLINI C	223, 180	176, 263	399, 44	3 -3, 145	396, 298	90.00
90. 01	09001 CLINI C	0	0	0,,,	0	0	1
90. 02	09002 WOUND CLINIC	o	1, 465, 519	1, 465, 51	9 -231, 249	1, 234, 270	90. 02
90. 03	09003 MOBILE CLINIC	0	11, 950	11, 95	-280	11, 670	
91. 00	09100 EMERGENCY	2, 434, 433	583, 861	3, 018, 29	4 -165, 085	2, 853, 209	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
100 00	OTHER REIMBURSABLE COST CENTERS 10000 I &R SERVI CES-NOT APPRVD PRGM		٥		0	0	100.00
	10000 TAR SERVICES-NOT APPROD FROM	1, 607, 476	232, 999	1, 840, 47	5 -23, 565		
101.00	SPECIAL PURPOSE COST CENTERS	1,007,470	232, 777	1, 040, 47	25, 505	1,010,710	1101.00
113.00	11300 I NTEREST EXPENSE		1, 383, 340	1, 383, 34	1, 383, 340	0	113. 00
116.00	11600 H0SPI CE	723, 837	807, 516		-215, 234	1, 316, 119	116. 00
118.00		59, 366, 801	122, 682, 393	182, 049, 19	4 -653, 025	181, 396, 169	118. 00
400.00	NONREI MBURSABLE COST CENTERS	1 05/ 433	500 400	1 770 //			
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1900 OTHER NR/CHP-GRANT I/COMMUNITY ED.	1, 256, 477	522, 183	1, 778, 66		1, 778, 167	
	19001 OTHER NRZCHP-GRANT TZCOMMONTTY ED. 219002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	158, 059	7, 527	165, 58	-1 0	165, 585	190. 01
	19003 LI FELI NE		0		0		190. 02
	19004 COMMUNITY RELATIONS	435, 818	3, 869, 626	4, 305, 44	653, 519		
	19005 TOTAL - PRIVATE DUTY	0	278	27			190. 05
	19006 TOTAL - PROFESSIONAL DEVELOPMENT	102, 243	1, 472, 497	1, 574, 74		1, 574, 740	
	19007 FOUNDATION	0	0		0		190. 07
	19100 RESEARCH	481, 799	195, 789			677, 588	
200.00	TOTAL (SUM OF LINES 118-199)	61, 801, 197	128, 750, 293	190, 551, 49	0	190, 551, 490	1200.00

Period: Worksheet A From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/29/2015 3:16 pm

			5/29/20	015 3: 16 pm
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS		·		
1.00 O0100 CAP REL COSTS-BLDG & FIXT	-2, 240, 440	3, 132, 060		1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	-1, 910, 305	4, 102, 180		2. 00
3.00 00300 OTHER CAP REL COSTS	l ol	ol		3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	o	19, 793, 602		4. 00
5. 01 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	o	2, 039, 766		5. 01
5. 02 00540 OTHER ADMINISTRATIVE & GENERAL	-12, 679, 025	26, 527, 422		5. 02
6. 00 00600 MAI NTENANCE & REPAI RS	-12,077,025	20, 327, 422		6. 00
		-		
7. 00 00700 OPERATION OF PLANT	0	3, 100, 672		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	467, 724		8. 00
9. 00 00900 HOUSEKEEPI NG	0	1, 352, 928		9. 00
10. 00 01000 DI ETARY	-17, 778	440, 698		10.00
11. 00 01100 CAFETERI A	-867, 554	256, 201		11. 00
13.00 01300 NURSING ADMINISTRATION	o	1, 609, 946		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	l ol	494, 887		14.00
15. 00 01500 PHARMACY	ol	1, 696, 534		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-50, 530	2, 784, 095		16.00
17. 00 01700 SOCIAL SERVICE	0	531, 019		17. 00
	- 1			
	-47, 945	158, 694		23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		7 405 045		
30. 00 03000 ADULTS & PEDI ATRI CS	0	7, 435, 915		30.00
31.00 03100 INTENSIVE CARE UNIT	0	1, 756, 080		31.00
43. 00 04300 NURSERY	0	262, 503		43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-37, 925	6, 971, 073		50.00
51.00 05100 RECOVERY ROOM	l ol	476, 376		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	l ol	1, 406, 544		52. 00
53. 00 05300 ANESTHESI OLOGY	أما	0		53. 00
53. 01 05301 PALN MANAGEMENT	-1, 410, 715	339, 530		53. 01
				54. 00
	-8, 144, 469	13, 663, 289		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	295, 285		55. 00
56. 00 05600 RADI OI SOTOPE	0	0		56. 00
56. 01 05601 CARDI AC CATH LAB	0	1, 387, 436		56. 01
60. 00 06000 LAB0RAT0RY	-978, 680	4, 196, 340		60.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 235, 795		65. 00
66. 00 06600 PHYSI CAL THERAPY	-81	2, 089, 931		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	l ol	469, 772		67. 00
68. 00 06800 SPEECH PATHOLOGY	ام	313, 520		68. 00
69. 00 06900 ELECTROCARDI OLOGY		88, 645		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		6, 797, 822		71.00
	1			•
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	5, 700, 893		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	22, 007, 069		73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	396, 298		90.00
90. 01 09001 CLI NI C		0		90. 01
90. 02 09002 WOUND CLINIC	-12, 023	1, 222, 247		90. 02
90. 03 09003 MOBI LE CLINIC	o	11, 670		90. 03
91. 00 09100 EMERGENCY	-24, 952	2, 828, 257		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1	, , , , , ,		92.00
OTHER REIMBURSABLE COST CENTERS				72.00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	O	0		100. 00
101. 00 10100 HOME HEALTH AGENCY	o	1, 816, 910		101.00
	<u> </u>	1, 616, 910		101.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0	O		113. 00
116. 00 11600 H0SPI CE	0	1, 316, 119		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-28, 422, 422	152, 973, 747		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	1, 778, 167		190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED.	l ol	165, 585		190. 01
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0		190. 02
190. 03 19003 LI FELI NE	. 0	ŏ		190. 03
		4 059 043		
190. 04 19004 COMMUNITY RELATIONS	0	4, 958, 963		190. 04
190. 05 19005 TOTAL - PRI VATE DUTY	0	278		190. 05
190. 06 19006 TOTAL - PROFESSIONAL DEVELOPMENT	0	1, 574, 740		190. 06
190. 07 19007 FOUNDATI ON	0	0		190. 07
191. 00 19100 RESEARCH	0	677, 588		191. 00
200.00 TOTAL (SUM OF LINES 118-199)	-28, 422, 422	162, 129, 068		200. 00
	,			•

Heal th	Financial Systems		IU HEALTH GO:	SHEN H	OSPI TAL		In Lie	u of Form CMS	-2552-10
	SIFICATIONS				Provi der	CCN: 150026	Peri od:	Worksheet A-	6
							From 01/01/2014 To 12/31/2014	Date/Time Pr	epared:
		Ingragas						5/29/2015 3:	17 pm
	Cost Center	Increases Line #	Sal ary	1 0	ther				
	2. 00	3.00	4. 00		5. 00				
	A - SUPPLIES				07.044				4.00
1.00	OTHER ADMINISTRATIVE & GENERAL	5. 02	0)	37, 346				1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0		6, 797, 878				2. 00
2 00	PATI ENTS	72.00	0		700 000				2.00
3. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	'l '	5, 700, 893				3. 00
4.00	.,	0.00	0		0				4. 00
5.00		0. 00	0		0				5. 00
6. 00 7. 00		0. 00 0. 00	0		0				6. 00 7. 00
8. 00		0.00	0		0				8. 00
9.00		0.00	0		0				9. 00
10.00		0.00	0		0				10.00
11. 00 12. 00	+	0. 00 0. 00	0		0				11. 00 12. 00
13. 00		0.00	0		0				13. 00
14. 00		0.00	0		0				14. 00
15.00		0.00	0		0				15. 00
16. 00 17. 00		0. 00 0. 00	0		0				16. 00 17. 00
18. 00		0. 00	0		0				18. 00
19. 00		0.00	0		0				19. 00
20. 00 21. 00		0. 00 0. 00	0		0				20. 00 21. 00
22. 00		0.00	0		0				22. 00
23. 00		0.00	0		0				23. 00
24. 00		0.00	0		0				24. 00
25. 00 26. 00		0. 00 0. 00	0		0				25. 00 26. 00
27. 00		0.00	0		0				27. 00
28. 00		0. 00	0	1	0				28. 00
29. 00 30. 00		0. 00 0. 00	0		0				29. 00 30. 00
31. 00		0.00	0		0				31. 00
32.00		0.00	0		0				32. 00
33. 00	TOTAL C		0		0				33. 00
	TOTALS B - PHARMACY		0	η <u>ι</u> .	2, 536, 117				
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	2:	2, 007, 069				1. 00
2.00		0.00	0		0				2. 00
3. 00 4. 00		0. 00 0. 00	0		0				3. 00 4. 00
5.00		0.00	0		0				5. 00
6.00		0.00	0	o	0				6. 00
7.00		0.00	0		0				7. 00
8. 00 9. 00		0. 00 0. 00	0		0				8. 00 9. 00
10. 00		0.00	0		0				10.00
11. 00		0. 00	0		0				11. 00
12. 00 13. 00		0. 00 0. 00	0	1	0				12. 00 13. 00
14. 00		0.00	0	1	0				14. 00
15.00		0.00	0	1	0				15. 00
16.00		0.00	0	1	0				16. 00
17. 00 18. 00		0. 00 0. 00	0	1	0				17. 00 18. 00
10.00	TOTALS — — — — —		— — — <u> </u>		2, 007, 069				10.00
	C - DIETARY								
1. 00	CAFETERI A		45 <u>5, 5</u> 84 455, 584		66 <u>8, 1</u> 71 668, 171				1. 00
	D - CAPITAL INSURANCE		400, 084	1	000, 171				1
1.00	OTHER ADMINISTRATIVE &	5. 02	0		138, 237				1. 00
2.00	GENERAL	4 00	-		240 707				2.00
2. 00 3. 00	EMPLOYEE BENEFITS DEPARTMENT OTHER ADMINISTRATIVE &	4. 00 5. 02	0	1	268, 787 901, 790				2. 00 3. 00
3.00	GENERAL	3.02	O		,51, 770				3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1	2, 130				4. 00
5. 00	OTHER ADMINISTRATIVE & GENERAL	5. 02	0)	100, 767				5. 00
	TOTALS	 	— — _ō	-	1, 411, 711				
	•	'		•	'				

Heal th	Financial Systems		IU HEALTH GO:	SHEN HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASS	SIFICATIONS			Provi der	CCN: 150026	Peri od: From 01/01/2014	Worksheet A-6	5
						To 12/31/2014	Date/Time Pro 5/29/2015 3: 1	
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4.00	5. 00				

					5/29/2015 3:	i/pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
	E - CAPITAL INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 383, 340		1. 00
	TOTALS		0	1, 383, 340		
	F - CAPITAL DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6, 010, 355		1. 00
2.00		0.00	O	0		2.00
	TOTALS			6, 010, 355		1
	G - CIRCLE OF CARE					
1.00	ADULTS & PEDIATRICS	30.00	967, 183	121, 159		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 249, 962	156, 582		2.00
	TOTALS		2, 217, 145	277, 741		
	H - COMMUNITY HEALTH			·		
1.00	COMMUNITY RELATIONS	190. 04	685, 066	197, 413		1.00
2.00		0.00	o	. 0		2.00
	TOTALS		685, 066	197, 413		
	I - EMT			, , , ,		
1.00		0.00	0	0		1.00
4. 00	ALLI ED HEALTH	23. 00	121, 578	85, 061		4. 00
	TOTALS	— <u> </u>	121, 578	85, 061		"
500.00	Grand Total: Increases		3, 479, 373			500.00
	12. 2	I I	2, 1, 1, 0, 0	, 5, 5, 7, 7		1 0. 00

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm

		Decreases				5/29/2015 3:	1/ pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	83			1. 00
2.00	CASHI ERI NG/ACCOUNTS	5. 01	0	66	0		2. 00
2 00	RECEI VABLE	0.00	0	107	0		2 00
3. 00 4. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	197 282	-		3. 00 4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	233			5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	o	5, 637			6. 00
7. 00	PHARMACY	15. 00	Ö	16, 341	0		7. 00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	6	0		8. 00
9.00	SOCI AL SERVI CE	17. 00	0	12	0		9. 00
10.00	ADULTS & PEDIATRICS	30.00	0	296, 010			10. 00
11. 00	INTENSIVE CARE UNIT	31.00	0	158, 840			11. 00
12.00	NURSERY	43.00	0	146, 963			12.00
13. 00 14. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	7, 177, 538			13. 00 14. 00
15. 00	PAIN MANAGEMENT	53. 01	0	76, 953 99			15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	681, 620			16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55.00	o	848	1		17. 00
18.00	CARDIAC CATH LAB	56. 01	0	2, 542, 557	0		18. 00
19.00	LABORATORY	60.00	0	936, 909	0		19. 00
20.00	RESPIRATORY THERAPY	65.00	0	33, 751	0		20. 00
21. 00	PHYSI CAL THERAPY	66.00	0	9, 762			21. 00
22. 00	OCCUPATI ONAL THERAPY	67.00	0	3, 853			22. 00
23. 00	SPEECH PATHOLOGY	68.00	0	815			23. 00
24. 00	ELECTROCARDI OLOGY	69.00	0	284			24. 00
25. 00 26. 00	CLINIC WOUND CLINIC	90. 00 90. 02	0	3, 145 227, 000	-		25. 00 26. 00
27. 00	MOBILE CLINIC	90.02	o o	227, 000			27. 00
28. 00	EMERGENCY	91.00	0	164, 806	-		28. 00
29. 00	HOME HEALTH AGENCY	101.00	Ö	21, 083			29. 00
30. 00	HOSPI CE	116.00	o	29, 387	0		30.00
31. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	Ö	493	0		31. 00
	CANTEEN						
32.00	OTHER NR/CHP-GRANT	190. 01	0	1	0		32. 00
00.00	I / COMMUNITY ED.	100.04		0.40			00.00
33. 00	COMMUNITY RELATIONS	190.04	0				33. 00
	TOTALS B - PHARMACY		<u> </u>	12, 536, 117			
1.00	PHARMACY	15. 00	0	8, 413, 497	0		1.00
2. 00	NURSERY	43. 00	Ö	9	0		2. 00
3.00	OPERATING ROOM	50.00	0	513	0		3. 00
4.00	PAIN MANAGEMENT	53. 01	0	129	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	13, 323, 891	0		5. 00
6.00	CARDIAC CATH LAB	56. 01	0	366			6. 00
7. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	393			7. 00
8.00	LABORATORY	60.00	0	20, 320			8. 00
9.00	RESPIRATORY THERAPY	65.00	0	12			9.00
10.00	PHYSI CAL THERAPY	66.00	0	1, 337			10.00
11. 00 12. 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68. 00 69. 00	0	40 20			11. 00 12. 00
13. 00	WOUND CLINIC	90. 02	0	4, 249			13. 00
14. 00	EMERGENCY	91.00	0	279			14. 00
15. 00	HOME HEALTH AGENCY	101.00	0	2, 482			15. 00
16. 00	HOSPI CE	116.00	o	185, 847			16. 00
17.00	COMMUNITY RELATIONS	190. 04	0	22, 058			17. 00
18.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	31, 627	0		18. 00
	TOTALS		0	22, 007, 069			
	C - DI ETARY						
1. 00	DI ETARY	10.00	455, 584	668, 171			1. 00
	TOTALS		455, 584	668, 171			-
1 00	D - CAPITAL INSURANCE	F4 00	م	120 227			1 00
1.00	RADIOLOGY-DIAGNOSTIC CAP REL COSTS-BLDG & FIXT	54. 00 1. 00	0	138, 237			1.00
2. 00 3. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	268, 787 901, 790			2. 00 3. 00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	901, 790 102, 897			4. 00
5.00	S. REE GOOTS BEDG & TIXI	0.00	ol o	102, 097	0		5. 00
	TOTALS			1, 411, 711			
	E - CAPITAL INTEREST		- 1				
1.00	INTEREST EXPENSE	113.00	0	1, 383, 340			1. 00
	TOTALS		0	1, 383, 340			

Health Financial Systems IU HEALTH GOSHEN HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 150026 Period: Worksheet A-6

From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Li ne # 10.00 8.00 6.00 7.00 9.00 F - CAPITAL DEPRECIATION 1.00 CAP REL COSTS-BLDG & FIXT 1.00 5, 594, 201 9 1.00 RADI OLOGY-DI AGNOSTI C 0 2.00 2.00 54.00 41<u>6, 1</u>54 TOTALS 6, 010, 355 G - CIRCLE OF CARE 1.00 NURSERY 43.00 2, 217, 145 277, 741 0 1.00 2.00 2.00 0. 00 0 2, 217, 145 TOTALS 277, 741 H - COMMUNITY HEALTH 197, 357 1.00 OTHER ADMINISTRATIVE & 5.02 0 1.00 685, 066 GENERAL 2.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 0 2.00 56 PATI ENTS 197, 413 685, 066 TOTALS I - EMT 1.00 0.00 0 1.00 0 COMMUNITY RELATIONS TOTALS 1<u>90.</u> 04 12<u>1, 5</u>78 4.00 8<u>5, 0</u>61 0 4.00 121, 578 85, 061

3, 479, 373

44, 576, 978

500.00

500.00 Grand Total: Decreases

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150026 Peri od: Worksheet A-7 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/29/2015 3:16 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 1.00 3, 883, 887 0 1.00 0 0 2.00 Land Improvements 2, 988, 795 0 0 2.00 3.00 3.00 Buildings and Fixtures 98, 219, 167 Ω 0 0 4.00 Building Improvements 113, 748 0 4.00 5.00 Fixed Equipment 12, 144, 774 1, 950, 069 0 1, 950, 069 816, 396 5.00 0 6.00 Movable Equipment 96, 833, 860 7, 555, 191 7, 555, 191 4, 653, 643 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 214, 184, 231 9, 505, 260 9, 505, 260 5, 470, 039 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 9, 505, 260 9, 505, 260 5, 470, 039 10.00 214, 184, 231 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 3,883,887 1.00 2.00 Land Improvements 2, 988, 795 431, 511 2.00 3.00 Buildings and Fixtures 98, 219, 167 7, 390, 729 3.00 4.00 Building Improvements 113, 748 76, 800 4.00 5.00 Fi xed Equipment 13, 278, 447 3, 585, 832 5.00 Movable Equipment 6.00 99, 735, 408 58, 876, 987 6.00

218, 219, 452

218, 219, 452

Ω

70, 361, 859

70, 361, 859

7. 00

8.00

9.00

10.00

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

Heal th	n Financial Systems	IU HEALTH GOSE	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150026	Peri od:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	nared:
					10 12/31/2014	5/29/2015 3: 1	6 pm
	·		SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	<u>KSHEET A, COLUM</u>	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	10, 856, 835	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	10, 856, 835	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL		<u>.</u>		
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	10, 856, 835				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	10, 856, 835				3. 00

Heal th	Financial Systems	IU HEALTH GOSI	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prep 5/29/2015 3:10	
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	5 piii
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col 2)	instructions)		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	118, 484, 044				0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	99, 735, 408		,		0	2. 00
3.00	Total (sum of lines 1-2)	218, 219, 452		2.0/2.7/10		0	3. 00
		ALLUCA	TION OF OTHER (CAPITAL	SUMMARY U	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	NIERS			5 050 040	0	4 00
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	0		0 5, 952, 068	0	1. 00 2. 00
2. 00 3. 00		0	0		0 6, 566, 307	0	
3.00	Total (sum of lines 1-2)	U	<u> </u>	L JMMARY OF CAPI	0 12, 518, 375	U	3. 00
			30	JIVIIVIART OF CAPT	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		44.00	10.00	10.00	instructions)	45.00	
	DADT III DECONCILIATION OF CADITAL COSTS OF	11. 00	12.00	13.00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	-1, 546, 534	-1, 273, 474		0 0	3, 132, 060	1. 00
2.00	CAP REL COSTS-BLDG & FIXI	-1, 546, 534 -2, 466, 257			0 0	3, 132, 060 4, 102, 180	2.00
3.00	Total (sum of lines 1-2)	-2, 466, 257 -4, 012, 791			0 0	7, 234, 240	
5.00	Tiotal (Sum of Times 1-2)	7,012,771	1,271,344	ı	0	1 7, 234, 240	3.00

ADJUSTMENTS TO EXPENSES Provider CCN: 150026 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -2.929.874 CAP REL COSTS-BLDG & FLXT 1. 00 В 1.00 11 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL В -2, 466, 257 CAP REL COSTS-MVBLE EQUIP 2.00 11 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 В -50, 699 OTHER ADMINISTRATIVE & 4 00 5 02 discounts (chapter 8) GENERAL 5.00 Refunds and rebates of В -638, 554 OTHER ADMINISTRATIVE & 5.02 5.00 expenses (chapter 8) GENERAL Rental of provider space by -1,079,164 CAP REL COSTS-BLDG & FIXT 6.00 1.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 Provider-based physician -9, 445, 696 10.00 A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 11, 062, 375 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -867, 554 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0.00 16.00 0 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents -50, 530 MEDI CAL RECORDS & LI BRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing school (tuition, fees, 19.00 19 00 0 00 books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of -237, 869 OTHER ADMINISTRATIVE & 21.00 В 5.02 21.00 interest, finance or penalty GENERAL charges (chapter 21) Interest expense on Medicare 0 0 00 22 00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 A - 8 - 365.00 23.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 66.00 24.00 Adjustment for physical A-8-3 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 26.00 1.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29. 00 29 00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30. 99 Hospice (non-distinct) (see 30.00 30.99 instructions) 31.00 Adjustment for speech OSPEECH PATHOLOGY 31.00 68 00 A - 8 - 3pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest

-47, 945 ALLI ED HEALTH

В

0 00

23.00

33 00 O

0 33.01

EMT TRAINING TUITION

33.00

33.01

From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

					0 12/31/2014	5/29/2015 3:1	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 02	MISC RADIOLOGY REVENUE	В	-1, 772, 571	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 02
33. 03	MISC A&G REVENUE	В	-3, 036	OTHER ADMINISTRATIVE &	5. 02	0	33. 03
				GENERAL			
33. 04	PERSONAL AUTO USAGE	A	-35, 683	OTHER ADMINISTRATIVE &	5. 02	0	33. 04
				GENERAL			
33. 05	ALCOHOLI C BEVERAGE	A	-463	OTHER ADMINISTRATIVE &	5. 02	0	33. 05
				GENERAL			
33. 06	LOBBYI NG	A	-43, 972	OTHER ADMINISTRATIVE &	5. 02	0	33. 06
				GENERAL		_	
33. 07	SHARED A&G EXPENSE	A	-1, 134, 701	OTHER ADMINISTRATIVE &	5. 02	0	33. 07
	DRIVE ADDE ADDEDOUGHT		40 554 754	GENERAL			
33. 08	PRIMECARE ASSESSMENT	A	-13, 551, 751	OTHER ADMINISTRATIVE &	5. 02	0	33. 08
00.00	MI CO. AGO. DEVENUE		07.040	GENERAL	F 00		00.00
33. 09	MI SC A&G REVENUE	В	-37, 319	OTHER ADMINISTRATIVE &	5. 02	0	33. 09
22 10	FOOD SERVICES REC(REVENUES	В	17 770	GENERAL DI ETARY	10.00	0	33. 10
33. 10	4700. XXX)	В	-17,778	DIETARY	10.00	U	33. 10
33. 11	,	В	225	 LABORATORY	60.00	0	33. 11
33. 12	l .	В		PHYSI CAL THERAPY	66.00		
33. 12	I NCOME	D	-01	PHISICAL THERAPT	00.00	U	33. 12
33. 13		A	-5 035 050	OTHER ADMINISTRATIVE &	5. 02	0	33. 13
55. 15	TIAL OLI SEL		-3, 033, 030	GENERAL	3.02	0	33. 13
33. 14	MISC OR/SURGERY INCOME	В	-37 925	OPERATING ROOM	50.00	n	33. 14
50.00		_	-28, 422, 422	1	30.00		50.00
55. 00	(Transfer to Worksheet A,		20, 422, 422				00.00
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

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

·			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	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 reimbursement under title XVIII.

6.00	В	IU HEALTH	0.00	0. 00	6. 00
7.00			0.00	0. 00	7.00
8.00			0.00	0. 00	8.00
9.00			0.00	0. 00	9.00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Transfer column 6, line 5 to Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syste	ems		I	U HEALTH	GOSHEN F	IOSPI TAL				In Li	eu of Form C	MS-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZAT	TONS AND	HOME	Provi der	r CCN	: 150026	Peri o	d:	Worksheet	A-8-1
OFFICE	COSTS										01/01/2014		
										То	12/31/2014		
		1										5/29/2015	3:1/ pm
	Net	Wkst. A-7 Ref.											
	Adjustments												
	(col. 4 minus												
	col. 5)*												
	6. 00	7. 00											
	A. COSTS INCUR	RED AND ADJUSTI	MENTS RE	QUI RED AS	A RESULT	OF TRANS	SACTIONS \	WI TH	RELATED	ORGANI Z	ATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:											
1.00	1, 768, 598	9											1. 00
2.00	555, 952	9											2.00
3.00	8, 702, 125												3.00
4.00	35, 700	l c											4.00
5.00	11, 062, 375												5. 00
* The	amounts on line	es 1-4 (and sub	scri pts	as approp	riate) ar	e transf	erred in	deta	il to Wo	rksheet	A, column	6, lines as	 S

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 Busi ness

6.00

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

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

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

6.00	6.00
7. 00	7.00
8. 00	8.00
9. 00	8. 00 9. 00
10. 00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	10. 00 100. 00

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

OSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150026 | Period: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						-	Γο 12/31/2014		
	Wkst. A Line #	Cost Center/Physician	Total	Professional Component		Provi der	RCE Amount	Physi ci an/Prov	7 5
		I denti fi er	Remuneration			Component		ider Component	
				·		,		Hours	
	1. 00	2. 00	3. 00	4. 00		5. 00	6. 00	7. 00	
1.00		OTHER ADMINISTRATIVE &	988, 163		79, 637	908, 526	171, 400	4, 131	1. 00
2. 00		GENERAL MEDICAL RECORDS & LIBRARY	162, 933		0	162, 933	171, 400	2, 090	2. 00
3. 00		PALN MANAGEMENT	1, 430, 327		394, 327				3. 00
4. 00	54. OO RADI OLOGY-DI AGNOSTI C		6, 670, 661		209, 353				
5. 00	60. OO LABORATORY		1, 003, 355		978, 355	· ·			5. 00
6. 00	0.00		1, 000, 000	1	0 0 0 0	· ·			6. 00
7. 00		WOUND CLINIC	24, 960		0	24, 960	171, 400	157	7. 00
8. 00	91. OO EMERGENCY		65, 000	1	0	65, 000			8.00
9. 00	0.00		0	1	0	0			9. 00
10. 00	0.00		0		0	0	l o	l o	10.00
200.00			10, 345, 399	8,	661, 672	1, 683, 727		10, 747	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Perc	ent of	Cost of		Physician Cost	
		I denti fi er	Limit	Unadj us	ted RCE	Memberships &	Component	of Mal practice	
				Lin	ni t	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00	2. 00	8. 00	9.		12. 00	13. 00	14. 00	
1. 00		OTHER ADMINISTRATIVE & GENERAL	340, 410	'	17, 021	0	0	0	1. 00
2.00		MEDICAL RECORDS & LIBRARY	172, 224		8, 611	0	0	0	2. 00
3.00		PAIN MANAGEMENT	19, 612		981	0	0	l o	
4. 00	54. OORADI OLOGY-DI AGNOSTI C		298, 763	1	14, 938	0	0	l o	
5. 00	60. OO LABORATORY		100, 885	1	5, 044		l o	l o	5. 00
6.00	0.00		0		0		0	o	6. 00
7. 00	90. 02 WOUND CLINIC		12, 937		647	0	0	o	7. 00
8.00	91. 00 EMERGENCY		40, 048		2, 002	0	0	o	8. 00
9.00	0.00		0		0	0	0	0	9. 00
10.00	0. 00		0		0	0	0	o	10.00
200.00			984, 879		49, 244	0	0	o	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adj ust	ed RCE	RCE	Adjustment		
		l denti fi er	Component	Lin	ni t	Di sal I owance			
			Share of col.						
	1.00	0.00	14	4.	00	17.00	10.00		
1 00	1. 00	2.00	15. 00	16.		17. 00	18.00		1 00
1. 00		OTHER ADMINISTRATIVE & GENERAL	0	'	340, 410	568, 116	647, 753		1. 00
2.00		MEDICAL RECORDS & LIBRARY	0		172, 224	0	0		2. 00
3.00	53. 01	PAIN MANAGEMENT	0		19, 612	16, 388	1, 410, 715		3. 00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	0		298, 763	162, 545	6, 371, 898		4. 00
5.00		LABORATORY	0	1	100, 885	0	978, 355		5. 00
6.00	0. 00		0	1	0		0		6. 00
7.00		WOUND CLINIC	0	1	12, 937				7. 00
8.00		EMERGENCY	0	1	40, 048	·			8. 00
9.00	0. 00		0	1	0	0	0		9. 00
10.00	0. 00		0		0	0	0		10. 00
200.00			0	1	984, 879	784, 024	9, 445, 696		200. 00

		cial Systems 10N - GENERAL SERVICE COSTS	IU HEALTH GOSH			In Lie eriod: rom 01/01/2014	wu of Form CMS-2 Worksheet B Part I	2552-10
						0 12/31/2014	Date/Time Pre 5/29/2015 3:1	
				CAPI TAL REI	ATED COSTS		372472013 3. 1	5 piii
		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	CASHI ERI NG/ACC OUNTS RECEI VABLE	
			col. 7) 0	1.00	2.00	4. 00	5. 01	
1 00		AL SERVICE COST CENTERS	2 400 040	2 422 242				4 00
1. 00 2. 00 4. 00 5. 01 5. 02	00200 00400 00550	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE & GENERAL	3, 132, 060 4, 102, 180 19, 793, 602 2, 039, 766 26, 527, 422	3, 132, 060 35, 206 53, 558 254, 444	4, 102, 180 1, 147 4, 967	19, 829, 955 277, 858	2, 376, 149 0	1. 00 2. 00 4. 00 5. 01 5. 02
6. 00 7. 00 8. 00	00700 00800	MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0 3, 100, 672 467, 724	0 248, 708 15, 200	30, 109 1, 147	10, 768	0 0 0	6. 00 7. 00 8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	1, 352, 928 440, 698	3, 942 17, 365			0 0	9. 00 10. 00
11. 00	01100	CAFETERI A	256, 201	45, 913	5, 558	147, 557	0	11. 00
13. 00 14. 00		NURSI NG ADMINISTRATION CENTRAL SERVICES & SUPPLY	1, 609, 946 494, 887	12, 476 21, 191	207, 749 68, 332	441, 786 66, 329	0 1 0	13. 00 14. 00
15. 00	01500	PHARMACY	1, 696, 534	17, 480			o o	15. 00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	2, 784, 095 531, 019	38, 803 5, 308		448, 500 165, 364	0	16. 00 17. 00
23. 00	02301	ALLI ED HEALTH	158, 694	1, 852		39, 377	0	23. 00
30. 00		ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	7, 435, 915	307, 179	114, 677	2, 226, 242	215 144	30. 00
31. 00		INTENSIVE CARE UNIT	1, 756, 080	81, 967			215, 144 52, 106	31. 00
43.00		NURSERY	262, 503	10, 641	6, 069	75, 556	10, 887	43. 00
50. 00		_ARY SERVICE COST CENTERS OPERATING ROOM	6, 971, 073	378, 522	972, 951	1, 247, 157	224, 096	50. 00
51.00		RECOVERY ROOM	476, 376	26, 088		146, 150	19, 454	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	1, 406, 544 0	57, 023 0		404, 844 0	31, 474	52. 00 53. 00
53. 01	05301	PAIN MANAGEMENT	339, 530	24, 113		269, 064	7, 063	53. 01
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	13, 663, 289 295, 285	620, 193 7, 028		4, 310, 435 85, 276	470, 329 4, 426	54. 00 55. 00
56.00	05600	RADI OI SOTOPE	0	0	0	0	0	56. 00
56. 01 60. 00		CARDI AC CATH LAB LABORATORY	1, 387, 436 4, 196, 340	22, 615 51, 213		275, 244 862, 013	68, 985 165, 195	56. 01 60. 00
65. 00		RESPI RATORY THERAPY	1, 235, 795	18, 196		343, 847	35, 404	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	2, 089, 931 469, 772	148, 545 0		559, 085 149, 336	l	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	313, 520	0	0	98, 309	5, 792	68. 00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	88, 645 6, 797, 822	55, 501 0			20, 065 53, 674	
71.00	07100	IMPL. DEV. CHARGED TO PATIENTS	5, 700, 893		·	0	79, 466	
73. 00		DRUGS CHARGED TO PATIENTS FIENT SERVICE COST CENTERS	22, 007, 069	0	0	0	705, 976	73. 00
90. 00	09000	CLINIC	396, 298	16, 295	13, 833	72, 285	6, 177	90. 00
90. 01 90. 02		CLINIC WOUND CLINIC	0 1, 222, 247	0 161, 087	0 6, 458	0	0	90. 01 90. 02
90. 02	1	MOBILE CLINIC	11, 222, 247	181,087	1, 096		22, 234	90. 02
91. 00 92. 00		EMERGENCY	2, 828, 257	168, 197	33, 860	788, 476	109, 814	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92. 00
	10100	I&R SERVICES-NOT APPRVD PRGM HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0 1, 816, 910	0 21, 093	0 10, 536	0 520, 637		100. 00 101. 00
	11300	INTEREST EXPENSE	4 047 440	24 26:		224 412	10 105	113.00
118.00	1	HOSPICE SUBTOTALS (SUM OF LINES 1-117)	1, 316, 119 152, 973, 747	21, 084 2, 968, 026				
100.00		MBURSABLE COST CENTERS	1 770 1/7	02 212	27.0//	407.054		100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN OTHER NR/CHP-GRANT I/COMMUNITY ED.	1, 778, 167 165, 585	92, 312 37, 939		406, 954 51, 193		190. 00 190. 01
190. 02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 02
		LI FELI NE COMMUNI TY RELATI ONS	4, 958, 963	0 33, 783	6, 538	323, 660	l e	190. 03 190. 04
190. 05	19005	TOTAL - PRIVATE DUTY	278	0	0	0	0	190. 05
		TOTAL - PROFESSIONAL DEVELOPMENT FOUNDATION	1, 574, 740 0	0	0 0	33, 115 0		190. 06 190. 07
191.00	19100	RESEARCH	677, 588	0	0	156, 047	0	191. 00
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers		n	0	0		200. 00 201. 00
202. 00	1	TOTAL (sum lines 118-201)	162, 129, 068	3, 132, 060	4, 102, 180	19, 829, 955	l e	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150026

				To 12/31/2014	Date/Time Pre 5/29/2015 3:1	
Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LI NEN SERVI CE	o pili
OFFICE ALL OFFICE OF COOT OFFITTED	5A. 01	5. 02	6.00	7. 00	8. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00550 CASHIERING/ACCOUNTS RECEIVABLE	04.447.407	04.447.407				1. 00 2. 00 4. 00 5. 01
5. 02 00540 OTHER ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT	31, 117, 127 0 3, 638, 415	0		0 4, 502, 590		5. 02 6. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING	494, 839 1, 673, 501	117, 531		26, 943 0 6, 987	l	8. 00 9. 00
10. 00 01000 DI ETARY	520, 403	1	1	30, 780	0	10.00
11. 00 01100 CAFETERI A	455, 229	1	1	81, 384	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	2, 271, 957 650, 739	l ·		22, 115 37, 563	0 0	13. 00 14. 00
15. 00 01500 PHARMACY	2, 194, 101	521, 130	1	30, 984	ő	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	3, 301, 079	l ·	1	0 68, 781	0	16.00
17. 00 01700 SOCI AL SERVI CE 23. 00 02301 ALLI ED HEALTH	703, 397 199, 923			9, 409 3, 282	0	17. 00 23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	177, 723	47, 403		3, 202		25.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	10, 299, 157 2, 526, 594	600, 101		544, 498 145, 293	44, 395	31. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	365, 656	86, 848		18, 862	4, 381	43. 00
50. 00 05000 OPERATI NG ROOM	9, 793, 799	2, 326, 164		670, 958	157, 224	50.00
51. 00 05100 RECOVERY ROOM	672, 689			0 46, 243	l	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	1, 932, 402		1	0 101, 078 0 0	23, 471	52. 00 53. 00
53. 00 05300 ANESTHEST OLOGT 53. 01 05301 PAI N MANAGEMENT	640, 194	_		0 42, 742		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 788, 266			1, 099, 339	l	
55. 00 05500 RADI OLOGY-THERAPEUTI C	414, 952	98, 557	1	12, 458		55. 00
56. 00 05600 RADI OI SOTOPE 56. 01 05601 CARDI AC CATH LAB	1, 906, 846	452, 903		0 0 40, 087	0 2,600	56. 00 56. 01
60. 00 06000 LABORATORY	5, 338, 822		1	90, 779		60.00
65. 00 06500 RESPI RATORY THERAPY	1, 641, 992	1	1	32, 253	l	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2, 865, 983 630, 124	1		263, 307	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	417, 621	1	1	0	ő	68. 00
69. 00 06900 ELECTROCARDI OLOGY	177, 946	l ·	1	98, 379	l e	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	6, 851, 496 5, 780, 359		1	0 0	0 1 0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	22, 713, 045		1	0 0	o o	73. 00
OUTPATIENT SERVICE COST CENTERS		I	ı			
90. 00 09000 CLI NI C 90. 01 09001 CLI NI C	504, 888		i	28, 884 0 0	0	90. 00 90. 01
90. 02 09002 WOUND CLI NI C	1, 412, 026	_		285, 538	l e	90. 01
90. 03 09003 MOBILE CLINIC	12, 766			0 0		90. 03
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 928, 604			298, 142	155, 340	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS			l		<u> </u>	92.00
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0		1	0		100. 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	2, 377, 175	564, 612		37, 388	0	101. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	1, 590, 128		l .	37, 374		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	151, 804, 240	28, 664, 835		0 4, 211, 830	639, 313	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 305, 399	547, 565		163, 629	0	190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED.	254, 717		1	67, 249	0	190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	_		0 0	l e	190. 02
190. 03 19003 LI FELI NE 190. 04 19004 COMMUNI TY RELATI ONS	5, 322, 944	_	1	59, 882		190. 03 190. 04
190. 05 19005 TOTAL - PRI VATE DUTY	278	66		0	0	190. 05
190. 06 19006 TOTAL - PROFESSI ONAL DEVELOPMENT	1, 607, 855	381, 888		0		190.06
190. 07 19007 FOUNDATI ON 191. 00 19100 RESEARCH	833, 635	0 198, 000		0		190. 07 191. 00
200.00 Cross Foot Adjustments	033,033					200. 00
201.00 Negative Cost Centers	0	0	1	0		201. 00
202.00 TOTAL (sum lines 118-201)	162, 129, 068	31, 117, 127	I	0 4, 502, 590	639, 313	1202.00

Provi der CCN: 150026

			'	0 12/31/2014	5/29/2015 3:1	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	
	9.00	10.00	11. 00	13. 00	SUPPLY 14.00	
GENERAL SERVICE COST CENTERS				,		
1. 00	2, 077, 968 14, 313 37, 845 10, 284 17, 467 14, 408 31, 984 4, 375 1, 526	689, 099 0 0 0 0 0 0	682, 581 16, 711 5, 260 16, 207 25, 114 8, 600 1, 998	2, 860, 689 0 0 0 0	865, 589 2, 070 13 148 0	15. 00 16. 00
30.00 O3000 ADULTS & PEDIATRICS	253, 197	665, 249	124, 566	980, 988	24, 589	30.00
31. 00 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	67, 563 8, 771	23, 850	22, 736 3, 968	239, 303	5, 332 527	1
50. 00 05000 OPERATI NG ROOM	312, 002	0	58, 701	380, 888	258, 067	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	21, 503 47, 002	0	5, 694 21, 260	64, 755 166, 541	285 2, 824	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	10.075	0	C 20E	1 4	0	53.00
53. 01 05301 PALIN MANAGEMENT 54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 875 511, 202	0	5, 305 134, 965		31 49, 681	53. 01 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 793	0	4, 369	I	181	1
56. 00 05600 RADI OI SOTOPE	3, 743	0	4, 309	13,070	0	56.00
56. 01 05601 CARDI AC CATH LAB	18, 641	0	10, 458	60, 287	73, 138	1
60. 00 06000 LABORATORY	42, 213	o	35, 275		53, 407	60.00
65. 00 06500 RESPIRATORY THERAPY	14, 998	O	15, 521		2, 926	1
66. 00 06600 PHYSI CAL THERAPY	122, 440	0	29, 246	o	445	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	6, 318	I I	995	
68.00 06800 SPEECH PATHOLOGY	0	0	3, 627	I I	49	68. 00
69. 00 06900 ELECTROCARDI OLOGY	45, 747	0	C	112	6, 434	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		191, 492	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	1 1	161, 555 0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	J U	<u> </u>		ıj Oj	U	73.00
90. 00 09000 CLINIC	13, 431	ol	3, 677	l ol	234	90.00
90. 01 09001 CLI NI C	0	0	·	o	0	90. 01
90. 02 09002 WOUND CLINIC	132, 778	0	C	0	4, 625	
90. 03 09003 MOBI LE CLI NI C	0	0	C	0	15	
91. 00 09100 EMERGENCY	138, 639	0	41, 567	336, 668	11, 297	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	O	ol	C	ol ol	0	100.00
101. 00 10100 HOME HEALTH AGENCY	17, 386	Ö	23, 072			101. 00
SPECIAL PURPOSE COST CENTERS		'	·	<u> </u>		1
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	17, 379	0	11, 577			116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 942, 762	689, 099	635, 792	2, 733, 546	865, 348	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	76, 089	ما	21, 479	84, 036	221	190. 00
190. 01 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED.	31, 271	0	10, 249	1		190.00
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	31,271	0	10, 247	l i		190. 02
190. 03 19003 LI FELI NE	Ö	Ö	C	o o		190. 03
190. 04 19004 COMMUNITY RELATIONS	27, 846	0	15, 061	82		190. 04
190. 05 19005 TOTAL - PRIVATE DUTY	0	0	C	0		190. 05
190. 06 19006 TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0	0		190.06
190. 07 19007 FOUNDATION	0	0	0			190. 07
191.00 19100 RESEARCH 200.00 Cross Foot Adjustments	١	٩	U	ή	U	191. 00 200. 00
201.00 Negative Cost Centers	0	n	n		n	201.00
202.00 TOTAL (sum lines 118-201)	2, 077, 968	689, 099	682, 581	2, 860, 689		
	·			·		

| Peri od: | Worksheet B | From 01/01/2014 | Part | To | 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150026

			T	0 12/31/2014		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	ALLIED HEALTH	5/29/2015 3:1 Subtotal	6 pm
2333. \$1.5.1		RECORDS &		THE ESTIMATION OF THE PROPERTY	oub to tu.	
	15. 00	16. 00	17. 00	23. 00	24. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00550 CASHI ERING/ACCOUNTS RECEIVABLE 5. 02 00540 OTHER ADMINISTRATIVE & GENERAL						5. 01 5. 02
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	2 779 000					14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 778, 900 0	4, 211, 023				15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	0	4, 211, 023				17. 00
23. 00 02301 ALLI ED HEALTH	o	0	1			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	· ·	_	1			
30. 00 03000 ADULTS & PEDIATRICS	0	381, 284	685, 836		16, 536, 932	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	92, 344			3, 855, 595	31. 00
43. 00 04300 NURSERY	0	19, 295	18, 684	0	558, 071	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM		207 140		ol	14, 354, 951	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	0 0	397, 148 34, 477		0	1, 005, 419	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		55, 779		0	2, 909, 722	52.00
53. 00 05300 ANESTHESI OLOGY	o	00,777	0	o	0	53. 00
53. 01 05301 PALN MANAGEMENT	0	12, 517	0	0	902, 397	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	833, 527	0	0	27, 492, 974	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	7, 843	0	0	557, 223	1
56. 00 05600 RADI 01 SOTOPE	0	0	0	0	0	56. 00
56. 01 05601 CARDI AC CATH LAB	0	122, 257		0	2, 687, 217	56. 01
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	292, 762 62, 744		0	7, 126, 896 2, 160, 430	1
66. 00 06600 PHYSI CAL THERAPY		55, 141		0	4, 017, 273	•
67. 00 06700 OCCUPATI ONAL THERAPY	o	19, 123		o	806, 223	67. 00
68. 00 06800 SPEECH PATHOLOGY	O	10, 265		0	530, 753	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	35, 560	0	o	406, 443	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	95, 123		0	8, 765, 437	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	140, 831	1	0	7, 455, 661	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	2, 778, 900	1, 251, 102	2 0	0	32, 137, 669	73. 00
90. 00 09000 CLINIC	O	10, 947	7 0	ol	681, 979	90.00
90. 01 09001 CLI NI C		10, 747		- 1	001, 777	90. 01
90. 02 09002 WOUND CLINIC	o	39, 404	1		2, 209, 747	90. 02
90. 03 09003 MOBILE CLINIC	O	0	0	0	15, 813	90. 03
91. 00 09100 EMERGENCY	0	194, 614	1 0	254, 214	6, 292, 183	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS 100. 00 10000 &R SERVI CES-NOT APPRVD PRGM	O	0	0	ol	0	100. 00
101.00 10100 HOME HEALTH AGENCY		14, 176		-	3, 139, 985	1
SPECIAL PURPOSE COST CENTERS	٥١	11,170	71	٥١	0, 107, 700	11011.00
113.00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	32, 760	0	O	2, 144, 816	
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 778, 900	4, 211, 023	892, 996	254, 214	148, 751, 809	118. 00
NONREI MBURSABLE COST CENTERS				ام	0.100.110	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	3, 198, 418	
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED. 190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	467, 015	190. 01
190. 03 19003 LI FELI NE		0		0		190. 02
190. 04 19004 COMMUNITY RELATIONS		0	ő	o	6, 690, 104	
190. 05 19005 TOTAL - PRI VATE DUTY	0	0	o o	o	344	190. 05
190.06 19006 TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0	О	1, 989, 743	
190. 07 19007 FOUNDATION	0	0	0	0		190. 07
191. 00 19100 RESEARCH	0	0	0	0	1, 031, 635	
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0		0		200. 00 201. 00
202.00 Regative cost centers 202.00 TOTAL (sum lines 118-201)	2, 778, 900	4, 211, 023	892, 996	254, 214	162, 129, 068	
202.00 101AL (30111 11163 110-201)	2, 110, 300	7, 211, 023	1 072, 370	234, 214	102, 127, 000	1202.00

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150026

			To 12/31/2014 Date/Time Pre 5/29/2015 3:1	
Cost Center Description	Intern &	Total	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , ,
	Residents Cost			
	& Post Stepdown			
	Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS				1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP				1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 01 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 01
5. 02 00540 OTHER ADMINISTRATIVE & GENERAL				5. 02
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT				6. 00 7. 00
7.00 00700 OPERATION OF PLANT 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
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY				13. 00 14. 00
15. 00 01500 PHARMACY				15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00 01700 SOCI AL SERVI CE				17. 00
23. 00 02301 ALLIED HEALTH				23. 00
30.00 O3000 ADULTS & PEDIATRICS	O	16, 536, 932		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	3, 855, 595		31.00
43. 00 04300 NURSERY	0	558, 071		43. 00
ANCILLARY SERVICE COST CENTERS		44.054.054		F0.00
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	0	14, 354, 951 1, 005, 419		50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		2, 909, 722		52.00
53. 00 05300 ANESTHESI OLOGY	O	0		53. 00
53. 01 05301 PAI N MANAGEMENT	0	902, 397		53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	27, 492, 974		54. 00 55. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE		557, 223 0		56. 00
56. 01 05601 CARDI AC CATH LAB	O	2, 687, 217		56. 01
60. 00 06000 LABORATORY	0	7, 126, 896		60.00
65. 00 06500 RESPIRATORY THERAPY	0	2, 160, 430		65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	4, 017, 273 806, 223		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		530, 753		68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	406, 443		69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	8, 765, 437		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 455, 661		72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	32, 137, 669		/3.00
90. 00 09000 CLI NI C	0	681, 979		90. 00
90. 01 09001 CLI NI C	0	0		90. 01
90. 02 09002 WOUND CLINIC	0	2, 209, 747		90. 02
90. 03 09003 MOBI LE CLI NI C 91. 00 09100 EMERGENCY	0	15, 813 6, 292, 183		90. 03 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0, 2, 2, 100		92. 00
OTHER REIMBURSABLE COST CENTERS				
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	3, 139, 985		101. 00
113. 00 11300 NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE	O	2, 144, 816		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	148, 751, 809		118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 198, 418		190. 00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED.		467, 015		190.00
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	o	0		190. 02
190. 03 19003 LI FELI NE	o	0		190. 03
190. 04 19004 COMMUNITY RELATIONS	0	6, 690, 104		190. 04
190. 05 19005 TOTAL - PRI VATE DUTY 190. 06 19006 TOTAL - PROFESSI ONAL DEVELOPMENT	0	344 1, 989, 743		190. 05 190. 06
190. 07 19007 FOUNDATION	O	0		190. 00
191. 00 19100 RESEARCH	0	1, 031, 635		191. 00
200.00 Cross Foot Adjustments	0	o		200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	0	0 162, 129, 068		201. 00 202. 00
202.00 TOTAL (30m TTHE3 TTO-201)	١	102, 127, 000		1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150026

					To	12/31/2014	Date/Time Pre 5/29/2015 3:1	
				CAPI TAL REI	LATED COSTS		3/24/2013 3. 1	э рііі
		Cost Center Description	Dimontly	DIDC 0 FLVT	MVBLE EQUIP	Cubtatal	EMDL OVEE	
		cost center bescription	Directly Assigned New	BLDG & FIXT	MARTE EGOLA	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1.00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	U	1.00	2.00	ZN	4.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00 4.00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	35, 206	1, 147	36, 353	36, 353	2. 00 4. 00
5. 01		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	53, 558		58, 525	50, 533	5. 01
5. 02	1	OTHER ADMINISTRATIVE & GENERAL	0	254, 444		1, 615, 702	5, 454	5. 02
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0	0 248, 708	-	0 278, 817	0 475	6. 00 7. 00
8.00	1	LAUNDRY & LINEN SERVICE	0	15, 200		16, 347	20	8. 00
9.00	1	HOUSEKEEPI NG	0	3, 942		9, 999	570	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	0	17, 365		19, 467	110	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	0	45, 913 12, 476		51, 471 220, 225	271 810	13. 00
14. 00	01400	CENTRAL SERVICES & SUPPLY	0	21, 191		89, 523	122	14. 00
15.00		PHARMACY MEDICAL RECORDS & LIBRARY	0	17, 480		23, 269	870	15.00
16. 00 17. 00		SOCIAL SERVICE	0	38, 803 5, 308		68, 484 7, 014	823 303	16. 00 17. 00
23. 00		ALLIED HEALTH	0	1, 852		1, 852	72	23. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	1 0	207 170	114 /77	424 057	4 002	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	307, 179 81, 967		421, 856 203, 396	4, 083 945	30. 00 31. 00
43. 00	1	NURSERY	0			16, 710	139	43. 00
F0 00		LARY SERVICE COST CENTERS		070 500	070.054	4 054 470	0.007	F0 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	0	378, 522 26, 088		1, 351, 473 30, 709	2, 287 268	50. 00 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	57, 023		89, 540	742	52. 00
53.00		ANESTHESI OLOGY	0	0		0	0	53.00
53. 01 54. 00		PAI N MANAGEMENT RADI OLOGY-DI AGNOSTI C	0	24, 113 620, 193		24, 537 1, 344, 213	493 7, 889	53. 01 54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0	7, 028		29, 965	156	55. 00
56. 00	1	RADI OI SOTOPE	0	0		0	0	56. 00
56. 01 60. 00		CARDI AC CATH LAB LABORATORY	0	22, 615 51, 213		175, 181 115, 274	505 1, 581	56. 01 60. 00
65. 00	1	RESPIRATORY THERAPY	0	18, 196	1	26, 946	631	65. 00
66. 00	1	PHYSI CAL THERAPY	0	148, 545	37, 308	185, 853	1, 025	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	226	226	274 180	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	0	55, 501	-	69, 236	0	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00		TIENT SERVICE COST CENTERS	0	0	<u> </u>	<u>U</u>	0	73. 00
90.00	09000	CLINIC	0	16, 295	13, 833	30, 128	133	
		CLINIC	0	1/1 007	0	147 545	0	90. 01
90. 02 90. 03		WOUND CLINIC MOBILE CLINIC	0	161, 087 0	6, 458 1, 096	167, 545 1, 096	0	90. 02 90. 03
91.00	09100	EMERGENCY	0	168, 197		202, 057	1, 446	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
100.00		REIMBURSABLE COST CENTERS I &R SERVI CES-NOT APPRVD PRGM	0	0	0	ol	0	100. 00
		HOME HEALTH AGENCY	0			31, 629		101. 00
112 00		AL PURPOSE COST CENTERS	T			Т		110.00
		I NTEREST EXPENSE HOSPI CE	0	21, 084	0	21, 084	430	113. 00 116. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	0			7, 035, 702	34, 572	
400.00		I MBURSABLE COST CENTERS		00.040	07.044	400 070	74/	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	92, 312 37, 939		120, 278 37, 939		190. 00 190. 01
	1	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0,,,0,	1	0,,,0,		190. 02
		LIFELINE	0	0	-	0		190. 03
		COMMUNITY RELATIONS TOTAL - PRIVATE DUTY	0	33, 783	6, 538	40, 321		190. 04 190. 05
		TOTAL - PRIVATE DOTT		0		ol		190. 05
190. 07	19007	FOUNDATI ON	0	0	0	O	0	190. 07
191. 00 200. 00	1	RESEARCH	0	0	0	0	286	191. 00 200. 00
200.00		Cross Foot Adjustments Negative Cost Centers		n	0	ol Ol		201. 00
202.00		TOTAL (sum lines 118-201)	0	3, 132, 060	4, 102, 180	7, 234, 240	36, 353	

Peri od: Worksheet B
From 01/01/2014 Part II
To 12/21/2014 Part III
To 12/21/2014 Part III Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150026

					o 12/31/2014		
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	OTHER ADMINI STRATI VE & GENERAL		PLANT	5/29/2015 3:1 LAUNDRY & LINEN SERVICE	6 pm
	CENEDAL CEDIU CE COCT CENTEDO	5. 01	5. 02	6. 00	7. 00	8. 00	
1. 00 2. 00 4. 00 5. 01 5. 02 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 17. 00 23. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BUDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 CASHI ERI NG/ACCOUNTS RECEIVABLE 00540 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01700 SOCIAL SERVICE	59, 035 () () () () () () () ()	1, 621, 156 2, 45, 022 6, 123 20, 708 6, 439 5, 633 28, 153 6, 8, 055 6, 40, 848 8, 704		324, 314 1, 941 503 2, 217 5, 862 1, 593 2, 706 0, 2, 232 4, 954	24, 431 0 0 0 0 0 0 0	1. 00 2. 00 4. 00 5. 01 5. 02 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 23. 00
30. 00 31. 00 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	5, 355 1, 297 271	31, 264	· c	10, 465	5, 020 1, 697 167	30. 00 31. 00 43. 00
50. 00 51. 00 52. 00 53. 00 53. 01 54. 00 55. 00 56. 01 60. 00 65. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05301 PAI N MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05601 CARDI AC CATH LAB 06000 LABORATORY 06500 RESPI RATORY THERAPY	5, 578 484 783 0 176 11, 707 110 0 1, 717 4, 112 881 774	8, 324 23, 912 5, 7, 922 7, 244, 860 5, 135 0, 23, 595 2, 66, 063 20, 318 4, 35, 464		3, 331 7, 280 0 3, 079 79, 183 897 0 2, 887 6, 539 2, 323 18, 966	0 0 4, 606 0 0 99 0 0	50. 00 51. 00 52. 00 53. 00 53. 01 54. 00 55. 00 56. 00 60. 00 65. 00 66. 00
67. 00 68. 00 69. 00 71. 00 72. 00 73. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	269 144 499 1, 336 1, 978 17, 465	5, 168 2, 202 5 84, 780 3 71, 526	3 (C	0 7, 086 0 0	0 0 0 0 0	67. 00 68. 00 69. 00 71. 00 72. 00 73. 00
90. 00 90. 01 90. 02 90. 03 91. 00 92. 00	09000 CLINIC 09001 CLINIC 09002 WOUND CLINIC 09003 MOBILE CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	154 (553 (2, 733) (3 3 17, 472) 158) (2 2 (3	0 20, 567 0	0 0 0 0 5, 936	90. 00 90. 01 90. 02 90. 03 91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS 10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	199					100. 00 101. 00
	11300 INTEREST EXPENSE 11600 HOSPI CE	460 59, 035		1	· ·		113. 00 116. 00 118. 00
190. 01 190. 02 190. 03 190. 04 190. 05	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED. 219002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 319003 LIFELINE 19004 COMMUNITY RELATIONS 519005 TOTAL - PRIVATE DUTY		3, 152 0 0 0 65, 866 0		4, 844 0	0 0 0 0	190. 00 190. 01 190. 02 190. 03 190. 04 190. 05
190. 07	Negative Cost Centers	(((59, 035	19, 896 0 10, 315 0 1, 621, 156) (C	0	0	190. 06 190. 07 191. 00 200. 00 201. 00 202. 00

Provi der CCN: 150026

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

				T	o 12/31/2014	Date/Time Pre 5/29/2015 3:1	
Cost Center Descripti	on	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	p.iii
					ADMI NI STRATI ON	SERVICES &	
		9. 00	10.00	11. 00	13. 00	SUPPLY 14.00	
GENERAL SERVICE COST CENTER	RS						
1.00 00100 CAP REL COSTS-BLDG &							1. 00
2. 00 00200 CAP REL COSTS-MVBLE E							2. 00
4. 00 00400 EMPLOYEE BENEFITS DEP 5. 01 00550 CASHI ERI NG/ACCOUNTS R							4. 00 5. 01
5. 02 00540 OTHER ADMINISTRATIVE							5. 01
6.00 00600 MAINTENANCE & REPAIRS							6. 00
7.00 00700 OPERATION OF PLANT							7. 00
8.00 00800 LAUNDRY & LINEN SERVI	CE						8. 00
9. 00 00900 HOUSEKEEPI NG		31, 780	00.450				9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A		219 579	28, 452	63, 816			10. 00 11. 00
13. 00 01300 NURSI NG ADMINI STRATI 0	N.	157	0	1, 562	252, 460		13. 00
14. 00 01400 CENTRAL SERVICES & SU		267	o	492	0	101, 162	14. 00
15. 00 01500 PHARMACY		220	О	1, 515	o	242	15. 00
16.00 01600 MEDICAL RECORDS & LIB	BRARY	489	0	2, 348		2	16. 00
17. 00 01700 SOCIAL SERVICE		67	0	804	l .	17	17. 00
23. 00 02301 ALLIED HEALTH INPATIENT ROUTINE SERVICE C	COST CENTEDS	23	0	187	0	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	LUSI CENTERS	3, 872	27, 467	11, 646	86, 574	2, 873	30. 00
31. 00 03100 I NTENSI VE CARE UNI T		1, 033	985	2, 126		623	31. 00
43. 00 04300 NURSERY		134	0	371	2, 743	62	43.00
ANCILLARY SERVICE COST CENT	TERS						
50. 00 05000 OPERATING ROOM		4, 772	0	5, 488		30, 167	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR	DOOM.	329 719	0	532 1, 988		33 330	51. 00 52. 00
53. 00 05300 DELI VERT ROOM & LABOR 53. 00 05300 ANESTHESI OLOGY	K KOOW	719	0	1, 900	14, 096	0	53. 00
53. 01 05301 PAI N MANAGEMENT		304	o	496	2, 619	4	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C		7, 818	О	12, 619		5, 806	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		89	0	408	1, 153	21	55. 00
56. 00 05600 RADI 01 SOTOPE		0	0	0	0	0	56. 00
56. 01 05601 CARDI AC CATH LAB 60. 00 06000 LABORATORY		285	0	978		8, 547	56. 01
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY		646 229	0	3, 298 1, 451	494	6, 241 342	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY		1, 873	ő	2, 734		52	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0	O	591	O	116	67. 00
68.00 06800 SPEECH PATHOLOGY		O	O	339	O	6	68. 00
69. 00 06900 ELECTROCARDI OLOGY		700	0	0	10	752	69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHAR		0	0	0	0	22, 377	71. 00
72.00 07200 IMPL. DEV. CHARGED TO 73.00 07300 DRUGS CHARGED TO PATI		0	O O	0	0	18, 879 0	72. 00 73. 00
OUTPATIENT SERVICE COST CEN		<u>ا</u>	<u></u>		<u>ا</u>		73.00
90. 00 09000 CLI NI C		205	0	344	0	27	90. 00
90. 01 09001 CLI NI C		0	0	0	0	0	90. 01
90. 02 09002 WOUND CLINIC		2, 031	0	0	0	540	90. 02
90. 03 09003 MOBILE CLINIC 91. 00 09100 EMERGENCY		2, 120	0	0 3, 886	29, 711	2 1, 320	90. 03 91. 00
92. 00 09200 OBSERVATION BEDS (NON	I-DISTINCT PART)	2, 120	U	3, 000	29, / 1 1	1, 320	91.00
OTHER REIMBURSABLE COST CEN							72.00
100.00 10000 I &R SERVI CES-NOT APPR	RVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY		266	0	2, 157	9, 325	60	101. 00
SPECIAL PURPOSE COST CENTER	RS						440.00
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE		266	0	1, 082	5, 599	1 602	113. 00 116. 00
118.00 SUBTOTALS (SUM OF LIN	IFS 1_117)	29, 712	28, 452	59, 442		101, 133	118 00
NONREI MBURSABLE COST CENTER		27, 712	20, 432	37, 442	241, 240	101, 133	110.00
190. 00 19000 GIFT, FLOWER, COFFEE		1, 164	0	2, 008	7, 416	26	190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/		478	0	958	3, 797		190. 01
190. 02 19002 GIFT, FLOWER, COFFEE	SHOP, & CANTEEN	0	0	0	0		190. 02
190. 03 19003 LI FELI NE		0	0	1 400	0		190. 03
190. 04 19004 COMMUNITY RELATIONS 190. 05 19005 TOTAL - PRIVATE DUTY		426	0	1, 408 0	/		190. 04 190. 05
190. 06 19006 TOTAL - PROFESSIONAL	DEVELOPMENT		o o	0			190. 05
190. 07 19007 FOUNDATION			Ö	0	0	0	190. 07
191. 00 19100 RESEARCH		0	o	0	0	0	191. 00
200.00 Cross Foot Adjustment							200. 00
201.00 Negative Cost Centers		0	0 450	0 63, 816	0		201. 00
202.00 TOTAL (sum lines 118-	-201)	31, 780	28, 452	03, 816	252, 460	101, 162	202.00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | Part | Part | Prepared: | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150026

Cost Center Description PHARMACY MEDICAL SOCIAL SERVICE ALLIED RECORDS &	5/29/2015 3:16 pm HEALTH Subtotal
LI BRARY	
	.00 24.00
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT	1.00
2. 00 00200 CAP REL COSTS - BUBG W TYXT	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4.00
5. 01 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 01
5.02 00540 OTHER ADMINISTRATIVE & GENERAL	5. 02
6. 00 00600 MAI NTENANCE & REPAI RS	6. 00
7. 00 00700 OPERATI ON OF PLANT	7. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	9.00
11. 00 01100 CAFETERI A	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	13. 00
14.00 O1400 CENTRAL SERVICES & SUPPLY	14. 00
15. 00 01500 PHARMACY 55, 498	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 117, 948	16. 00
17. 00 01700 SOCI AL SERVI CE 0 17, 587	17.00
23. 00 02301 ALLI ED HEALTH 0 0 0 0 0 1 1 1 1 1	4, 844 23. 00
30. 00 03000 ADULTS & PEDI ATRI CS 0 10, 665 13, 507	759, 579 30. 00
31. 00 03100 INTENSIVE CARE UNIT 0 2,583 1,735	279, 268 31. 00
43. 00 04300 NURSERY 0 540 368	27, 389 43. 00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0 11, 109 0	1, 620, 013 50. 00
51. 00 05100 RECOVERY ROOM	50, 689 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 1, 560 1, 977 53. 00 05300 ANESTHESI OLOGY 0 0 0	144, 426 52. 00 0 53. 00
53. 01 05300 ANESTHEST GEOGRAPH	39, 980 53. 01
54. 00 05400 RADI 0LOGY - DI AGNOSTI C	1, 764, 562 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 219 0	38, 153 55. 00
56. 00 05600 RADI 0I SOTOPE 0 0 0	0 56.00
56. 01 05601 CARDI AC CATH LAB 0 3, 420 0	222, 534 56. 01
60. 00 06000 LABORATORY 0 8, 189 0	212, 437 60. 00
65. 00 06500 RESPI RATORY THERAPY 0 1, 755 0 66. 00 06600 PHYSI CAL THERAPY 0 1, 542 0	54, 876 65. 00 248, 283 66. 00
66. 00 06600 PHYSI CAL THERAPY 0 1, 542 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 535 0	248, 283 66. 00 9, 808 67. 00
68. 00 06800 SPEECH PATHOLOGY 0 287 0	6, 124 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 995 0	81, 480 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2,661 0	111, 154 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 3, 939 0	96, 322 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 55, 498 35, 155 0	389, 183 73. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 306 0	39, 624 90. 00
90. 01 09001 CLI NI C	0 90.01
90. 02 09002 WOUND CLINIC 0 1, 102 0	209, 810 90. 02
90. 03 09003 MOBILE CLINIC 0 0 0	1, 256 90. 03
91. 00 09100 EMERGENCY 0 5, 444 0	324, 741 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART)	92. 00
OTHER REIMBURSABLE COST CENTERS 100. 00 10000 1 &R SERVI CES-NOT APPRVD PRGM 0 0 0	0 100.00
101. 00 10100 HOME HEALTH AGENCY 0 397 0	77, 096 101. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE	113. 00
116. 00 11600 H0SPI CE 0 916 0	53, 897 116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 55, 498 117, 948 17, 587	0 6, 862, 684 118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0	171, 951 190. 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED.	51, 263 190. 01
190. 02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0	0 190. 02
190. 03 19003 LI FELI NE 0 0	0 190. 03
190. 04 19004 COMMUNITY RELATIONS 0 0 0	112, 937 190. 04
190. 05 19005 TOTAL - PRI VATE DUTY 0 0 0	3 190. 05
190. 06 19006 TOTAL - PROFESSI ONAL DEVELOPMENT 0 0 0	19, 957 190. 06 0 190. 07
190. 07 19007 FOUNDATI ON 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 0 0	10, 601 191. 00
200.00 Cross Foot Adjustments	4, 844 4, 844 200. 00
201.00 Negative Cost Centers 0 0 0	0 0 201. 00
202.00 TOTAL (sum lines 118-201) 55, 498 117, 948 17, 587	4, 844 7, 234, 240 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS In Lieu of Form CMS-2552-10 IU HEALTH GOSHEN HOSPITAL Peri od: Worksheet B
From 01/01/2014 Part II
To 12/31/2014 Date/Time Prepared: 5/29/2015 3:16 pm Provi der CCN: 150026 Cost Center Description Intern & Total Residents Cost & Post Stepdown

	Stepdown		
	Adj ustments	0, 00	
OFNEDAL CEDIU OF COCT OFNITEDS	25. 00	26. 00	
GENERAL SERVICE COST CENTERS			1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP			1.00
· ·			1
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 01 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 01
5. 02 00540 OTHER ADMINISTRATIVE & GENERAL			5. 02
6. 00 00600 MAI NTENANCE & REPAI RS			6.00
7. 00 00700 OPERATION OF PLANT			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING			8. 00
			9.00
			10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON			11. 00 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
23. 00 02301 ALLI ED HEALTH			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	759, 579	30.00
31. 00 03100 I NTENSI VE CARE UNI T	o	279, 268	31.00
43. 00 04300 NURSERY		27, 389	43. 00
ANCI LLARY SERVI CE COST CENTERS	1 9	27,007	10.00
50. 00 05000 OPERATI NG ROOM	0	1, 620, 013	50.00
51. 00 05100 RECOVERY ROOM	o	50, 689	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	144, 426	52. 00
53. 00 05300 ANESTHESI OLOGY	ol	0	53. 00
53. 01 05301 PAI N MANAGEMENT	ol	39, 980	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	1, 764, 562	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	38, 153	55. 00
56. 00 05600 RADI 0I SOTOPE	o	0	56.00
56. 01 05601 CARDI AC CATH LAB	o	222, 534	56. 01
60. 00 06000 LABORATORY	o	212, 437	60.00
65. 00 06500 RESPIRATORY THERAPY	o	54, 876	65. 00
66. 00 06600 PHYSI CAL THERAPY	o	248, 283	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	9, 808	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	6, 124	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	81, 480	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	111, 154	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	96, 322	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	389, 183	73. 00
OUTPATIENT SERVICE COST CENTERS			
90. 00 09000 CLI NI C	0	39, 624	90. 00
90. 01 09001 CLI NI C	0	0	90. 01
90. 02 09002 WOUND CLINIC	0	209, 810	90. 02
90. 03 09003 MOBI LE CLINI C	0	1, 256	90. 03
91. 00 09100 EMERGENCY	0	324, 741	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		92. 00
OTHER REIMBURSABLE COST CENTERS		_1	4
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	100.00
101. 00 10100 HOME HEALTH AGENCY	0	77, 096	101. 00
SPECIAL PURPOSE COST CENTERS			140.00
113. 00 11300 INTEREST EXPENSE		F2 007	113.00
116. 00 11600 HOSPI CE	0	53, 897	116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	6, 862, 684	118. 00
NONREI MBURSABLE COST CENTERS	0	171, 951	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	51, 263	190. 00 190. 01
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		31, 203	190. 01
190. 03 19003 LI FELI NE	0	0	190. 02
190. 04 19004 COMMUNITY RELATIONS	0	112, 937	190. 04
190. 05 19005 TOTAL - PRI VATE DUTY		114,737	190. 04
190. 06 19006 TOTAL - PROFESSIONAL DEVELOPMENT		19, 957	190.05
190. 07 19000 FOUNDATION		17, 737	190. 00
191. 00 19100 RESEARCH		10, 601	191.00
200.00 Cross Foot Adjustments	0	4, 844	200.00
201.00 Negative Cost Centers	o o	0	201. 00
202.00 TOTAL (sum lines 118-201)	o	7, 234, 240	202. 00
1	, 91	, =	

	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH GOSHE		CCN: 150026 F	In Lie Period:	u of Form CMS-2 Worksheet B-1	
000. 7.			11011461	F	rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
		CAPITAL RELA	TED COSTS			5/29/2015 3: 1	6 pm
	Cost Center Description	(SQUARE FEET) (MVBLE EQUIP DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES)	Reconci I i ati on	
	CENEDAL CEDIU CE COCT CENTEDO	1.00	2. 00	4. 00	5. 01	5A. 02	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FLXT	380, 583					1.00
2.00 4.00 5.01 5.02 6.00 7.00 8.00 9.00 10.00 11.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 CASHIERING/ACCOUNTS RECEIVABLE 00540 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	4, 278 6, 508 30, 918 0 30, 221 1, 847 479 2, 110 5, 579	6, 013, 747 1, 682 7, 281 1, 995, 592 0 44, 139 1, 682 8, 879 3, 081 8, 148	61, 225, 348 857, 891 9, 182, 282 799, 437 33, 247 958, 903 185, 986 455, 584	497, 017, 150 0 0 0 0 0 0 0 0 0 0 0 0	-31, 117, 127 0 0 0 0 0	2. 00 4. 00 5. 01 5. 02 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 516 2, 575	304, 557 100, 174	1, 364, 021 204, 792		0	13. 00 14. 00
15.00	01500 PHARMACY	2, 124	8, 486	1, 464, 403		0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	4, 715	43, 512	1, 384, 750		0	16.00
	01700 SOCI AL SERVI CE 02301 ALLI ED HEALTH	645	2, 501 0	510, 563 121, 578		0	
	INPATIENT ROUTINE SERVICE COST CENTERS		-1			_	
30.00	03000 ADULTS & PEDI ATRI CS	37, 326	168, 115	6, 873, 556		0	
	03100 INTENSIVE CARE UNIT 04300 NURSERY	9, 960 1, 293	178, 013 8, 897	1, 590, 108 233, 280		0	31. 00 43. 00
.0. 00	ANCILLARY SERVICE COST CENTERS	1,7270	3, 3, 1	200, 200	2/2////	<u> </u>	10.00
	05000 OPERATING ROOM	45, 995	1, 426, 334	3, 850, 617		0	
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 170 6, 929	6, 774 47, 669	451, 240 1, 249, 962		0	
53. 00	05300 ANESTHESI OLOGY	0	0	., 2.,, , , o		0	•
53. 01	05301 PAIN MANAGEMENT	2, 930	621	830, 740		0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	75, 361 854	1, 061, 405 33, 626	13, 308, 579 263, 292		0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	0	0	203, 272) 725, 075	0	56. 00
	05601 CARDI AC CATH LAB	2, 748	223, 660	849, 821		0	56. 01
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	6, 223 2, 211	93, 913 12, 828	2, 661, 480 1, 061, 632		0	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	18, 050	54, 693	1, 726, 185		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	331	461, 078		0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6,744	0 20, 135	303, 531	1, 211, 524 4, 196, 874	0	68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 744	20, 133	C	11, 226, 588	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	16, 621, 156		
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	C	147, 681, 419	0	73. 00
90. 00	09000 CLI NI C	1, 980	20, 279	223, 180	1, 291, 996	0	90.00
	09001 CLI NI C	0	0	C	0	0	
90. 02 90. 03	09002 WOUND CLINIC 09003 MOBILE CLINIC	19, 574	9, 468 1, 606	C	4, 650, 541	0	
	09100 EMERGENCY	20, 438	49, 638	2, 434, 433	22, 968, 782	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
100 00	OTHER REIMBURSABLE COST CENTERS 10000 &R SERVI CES-NOT APPRVD PRGM	0	ol	(0	0	100. 00
	10100 HOME HEALTH AGENCY	2, 563	15, 446	1, 607, 476	1, 673, 090		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE 11600 HOSPI CE	2, 562	0	723, 837	3, 866, 369	0	113. 00 116. 00
118. 00		360, 651	5, 963, 165	58, 227, 464			
	NONRE MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED.	11, 217 4, 610	40, 998 0	1, 256, 477 158, 059			190. 00 190. 01
190.02	19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	o	100, 007 C) O	0	190. 02
	19003 LI FELI NE	0	0	000.200	0		190. 03
	19004 COMMUNITY RELATIONS 19005 TOTAL - PRIVATE DUTY	4, 105 0	9, 584 0	999, 306 0			190. 04 190. 05
190.06	19006 TOTAL - PROFESSIONAL DEVELOPMENT	o o	ō	102, 243	o o	0	190. 06
	19007 FOUNDATION	0	0	401 700	0		190. 07
200.00	19100 RESEARCH Cross Foot Adjustments		o _l	481, 799		0	191. 00 200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	3, 132, 060	4, 102, 180	19, 829, 955	2, 376, 149		202. 00
	1 (101 (17)	1 1	l		1	<u> </u>	<u> </u>

Heal th Finar	ncial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 Fo 12/31/2014		
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		CASHI ERI NG/ACC OUNTS	Reconciliation	
				DEPARTMENT (GROSS SALARI ES)	RECEI VABLE (GROSS CHARGES)		
		1.00	2.00	4. 00	5. 01	5A. 02	
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 229637	0. 682134	0. 32388	0. 004781		203. 00
204.00	Cost to be allocated (per Wkst. B,			36, 35	59, 035		204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part II)			0.00059	0. 000119		205. 00

	Financial Systems	TU HEALTH GUS		2011 452224 5		eu of Form CMS-	
COSTA	LLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2014 o 12/31/2014		pared:
	Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	Piii
		ADMI NI STRATI VE & GENERAL	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	
		(ACCUM. COST)	,		LAUNDRY)		
	GENERAL SERVICE COST CENTERS	5. 02	6. 00	7. 00	8. 00	9. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	OO4OO EMPLOYEE BENEFI TS DEPARTMENT OO55O CASHI ERI NG/ACCOUNTS RECEI VABLE						4. 00 5. 01
5. 02	00540 OTHER ADMINISTRATIVE & GENERAL	131, 011, 941					5. 02
6.00	00600 MAINTENANCE & REPAIRS	0	,				6. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	3, 638, 415 494, 839	l .				7. 00 8. 00
9. 00	00900 HOUSEKEEPING	1, 673, 501	l ·			l	1
10.00	01000 DI ETARY	520, 403					1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	455, 229 2, 271, 957	1				1
14. 00	01400 CENTRAL SERVICES & SUPPLY	650, 739					1
15. 00	01500 PHARMACY	2, 194, 101	2, 124				1
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 301, 079					1
17. 00 23. 00	01700 SOCIAL SERVICE 02301 ALLIED HEALTH	703, 397 199, 923					1
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	177,720					20.00
30. 00	03000 ADULTS & PEDI ATRI CS	10, 299, 157					
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	2, 526, 594 365, 656					
43.00	ANCI LLARY SERVI CE COST CENTERS	303, 030	1, 293	1, 293	5, 475	1, 293	43.00
50.00	05000 OPERATING ROOM	9, 793, 799	45, 995	45, 995	196, 498	45, 995	50. 00
51.00	05100 RECOVERY ROOM	672, 689				-,	1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 932, 402	6, 929 0	6, 929 0		1	1
53. 01	05301 PAI N MANAGEMENT	640, 194	_		_	2, 930	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 788, 266	1	75, 361			
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	414, 952		854 0		854 0	1
56. 01	05601 CARDI AC CATH LAB	1, 906, 846	_	1	_	-	
60.00	06000 LABORATORY	5, 338, 822	l ·				
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 641, 992	l ·				1
67. 00	06700 OCCUPATIONAL THERAPY	2, 865, 983 630, 124	l ·	18, 050 0			1
68. 00	06800 SPEECH PATHOLOGY	417, 621	0	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	177, 946				6, 744	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	6, 851, 496 5, 780, 359	l .	0			
73. 00	07300 DRUGS CHARGED TO PATIENTS	22, 713, 045	l .	Ö			1
	OUTPATIENT SERVICE COST CENTERS		1 000			1 000	
	09000 CLI NI C 09001 CLI NI C	504, 888	1, 980	1, 980	0		90.00
	09002 WOUND CLINIC	1, 412, 026	19, 574	19, 574	0		90.01
90. 03	09003 MOBILE CLINIC	12, 766		0	0	0	
	09100 EMERGENCY	3, 928, 604	20, 438	20, 438	194, 142	20, 438	91. 00 92. 00
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	10000 I&R SERVICES-NOT APPRVD PRGM	0	_				100. 00
101.00	10100 HOME HEALTH AGENCY	2, 377, 175	2, 563	2, 563	0	2, 563	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE] 113. 00
	11600 HOSPI CE	1, 590, 128	2, 562	2, 562	0	2, 562	116. 00
118.00		120, 687, 113	318, 947	288, 726	799, 006	286, 400	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 305, 399	11, 217	11, 217	0	11 217	190. 00
	19001 OTHER NR/CHP-GRANT I/COMMUNITY ED.	254, 717					190.00
	19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 02
	19003 LI FELI NE 19004 COMMUNI TY RELATI ONS	5, 322, 944	0 4, 105	0 4, 105	0		190. 03 190. 04
	19005 TOTAL - PRIVATE DUTY	278		1 4, 103	0		190. 04
	19006 TOTAL - PROFESSIONAL DEVELOPMENT	1, 607, 855		0	0		190. 06
	19007 FOUNDATION	000 (05	0	0	0		190. 07
191. 00 200. 00	19100 RESEARCH Cross Foot Adjustments	833, 635	0	0	0	0	191. 00 200. 00
201.00							201. 00
202.00	Cost to be allocated (per Wkst. B,	31, 117, 127	0	4, 502, 590	639, 313	2, 077, 968	202. 00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 237514	0. 000000	14. 587634	0. 800135	6. 783385	203 00
204.00		1, 621, 156	l .	324, 314			204. 00
	Part II)		<u> </u>	<u> </u>		<u> </u>	<u> </u>
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Health Financial Systems	IU HEALTH GOSI	HEN HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/29/2015 3:1	
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	
	& GENERAL	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		
	(ACCUM. COST)			LAUNDRY)		
	5. 02	6. 00	7. 00	8. 00	9. 00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 012374	0. 000000	1. 050723	0. 030577	0. 103744	205.00

	Financial Systems LOCATION - STATISTICAL BASIS	TU HEALTH GOSH			<u>In Lie</u> eriod: om 01/01/2014	u of Form CMS-2 Worksheet B-1	
				To		Date/Time Pre 5/29/2015 3:1	pared: 6 pm
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	·
				(DI RECT NURS. HRS.)	(COSTED REQUIS.)		
	ENERAL CERVICE COST CENTERS	10.00	11. 00	13. 00	14.00	15. 00	
	ENERAL SERVICE COST CENTERS 10100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP 10400 EMPLOYEE BENEFITS DEPARTMENT 10550 CASHI ERI NG/ACCOUNTS RECEIVABLE 10540 OTHER ADMINISTRATIVE & GENERAL 10600 MAINTENANCE & REPAIRS 10700 OPERATION OF PLANT 10800 LAUNDRY & LINEN SERVICE 10900 DI ETARY 11100 CAFETERIA 11300 NURSI NG ADMINISTRATION 11400 CENTRAL SERVICES & SUPPLY 11500 PHARMACY 11600 MEDICAL RECORDS & LIBRARY 11700 SOCIAL SERVICE 12301 ALLIED HEALTH	76, 884 0 0 0 0 0 0 0	1, 631, 600 39, 945 12, 574 38, 741 60, 032 20, 556 4, 775	485, 904 0 0 0 0	30, 969, 782 74, 056 479 5, 287 0	22, 007, 069 0 0 0	16. 00 17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS	74, 223	297, 755	166, 626	879, 783	0	30.00
31.00	3100 INTENSIVE CARE UNIT	2, 661	54, 347	40, 647	190, 776	0	31.00
	14300 NURSERY NCILLARY SERVICE COST CENTERS	0	9, 484	5, 279	18, 859	0	43. 00
50.00	5000 OPERATING ROOM	0	140, 315		9, 233, 014	0	
	15100 RECOVERY ROOM 15200 DELIVERY ROOM & LABOR ROOM	0	13, 610 50, 818		10, 200 101, 051	0	
53.00	5300 ANESTHESI OLOGY	0	C	0	O	0	53. 00
	15301 PALN MANAGEMENT 15400 RADLOLOGY-DLAGNOSTLC	0	12, 681 322, 618		1, 108 1, 777, 567	0	53. 01 54. 00
55.00	5500 RADI OLOGY-THERAPEUTI C	O	10, 443		6, 477	0	55. 00
	15600 RADI OI SOTOPE 15601 CARDI AC CATH LAB	0	24, 997	0 10, 240	0 2, 616, 853	0	56. 00 56. 01
60.00	6000 LABORATORY	0	84, 319		1, 910, 868	0	60.00
	16500 RESPI RATORY THERAPY 16600 PHYSI CAL THERAPY	0	37, 101 69, 908		104, 702 15, 906	0	65. 00 66. 00
67.00	6700 OCCUPATI ONAL THERAPY	0	15, 102		35, 588	0	67. 00
	16800 SPEECH PATHOLOGY 16900 ELECTROCARDI OLOGY	0	8, 669	0 19	1, 741 230, 207	0	68. 00 69. 00
71.00	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	C	Ó	6, 851, 496	0	71. 00
	17200 IMPL. DEV. CHARGED TO PATIENTS 17300 DRUGS CHARGED TO PATIENTS	0	C	1	5, 780, 359 0	0 22, 007, 069	72. 00 73. 00
0	UTPATIENT SERVICE COST CENTERS	J		, 0		22,007,007	73.00
	19000 CLI NI C 19001 CLI NI C	0	8, 789	0 0	8, 356 0	0	
90. 02	9002 WOUND CLINIC	0	C	o o	165, 485	0	90. 02
	19003 MOBILE CLINIC 19100 EMERGENCY	0	99, 358	0 3 57, 185	540 404, 191	0	90. 03 91. 00
92.00	9200 OBSERVATION BEDS (NON-DISTINCT PART)			37,100	.0., .7.		92. 00
	THER REIMBURSABLE COST CENTERS 0000 &R SERVICES-NOT APPRVD PRGM	0		0	ol	0	100. 00
101.001	0100 HOME HEALTH AGENCY	0	55, 149		18, 232		101. 00
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE						113. 00
116.001	1600 HOSPI CE	0	27, 674		518, 001		116. 00
118. 00 N	SUBTOTALS (SUM OF LINES 1-117) ONREI MBURSABLE COST CENTERS	76, 884	1, 519, 760	464, 308	30, 961, 182	22, 007, 069	1118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	51, 341		7, 904		190.00
	9001 OTHER NR/CHP-GRANT I/COMMUNITY ED. 9002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	24, 499 C	7, 308	168 0		190. 01 190. 02
190. 03 1	9003 LI FELI NE	0	0	0	0		190. 03
	9004 COMMUNITY RELATIONS 9005 TOTAL - PRIVATE DUTY	0	36, 000 C	14	528 0		190. 04 190. 05
	9006 TOTAL - PROFESSIONAL DEVELOPMENT	0	C	o	o		190.06
	9007 FOUNDATION 9100 RESEARCH	0	C		0		190. 07 191. 00
200.00	Cross Foot Adjustments						200. 00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	689, 099	682, 581	2, 860, 689	865, 589	2, 778, 900	201. 00 202. 00
	Part I)				·		
203. 00	Unit cost multiplier (Wkst. B, Part I)	8. 962840	0. 418351	5. 887354	0. 027949	0. 126273	J∠U3. UU

Heal th Fina	ncial Systems	IU HEALTH GOSH	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 3:1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)	(MANHOURS)	ADMI NI STRATI O	N SERVICES &	(COSTED	
					SUPPLY	REQUIS.)	
				(DIRECT NURS.	(COSTED		
				HRS.)	REQUIS.)		
		10.00	11. 00	13.00	14. 00	15. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	28, 452	63, 816	252, 46	0 101, 162	55, 498	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 370064	0. 039113	0. 51956	0. 003266	0. 002522	205. 00

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 150026

Peri od: Worksheet B-1 From 01/01/2014

12/31/2014 Date/Time Prepared: 5/29/2015 3:16 pm Cost Center Description MEDI CAL SOCIAL SERVICE ALLIED HEALTH RECORDS & (ASSI GNED LI BRARY (TIME SPENT) TIME) (GROSS CHARGES) 16.00 17.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.01 5.01 00540 OTHER ADMINISTRATIVE & GENERAL 5.02 5.02 00600 MAINTENANCE & REPAIRS 6.00 6.00 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 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 497, 017, 150 16.00 01700 SOCIAL SERVICE 17 00 6,022 17 00 23.00 02301 ALLIED HEALTH 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 44, 999, 828 30.00 4,625 C 03100 INTENSIVE CARE UNIT 10, 898, 608 0 31 00 594 31.00 43.00 04300 NURSERY 2, 277, 187 126 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 872, 131 0 50.00 0 05100 RECOVERY ROOM 51 00 51.00 4, 069, 075 C 52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 583, 134 677 52.00 05300 ANESTHESI OLOGY 0 53.00 C 53.00 05301 PALN MANAGEMENT 1, 477, 299 0 53.01 0 53.01 0 05400 RADI OLOGY-DI AGNOSTI C 98, 374, 523 0 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 925, 675 0 0 55.00 0 56.00 05600 RADI OI SOTOPE 56.00 56, 01 05601 CARDI AC CATH LAB 14, 428, 954 0 0 56, 01 0 06000 LABORATORY 60.00 34, 552, 385 0 60.00 06500 RESPIRATORY THERAPY 7, 405, 206 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 6, 507, 868 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 2, 256, 938 0 67.00 68.00 06800 SPEECH PATHOLOGY 1, 211, 524 0 68.00 69.00 06900 ELECTROCARDI OLOGY 4, 196, 874 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 11, 226, 588 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS Λ 0 72.00 16, 621, 156 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 147, 681, 419 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 291, 996 0 0 90.00 09001 CLI NI C 0 90.01 C 90.01 90.02 09002 WOUND CLINIC 4, 650, 541 0 0 90.02 09003 MOBILE CLINIC 0 0 90.03 90.03 09100 EMERGENCY 22, 968, 782 91 00 C 100 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 100, 00 10000 I &R SERVI CES-NOT APPRVD PRGM 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 1, 673, 090 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 3 866 369 O 116 00 SUBTOTALS (SUM OF LINES 1-117) 118.00 497, 017, 150 6,022 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED. 0 0 190 01 Ω 0 190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 190.02 190. 03 19003 LI FELI NE 0 190.03 0 0 190. 04 19004 COMMUNITY RELATIONS 0 0 190.04 190. 05 19005 TOTAL - PRI VATE DUTY 190. 06 19006 TOTAL - PROFESSI ONAL DEVELOPMENT 0 190.05 Ω 0 0 0 190.06 190. 07 19007 FOUNDATI ON 0 0 190.07 191. 00 19100 RESEARCH 0 0 191. 00 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 4, 211, 023 892.996 254, 214 202.00 Part I) 203.00 203.00 0.008473 148. 288941 2, 542. 140000 Unit cost multiplier (Wkst. B, Part I)

Health Financial Systems	IU HEALTH GOSI	HEN HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od: From 01/01/2014	Worksheet B-1	
				To 12/31/2014		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	ALLIED HEALTH	1		
	RECORDS &		(ASSI GNED			
	LI BRARY	(TIME SPENT)	TIME)			
	(GROSS					
	CHARGES)					
	16.00	17. 00	23.00			
204.00 Cost to be allocated (per Wkst. B,	117, 948	17, 587	4, 84	4		204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000237	2. 920458	48. 44000	0		205. 00
11)						

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150026	
		From 01/01/2014 Part

				To 12/31/2014	Date/Time Pre 5/29/2015 3:1	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
		1.1.1		Costs		
Cost Center Description	Total Cost	Therapy 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	
INPATIENT ROUTINE SERVICE COST CENTERS			•	<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	16, 536, 932		16, 536, 93	2 0	16, 536, 932	30. 00
31.00 03100 INTENSIVE CARE UNIT	3, 855, 595		3, 855, 59	5 0	3, 855, 595	31.00
43. 00 04300 NURSERY	558, 071		558, 07		558, 071	43.00
ANCILLARY SERVICE COST CENTERS			<u> </u>	<u> </u>	· · · · · · · · · · · · · · · · · · ·	
50. 00 05000 OPERATING ROOM	14, 354, 951		14, 354, 95	1 0	14, 354, 951	50. 00
51.00 05100 RECOVERY ROOM	1, 005, 419		1, 005, 41	9 0	1, 005, 419	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 909, 722		2, 909, 72	2 0	2, 909, 722	52. 00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53. 00
53. 01 05301 PALN MANAGEMENT	902, 397		902, 39	7 16, 388	918, 785	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	27, 492, 974		27, 492, 97		27, 655, 519	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	557, 223		557, 22	3 0	557, 223	55. 00
56. 00 05600 RADI 0I SOTOPE	0			o o	0	56.00
56. 01 05601 CARDI AC CATH LAB	2, 687, 217		2, 687, 21	7 0	2, 687, 217	56. 01
60. 00 06000 LABORATORY	7, 126, 896		7, 126, 89		7, 126, 896	
65. 00 06500 RESPIRATORY THERAPY	2, 160, 430	l .			2, 160, 430	1
66. 00 06600 PHYSI CAL THERAPY	4, 017, 273		4, 017, 27		4, 017, 273	
67. 00 06700 OCCUPATI ONAL THERAPY	806, 223	0	806, 22		806, 223	67.00
68. 00 06800 SPEECH PATHOLOGY	530, 753		530, 75		530, 753	
69. 00 06900 ELECTROCARDI OLOGY	406, 443	l .	406, 44		406, 443	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 765, 437		8, 765, 43		8, 765, 437	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	7, 455, 661		7, 455, 66		7, 455, 661	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 137, 669		32, 137, 66		32, 137, 669	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	681, 979		681, 97	9 0	681, 979	90.00
90. 01 09001 CLI NI C	0			0 0	0	90. 01
90. 02 09002 WOUND CLINIC	2, 209, 747		2, 209, 74	7 12, 023	2, 221, 770	90. 02
90. 03 09003 MOBILE CLINIC	15, 813		15, 81		15, 813	
91. 00 09100 EMERGENCY	6, 292, 183		6, 292, 18	3 24, 952	6, 317, 135	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 192, 412		2, 192, 41		2, 192, 412	
OTHER REIMBURSABLE COST CENTERS				•		
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	3, 139, 985		3, 139, 98	5	3, 139, 985	101.00
SPECIAL PURPOSE COST CENTERS				•		
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	2, 144, 816		2, 144, 81	6	2, 144, 816	116. 00
200.00 Subtotal (see instructions)	150, 944, 221	0			151, 160, 129	
201.00 Less Observation Beds	2, 192, 412		2, 192, 41	2	2, 192, 412	
202.00 Total (see instructions)	148, 751, 809					
		•	•			

IU HEALTH GOSHEN HOSPITAL	In Lie	u of Form CMS-2552-10
Provi der CCN: 150026	Peri od:	Worksheet C
	From 01/01/2014	
		Provi der CCN: 150026 Peri od:

				Τ̈́	o 12/31/2014	Date/Time Pre 5/29/2015 3:1	
			Ti tl	e XVIII	Hospi tal	PPS	<u>- </u>
			Charges			<u> </u>	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	'	+ col. 7)	Rati o	Inpati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	33, 831, 694		33, 831, 694			30.00
31.00	03100 INTENSIVE CARE UNIT	10, 898, 608		10, 898, 608			31.00
43.00	04300 NURSERY	2, 277, 187		2, 277, 187			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	17, 127, 080	29, 745, 051	46, 872, 131	0. 306258	0.000000	50.00
51.00	05100 RECOVERY ROOM	1, 546, 938	2, 522, 137	4, 069, 075	0. 247088	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 583, 134	0	6, 583, 134	0. 441996	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0.000000	0.000000	53. 00
53. 01	05301 PAIN MANAGEMENT	221, 008	1, 256, 291	1, 477, 299	0. 610842	0.000000	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 530, 128	86, 844, 395	98, 374, 523	0. 279473	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	44, 535	881, 140	925, 675	0. 601964	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	O	0	C	0. 000000	0.000000	56. 00
56. 01	05601 CARDI AC CATH LAB	7, 207, 914	7, 221, 040	14, 428, 954	0. 186238	0.000000	56. 01
60.00	06000 LABORATORY	12, 567, 932	21, 984, 453	34, 552, 385	0. 206264	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	6, 132, 233	1, 272, 973	7, 405, 206	0. 291745	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 286, 249	5, 221, 619	6, 507, 868	0. 617295	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 034, 304	1, 222, 634	2, 256, 938	0. 357220	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	185, 540	1, 025, 984	1, 211, 524	0. 438087	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 049, 351	3, 147, 523	4, 196, 874	0. 096844	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 010, 695	3, 215, 893	11, 226, 588	0. 780775	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 911, 286	6, 709, 870	16, 621, 156	0. 448565	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	33, 529, 220	114, 152, 199	147, 681, 419	0. 217615	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS	·					1
90.00	09000 CLI NI C	0	1, 291, 996	1, 291, 996	0. 527849	0.000000	90. 00
90. 01	09001 CLI NI C	0	0	l c	0.000000	0.000000	90. 01
90. 02	09002 WOUND CLINIC	0	4, 650, 541	4, 650, 541	0. 475159	0.000000	90. 02
90. 03	09003 MOBILE CLINIC	0	0	C	0.000000	0.000000	90. 03
91.00	09100 EMERGENCY	3, 760, 372	19, 208, 410	22, 968, 782	0. 273945	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11, 168, 134	11, 168, 134	0. 196310	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C			100. 00
101.00	10100 HOME HEALTH AGENCY	O	1, 673, 090	1, 673, 090)		101.00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	3, 866, 369	3, 866, 369			116. 00
200.00	Subtotal (see instructions)	168, 735, 408	328, 281, 742	497, 017, 150) i		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	168, 735, 408	328, 281, 742	497, 017, 150) I		202. 00
							-

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lieu of Form CMS-		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150026	From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 3:16 pm	

			10 12/31/2014	5/29/2015 3:16 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
· ·	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
50. 00 05000 OPERATI NG ROOM	0. 306258			50.00
51. 00 05100 RECOVERY ROOM	0. 247088			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 441996			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
53. 01 05301 PAI N MANAGEMENT	0. 621936			53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 281125			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 601964			55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000			56.00
56. 01 05601 CARDI AC CATH LAB	0. 186238			56. 01
60. 00 06000 LABORATORY	0. 206264			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 291745			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 617295			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 357220			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 438087			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 096844			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 780775			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 448565			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 217615			73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 527849			90.00
90. 01 09001 CLINIC	0. 000000			90. 01
90. 02 09002 WOUND CLINIC	0. 477744			90. 02
90. 03 09003 MOBI LE CLINI C	0. 000000			90. 03
91. 00 09100 EMERGENCY	0. 275031			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 196310			92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM				100. 00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS	'			
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201. 00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00
	1			1202. 00

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150026	
		From 01/01/2014 Part

				To 12/31/2014	Date/Time Pre 5/29/2015 3:1	
		Ti t	le XIX	Hospi tal	Cost	<u> </u>
				Costs		
Cost Center Description	Total Cost	Therapy 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	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	16, 536, 932		16, 536, 93	2 0	16, 536, 932	30. 00
31.00 03100 INTENSIVE CARE UNIT	3, 855, 595		3, 855, 59	5 0	3, 855, 595	31.00
43. 00 04300 NURSERY	558, 071		558, 07			43.00
ANCILLARY SERVICE COST CENTERS	<u> </u>		<u> </u>			
50. 00 05000 OPERATING ROOM	14, 354, 951		14, 354, 95	1 0	14, 354, 951	50. 00
51.00 05100 RECOVERY ROOM	1, 005, 419		1, 005, 41	9 0	1, 005, 419	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 909, 722		2, 909, 72	2 0	2, 909, 722	52. 00
53. 00 05300 ANESTHESI OLOGY	0			0	0	53. 00
53. 01 05301 PALN MANAGEMENT	902, 397		902, 39	7 16, 388	918, 785	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	27, 492, 974		27, 492, 97		27, 655, 519	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	557, 223		557, 22	3 0	557, 223	55. 00
56. 00 05600 RADI 0I SOTOPE	0			0	0	56.00
56. 01 05601 CARDI AC CATH LAB	2, 687, 217		2, 687, 21	7 0	2, 687, 217	56. 01
60. 00 06000 LABORATORY	7, 126, 896		7, 126, 89		7, 126, 896	
65. 00 06500 RESPIRATORY THERAPY	2, 160, 430				2, 160, 430	1
66. 00 06600 PHYSI CAL THERAPY	4, 017, 273		4, 017, 27		4, 017, 273	
67. 00 06700 OCCUPATI ONAL THERAPY	806, 223	l 0	806, 22		806, 223	67.00
68. 00 06800 SPEECH PATHOLOGY	530, 753		530, 75		530, 753	
69. 00 06900 ELECTROCARDI OLOGY	406, 443		406, 44		406, 443	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 765, 437		8, 765, 43		8, 765, 437	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	7, 455, 661		7, 455, 66		7, 455, 661	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 137, 669		32, 137, 66		32, 137, 669	
OUTPATIENT SERVICE COST CENTERS		'				
90. 00 09000 CLI NI C	681, 979		681, 97	9 0	681, 979	90.00
90. 01 09001 CLI NI C	0			0	0	90. 01
90. 02 09002 WOUND CLINIC	2, 209, 747		2, 209, 74	7 12, 023	2, 221, 770	90. 02
90. 03 09003 MOBILE CLINIC	15, 813		15, 81		15, 813	
91. 00 09100 EMERGENCY	6, 292, 183		6, 292, 18	3 24, 952	6, 317, 135	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 192, 412		2, 192, 41		2, 192, 412	
OTHER REIMBURSABLE COST CENTERS						
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			O	0	100. 00
101.00 10100 HOME HEALTH AGENCY	3, 139, 985		3, 139, 98	5	3, 139, 985	101. 00
SPECIAL PURPOSE COST CENTERS		•				
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	2, 144, 816		2, 144, 81	6	2, 144, 816	116. 00
200.00 Subtotal (see instructions)	150, 944, 221					
201.00 Less Observation Beds	2, 192, 412		2, 192, 41	2	2, 192, 412	
202.00 Total (see instructions)	148, 751, 809					
		•				•

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150026	Peri od: Worksheet C From 01/01/2014 Part I

				rom 01/01/2014 to 12/31/2014	Date/Time Pre	
		Ti t	le XIX	Hospi tal	5/29/2015 3:1 Cost	<u>6 pm</u>
		Charges		lioopi tui	0001	
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	33, 831, 694		33, 831, 694			30.00
31.00 03100 INTENSIVE CARE UNIT	10, 898, 608		10, 898, 608	1		31.00
43. 00 04300 NURSERY	2, 277, 187		2, 277, 187			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	17, 127, 080	29, 745, 051			0.000000	50.00
51.00 05100 RECOVERY ROOM	1, 546, 938	2, 522, 137			0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 583, 134	0	6, 583, 134		0.000000	
53. 00 05300 ANESTHESI OLOGY	0	0) c	0.000000	0.000000	53.00
53. 01 05301 PAI N MANAGEMENT	221, 008	1, 256, 291	1, 477, 299	0. 610842	0.000000	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 530, 128	86, 844, 395	98, 374, 523		0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	44, 535	881, 140	925, 675	0. 601964	0.000000	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	C	0.000000	0.000000	56.00
56. 01 05601 CARDI AC CATH LAB	7, 207, 914	7, 221, 040	14, 428, 954	0. 186238	0.000000	56. 01
60. 00 06000 LABORATORY	12, 567, 932	21, 984, 453	34, 552, 385	0. 206264	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	6, 132, 233	1, 272, 973	7, 405, 206	0. 291745	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 286, 249	5, 221, 619	6, 507, 868	0. 617295	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 034, 304	1, 222, 634	2, 256, 938	0. 357220	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	185, 540	1, 025, 984	1, 211, 524	0. 438087	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 049, 351	3, 147, 523	4, 196, 874	0. 096844	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 010, 695	3, 215, 893	11, 226, 588	0. 780775	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 911, 286	6, 709, 870	16, 621, 156	0. 448565	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	33, 529, 220	114, 152, 199	147, 681, 419	0. 217615	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	1, 291, 996	1, 291, 996	0. 527849	0.000000	90.00
90. 01 09001 CLI NI C	o	0	ıl c	0. 000000	0.000000	90. 01
90. 02 09002 WOUND CLINIC	o	4, 650, 541	4, 650, 541	0. 475159	0.000000	90. 02
90. 03 09003 MOBI LE CLI NI C	o	0	l c	0. 000000	0.000000	90. 03
91. 00 09100 EMERGENCY	3, 760, 372	19, 208, 410	22, 968, 782	0. 273945	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11, 168, 134	11, 168, 134	0. 196310	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		· · · · ·				1
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	C)		100. 00
101.00 10100 HOME HEALTH AGENCY	o	1, 673, 090	1, 673, 090)		101.00
SPECIAL PURPOSE COST CENTERS		· · · · · ·		'		1
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	3, 866, 369	3, 866, 369			116. 00
200.00 Subtotal (see instructions)	168, 735, 408	328, 281, 742	497, 017, 150)		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	168, 735, 408	328, 281, 742	497, 017, 150)		202.00
	. '		•	. '		•

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150026	Peri od: Worksheet C From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/29/2015 3:16 pm			

Cost Center Description					5/29/2015 3:16 pm
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 3000 ADULTS & PEDIATRICS 31.00			Title XIX	Hospi tal	Cost
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00	Cost Center Description	PPS Inpatient			
IMPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.00 031000 03100 031000 031000 031000 031000 031000 03100		Ratio			
30.00 03000 ADULTS & PEDI ATRICS 31.00 04300 NURSERY 43.00 ADULTS & SERVICE COST CENTERS 50.00 0300 NURSERY 50.00 05000 OPERATI NG ROOM 0.000000 51.00 050.00 050.00		11. 00			
31.00 03100 INTERNSI VE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS				
43. 00 04300 NURSERY					30.00
ANCILLARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT				31.00
50.00 05000 05100 05100 RECOVERY ROOM 0.000000 0.000000 51.00 05200 DELI VERY ROOM 0.000000 52.00 DELI VERY ROOM 0.000000 52.00 DELI VERY ROOM 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 55.00 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.000000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	43. 00 04300 NURSERY				43. 00
51.00 05100 RECOVERY ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 53.00 05300 DALI VERY ROOM & LABOR ROOM 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY - DI AGRINSTI C 0.000000 55.00 05500 RADI OLOGY-DI AGRINSTI C 0.000000 55.00 05500 RADI OLOGY-DI AGRINSTI C 0.000000 55.00 05500 RADI OLOGY-DI AGRINSTI C 0.000000 55.00 05600 RADI OLOGY-DI AGRINSTI C 0.000000 56.00 05600 RADI OLOGY-DI AGRINSTI C 0.000000 56.00 05600 RADI ROOM 0.000000 66.00 0.000000 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.000000 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.00000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.000000 66.00 0.0000000 66.00 0.00	ANCILLARY SERVICE COST CENTERS				
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 53.00 0.000000 54.00 0.000000 54.00 0.000000 55.0000000 55.00000000 55.0000000000	50.00 05000 OPERATING ROOM	0. 000000			50.00
53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 55.00 05300 AND IN MANAGEMENT 0.000000 55.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55.00 05500 RADI OLOGY-DI AGNOSTI C 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05500 RADI RADI CATRI LAB 0.000000 56.00 06500 RESPI RATORY THERAPY 0.000000 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 06500 RESPI RATORY THERAPY 0.000000 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 06900 ELECTROCARDI OLOGY 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	51.00 05100 RECOVERY ROOM	0. 000000			51.00
53.01 05301 PAIN MANAGEMENT 0.000000 55.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05601 CARDI AC CATH LAB 0.000000 56.01 06500 CARDIA C CATH LAB 0.000000 56.01 06500 RADIA C CATH LAB 0.000000 65.00 06500 RADIA C CATH LAB 0.000000 065.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 RESPI RATORY THERAPY 0.000000 067.00 06700 0CCUPATI ONAL THERAPY 0.000000 067.00 06700 0CCUPATI ONAL THERAPY 0.000000 06900 ELECTROCARDI OLOGY 0.000000 0.000000 0.00000 0.00000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY_DI AGNOSTIC 0. 000000 55. 00 05500 RADI OLOGY_THERAPEUTIC 0. 000000 55. 00 05600 RADI OLOGY_THERAPEUTIC 0. 000000 55. 01 05601 CARDI AC CATH LAB 0. 000000 56. 01 05601 CARDI AC CATH LAB 0. 000000 65. 01 05601 CARDI AC CATH LAB 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 66. 00 06500 RESPI RATORY THERAPY 0. 000000 66. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 06800 SPEECH PATHOLOGY 0. 000000 67. 00 06900 ELECTROCARDI OLOGY 0. 000000 07. 00	53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 55. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 55. 00 05601 CARDI IAC CATH LAB 0. 000000 56. 00 05601 CARDI IAC CATH LAB 0. 000000 65. 00 05000 RESPIRATORY THERAPY 0. 000000 65. 00 05000 RESPIRATORY THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000 06. 00 06900 06000 DELECTROCARDI OLOGY 0. 000000 069. 00 06900 DELECTROCARDI OLOGY 0. 000000 069. 00 06900 DELECTROCARDI OLOGY 0. 000000 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 073. 00 0730	53. 01 05301 PAI N MANAGEMENT	0. 000000			53. 01
56. 00 05600 RADI OI SOTOPE 0.000000 56. 01 05601 CARDI AC CATH LAB 0.000000 56. 01 05601 CARDI AC CATH LAB 0.000000 66. 00 06.	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
56. 01 05601 CARDI AC CATH LAB 0.000000 0.000000 0.00000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
60. 00 06000 LABORATORY 0. 000000 65. 00 65. 00 66. 00	56. 00 05600 RADI 0I SOTOPE	0. 000000			56.00
60. 00 06000 LABORATORY 0. 000000 65. 00 65. 00 66. 00	56. 01 05601 CARDI AC CATH LAB	0. 000000			56. 01
66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 00TPATIENT SERVICE COST CENTERS 0. 000000 90. 01 90. 01 09001 CLI NI C 0. 000000 90. 01 90. 02 09002 WOUND CLI NI C 0. 000000 90. 01 90. 03 09003 MOBI LE CLI NI C 0. 000000 90. 02 90. 03 09003 MOBI LE CLI NI C 0. 000000 90. 03 91. 00 09100 EMERGENCY 0. 000000 91. 00 92. 00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 91. 00 0THER REI MBURSABLE COST CENTERS 100. 00 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 113. 00 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00		0. 000000			60.00
66. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 001794TIENT SERVICE COST CENTERS 0.000000 73. 00 90. 01 09001 CLI NI C 0.000000 90. 01 90. 02 09002 WOUND CLI NI C 0.000000 90. 01 90. 03 09003 MOBI LE CLI NI C 0.000000 90. 02 90. 03 09003 MOBI LE CLI NI C 0.000000 90. 02 91. 00 09000 EMERGENCY 0.000000 91. 00 92. 00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92. 00 91. 00 010000 L&R SERVI CES-NOT APPRVD PRGM 100. 00 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 113. 00 116. 00 11600 HOSPI CE Subtotal (see instructions) 200. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
67. 00	ł 1				66. 00
68. 00	· · · · · · · · · · · · · · · · · · ·				
69. 00					
72. 00					69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 090.01 09001 CLINIC 0.000000 090.01 09001 CLINIC 0.000000 090.01 090.01 090.02 09002 WOUND CLINIC 0.000000 090.02 090.03 MOBILE CLINIC 0.000000 091.00 EMERGENCY 0.000000 091.00 09100 EMERGENCY 0.000000 092.00 095ERVATION BEDS (NON-DISTINCT PART) 0.000000 092.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 092.00 092	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 090.01 09001 CLINIC 0.000000 090.01 09001 CLINIC 0.000000 090.01 090.01 090.02 09002 WOUND CLINIC 0.000000 090.02 090.03 MOBILE CLINIC 0.000000 091.00 EMERGENCY 0.000000 091.00 09100 EMERGENCY 0.000000 092.00 095ERVATION BEDS (NON-DISTINCT PART) 0.000000 092.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 092.00 092	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
90. 00 09000 CLINI C 0.000000 90. 01 90. 01 90. 01 90. 01 90. 02 90. 02 90. 02 90. 02 90. 03 90. 03 90. 03 90. 05 90. 05 90. 00 90. 03 90. 00 9					
90. 02 09002 WOUND CLINIC 0.000000 90. 03 90. 03 09003 MOBILE CLINIC 0.000000 90. 03 91. 00 9100 EMERGENCY 0.000000 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 000000 000000 000000 000000		0. 000000			90.00
90. 03 09003 MOBILE CLINIC 0.000000 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 92. 00 000000 0THER REIMBURSABLE COST CENTERS 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 1000 HOSPI CE 116. 00 1000 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 201. 00	90. 01 09001 CLI NI C	0. 000000			90. 01
90. 03 09003 MOBILE CLINIC 0.000000 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 92. 00 OTHER REIMBURSABLE COST CENTERS 100. 00 10000 I&R SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 116. 00 116. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	90. 02 09002 WOUND CLINIC	0. 000000			90. 02
91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	90. 03 09003 MOBI LE CLINIC				90. 03
OTHER REIMBURSABLE COST CENTERS 100. 00 10000 1 &R SERVI CES-NOT APPRVD PRGM 100. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	91. 00 09100 EMERGENCY				
100. 00 10000 1 &R SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	100.00 10000 I &R SERVICES-NOT APPRVD PRGM				100. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
113. 00					
116. 00 116.00 200. 00 Subtotal (see instructions) 201. 00 Less Observation Beds					113. 00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
201.00 Less Observation Beds 201.00					
202,001 10141 355 1131 4013 1202,00	202.00 Total (see instructions)				202. 00

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lieu of Form CMS-25		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	Provi der		Peri od:	Worksheet D		
				From 01/01/2014		narad.
				To 12/31/2014	Date/Time Prep 5/29/2015 3:1	pared: 7 nm
		Ti tl	e XVIII	Hospi tal	PPS	, p
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	759, 579	0	759, 57	9 20, 109	37. 77	30. 00
31.00 INTENSIVE CARE UNIT	279, 268		279, 26	8 2, 626	106. 35	31.00
43. 00 NURSERY	27, 389		27, 38	9 2, 315	11. 83	43.00
200.00 Total (lines 30-199)	1, 066, 236		1, 066, 23	6 25, 050		200. 00
Cost Center Description	I npati ent	I npati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6, 966	263, 106)			30. 00
31.00 INTENSIVE CARE UNIT	1, 085	115, 390)			31.00
43. 00 NURSERY	0	0)			43.00
200.00 Total (lines 30-199)	8, 051	378, 496				200. 00

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL In Lieu o					2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/29/2015 3:1	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 620, 013	46, 872, 131	0. 03456	2 5, 305, 123	183, 356	50. 00
51.00 05100 RECOVERY ROOM	50, 689	4, 069, 075	0. 01245	7 568, 471	7, 081	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	144, 426	6, 583, 134	0. 02193	9 236	5	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53. 00
53. O1 O53O1 PALN MANAGEMENT	39, 980	1, 477, 299	0. 02706	3 219, 528	5, 941	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 764, 562	98, 374, 523	0. 01793	7 4, 298, 245	77, 098	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	38, 153	925, 675	0. 04121	6 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000	0	0	56. 00
56. 01 05601 CARDI AC CATH LAB	222, 534	14, 428, 954	0. 01542	3 2, 699, 044	41, 627	56. 01
60. 00 06000 LABORATORY	212, 437	34, 552, 385	0. 00614	8 5, 941, 255	36, 527	60.00
65. 00 06500 RESPIRATORY THERAPY	54, 876	7, 405, 206	0. 00741	0 2, 570, 879	19, 050	65. 00
66. 00 06600 PHYSI CAL THERAPY	248, 283	6, 507, 868	0. 03815	1 678, 417	25, 882	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	9, 808	2, 256, 938	0. 00434	6 568, 084	2, 469	67. 00
68. 00 06800 SPEECH PATHOLOGY	6, 124	1, 211, 524	0.00505	5 114, 204	577	68. 00
69. 00 06900 ELECTROCARDI OLOGY	81, 480	4, 196, 874	0. 01941	4 765, 550	14, 862	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	111, 154	11, 226, 588	0.00990	1 5, 930, 294	58, 716	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	96, 322	16, 621, 156	0.00579	5 4, 225, 107	24, 484	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	389, 183	147, 681, 419	0. 00263	5 13, 226, 472	34, 852	73. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	39, 624	1, 291, 996	0. 03066	9 0	0	90.00
90. 01 09001 CLI NI C	0	0	0. 00000	0 0	0	90. 01
90. 02 09002 WOUND CLINIC	209, 810	4, 650, 541	0. 04511	5 0	0	90. 02
90. 03 09003 MOBILE CLINIC	1, 256		0.00000	0 0	0	90. 03
91. 00 09100 EMERGENCY	324, 741	22, 968, 782	0. 01413	8 1, 805, 559	25, 527	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	100, 702	11, 168, 134	0. 00901		0	92.00
200.00 Total (lines 50-199)	5, 766, 157			48, 916, 468	558, 054	200. 00

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Period: From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/29/2015 3:1	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0	0	30. 00
31.00 03100 NTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	20, 109	0.00	6, 96	6 0	4	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 626		1, 08	5 0	4	31. 00
43. 00 04300 NURSERY	2, 315	0.00	1	0		43. 00
200.00 Total (lines 30-199)	25, 050		8, 05	1 0	,	200. 00

Health Financial Systems	IU HEALTH GOSHEN I	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150026	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2014	Part IV

THROUGH COSTS						art IV ate/Time Prep	ared:
						/29/2015 3:17	
			Title XVIII		oi tal	PPS	
Cost Center Description	Non Phy	ysician Nursing	School Allied	Health All	Other -	Total Cost	
		netist				um of col 1	
	Со	st		Educat	ion Cost th	nrough col.	
						4)	
	1.	00 2.0	00 3.	00 4	1. 00	5. 00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM		0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM		0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR RO	OM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0	0	0	0	0	53.00
53.01 O5301 PALN MANAGEMENT		0	0	0	0	0	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	0	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0	0	0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE		0	0	0	0	0	56.00
56. 01 05601 CARDI AC CATH LAB		0	0	0	0	0	56. 01
60. 00 06000 LABORATORY		0	0	0	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY		0	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0	0	0	O	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENTS	o	0	0	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PA	TI ENTS	o	0	0	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENT	S	o	0	0	o	0	73.00
OUTPATIENT SERVICE COST CENTER	RS .		<u> </u>				
90. 00 09000 CLI NI C		0	0	0	0	0	90.00
90. 01 09001 CLI NI C		o	o	0	o	0	90. 01
90. 02 09002 WOUND CLINIC		o	o	0	o	0	90. 02
90. 03 09003 MOBILE CLINIC		o	o	0	o	0	90. 03
91. 00 09100 EMERGENCY		o	O	254, 214	ol	254, 214	91.00
92. 00 09200 OBSERVATION BEDS (NON-DI	STINCT PART)	o	O	0	o	0	92.00
200.00 Total (lines 50-199)		o	o	254, 214	o	254, 214	200. 00

Heal th Financial	Systems		IUI	HEALTH	GOSHEN I	HOSPI TAL			In Lie	u of Form CMS-2552-10
APPORTIONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER	PASS	Provi der	CCN:	150026	From 01/01/2014	Worksheet D Part IV Date/Time Prepared:

THROUGH COSTS	VIOL OTHER TASK	riovidei		From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/29/2015 3:1	
	1		le XVIII	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		I npati ent	
		(from Wkst. C		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col . 2, 3 and	8)	7)	(col . 6 ÷ col .		
	4) 6. 00	7. 00	8. 00	7) 9. 00	10.00	
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
50. 00 05000 OPERATING ROOM		46, 872, 13	0.00000	0. 000000	5, 305, 123	50.00
51. 00 05100 RECOVERY ROOM	0	4, 069, 07	1		568, 471	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 583, 13	1		236	
53. 00 05300 ANESTHESI OLOGY	0	0, 303, 13	0.0000		230	53. 00
53. 01 05301 PAI N MANAGEMENT	0	1, 477, 29	1		219, 528	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	98, 374, 52	1		4, 298, 245	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	925, 67	•		4, 270, 243 N	55. 00
56. 00 05600 RADI OI SOTOPE	0	723, 07	0. 00000		0	56.00
56. 01 05601 CARDI AC CATH LAB	0	14, 428, 95	1		2, 699, 044	56. 01
60. 00 06000 LABORATORY	0	34, 552, 38	1		5, 941, 255	
65. 00 06500 RESPIRATORY THERAPY	0	7, 405, 20	1		2, 570, 879	
66. 00 06600 PHYSI CAL THERAPY	0	6, 507, 86	1		678, 417	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	2, 256, 93	•		568, 084	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	1, 211, 52	•		114, 204	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	4, 196, 87		0. 000000	765, 550	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 226, 58	1		5, 930, 294	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	16, 621, 15	6 0.00000	0. 000000	4, 225, 107	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	147, 681, 41	9 0.00000	0. 000000	13, 226, 472	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	1, 291, 99	6 0.00000	0.000000	0	90.00
90. 01 09001 CLI NI C	0	(0. 00000	0. 000000	0	90. 01
90. 02 09002 WOUND CLINIC	0	4, 650, 54	0.00000	0. 000000	0	90. 02
90. 03 09003 MOBILE CLINIC	0	(0. 00000		0	90. 03
91. 00 09100 EMERGENCY	254, 214	22, 968, 78	0. 01106	0. 011068	1, 805, 559	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11, 168, 13		0. 000000	0	, 2. 00
200.00 Total (lines 50-199)	254, 214	444, 470, 20	2		48, 916, 468	200. 00

| Period: | Worksheet D | From 01/01/2014 | Part IV | Date/Time Prepared: | 5/29/2015 3:17 pm THROUGH COSTS

					5/29/2015 3:1	7 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	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	6, 701, 423		0		50. 00
51. 00 05100 RECOVERY ROOM	0	815, 291		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	732		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
53. 01 05301 PAI N MANAGEMENT	0	346, 360		0		53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	19, 352, 174		0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0		56. 00
56. 01 05601 CARDI AC CATH LAB	0	2, 414, 841		0		56. 01
60. 00 06000 LABORATORY	0	4, 501, 874		0		60.00
65. 00 06500 RESPIRATORY THERAPY	0	781, 473		0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0		67. 00
68. 00 06800 SPEECH PATHOLOGY	o	1, 892		0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	3, 389, 132		0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	2, 801, 336		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	1, 470, 832		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	39, 068, 899		0		73. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>	· · · · · ·	•	<u>'</u>		
90. 00 09000 CLI NI C	0	753, 968		0		90. 00
90. 01 09001 CLI NI C	o	0		0		90. 01
90. 02 09002 WOUND CLINIC	o	0		0		90. 02
90. 03 09003 MOBI LE CLI NI C	0	0		0		90. 03
91. 00 09100 EMERGENCY	19, 984	2, 849, 925	31, 54	13		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2, 723, 607		o		92.00
200.00 Total (lines 50-199)	19, 984	87, 973, 759	l .	13		200. 00
				1		

Heal th Fina	ncial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150026	Peri od:	Worksheet D	
					From 01/01/2014		
					To 12/31/2014		
			T; +1	e XVIII	Hospi tal	5/29/2015 3: 1 PPS	7 pili
			11 (1	Charges	поѕрітаі	Costs	
	Cost Center Description	Cost to Charge	DDC Doimburgos		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9		Subject To	Subject To		
		1 41 1 7 001.		Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
ANCIL	LLARY SERVICE COST CENTERS						
50. 00 05000	O OPERATING ROOM	0. 306258	6, 701, 423	3	0 0	2, 052, 364	50.00
	O RECOVERY ROOM	0. 247088			0	201, 449	51.00
	O DELIVERY ROOM & LABOR ROOM	0, 441996			0	324	1
	O ANESTHESI OLOGY	0. 000000		1	0	0	53. 00
	1 PAIN MANAGEMENT	0. 610842			0	211, 571	53. 01
	O RADI OLOGY-DI AGNOSTI C	0. 279473	19, 352, 174		0	5, 408, 410	54.00
55. 00 05500	O RADI OLOGY-THERAPEUTI C	0. 601964			0	0	55. 00
56. 00 05600	O RADI OI SOTOPE	0. 000000			0	0	56. 00
56. 01 0560°	1 CARDI AC CATH LAB	0. 186238	2, 414, 841		0	449, 735	56. 01
60.00 06000	O LABORATORY	0. 206264			4 0	928, 575	60.00
65.00 06500	O RESPIRATORY THERAPY	0. 291745	781, 473	3	0	227, 991	65. 00
66.00 06600	O PHYSI CAL THERAPY	0. 617295			0	0	66. 00
67.00 06700	O OCCUPATIONAL THERAPY	0. 357220	l c		0	0	67. 00
	O SPEECH PATHOLOGY	0. 438087	1, 892	2	0	829	68. 00
69. 00 06900	O ELECTROCARDI OLOGY	0. 096844	3, 389, 132	2	0	328, 217	69. 00
71. 00 07100	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 780775	2, 801, 336		0	2, 187, 213	71. 00
72.00 07200	O IMPL. DEV. CHARGED TO PATIENTS	0. 448565	1, 470, 832	2	0	659, 764	72. 00
73. 00 07300	O DRUGS CHARGED TO PATIENTS	0. 217615	39, 068, 899	18	9 89, 123	8, 501, 978	73. 00
	ATIENT SERVICE COST CENTERS						
90.00 09000	O CLI NI C	0. 527849	753, 968	3	0 0	397, 981	90.00
90. 01 0900	1 CLI NI C	0. 000000	C		0 0	0	90. 01
	2 WOUND CLINIC	0. 475159	· C		0	0	90. 02
90. 03 09003	3 MOBILE CLINIC	0. 000000	C		0	0	90. 03
91.00 09100	O EMERGENCY	0. 273945	2, 849, 925	5	0 405	780, 723	91. 00
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 196310	2, 723, 607			534, 671	92. 00
200. 00	Subtotal (see instructions)		87, 973, 759	2, 00	2 89, 528		
201. 00	Less PBP Clinic Lab. Services-Program				0	l	201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)	1	87, 973, 759	2, 00	2 89, 528	22, 871, 795	202. 00

Health Financial Systems		IU HEALTH GOSHEN H	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES A	ND VACCINE COST	Provider CCN: 150026	From 01/01/2014	Worksheet D Part V Date/Time Prepared:

				To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
	Cos	sts				
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANALL ARV OFFICE OF COST OFFITTERS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	,	1			50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0					52. 00
53. 00 05300 ANESTHESI OLOGY	0					53. 00
53. 01 05301 PALN MANAGEMENT	0					53. 01
54. 00 05400 RADI OLOGY -DI AGNOSTI C	0					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0					55. 00 56. 00
56. 01 05601 CARDI AC CATH LAB	0					56. 00
60. 00 06000 LABORATORY	337	_				60.00
65. 00 06500 RESPI RATORY THERAPY	337					65. 00
66. 00 06600 PHYSI CAL THERAPY						66. 00
67. 00 06700 OCCUPATIONAL THERAPY						67. 00
68. 00 06800 SPEECH PATHOLOGY	0					68. 00
69. 00 06900 ELECTROCARDI OLOGY	0					69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	41	19, 395	1			73. 00
OUTPATIENT SERVICE COST CENTERS		177070	1			70.00
90. 00 09000 CLI NI C	0	0				90.00
90. 01 09001 CLI NI C	0	l o	ı			90. 01
90. 02 09002 WOUND CLINIC	0	0	1			90. 02
90. 03 09003 MOBILE CLINIC	0	l c	1			90. 03
91. 00 09100 EMERGENCY	0	111				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	35	0				92. 00
200.00 Subtotal (see instructions)	413	19, 506				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	413	19, 506	,			202. 00

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 01/01/2014	Part V	
				To 12/31/2014	Date/Time Pre	pared:
		T: +	le XIX	Hospi tal	5/29/2015 3:1 Cost	/ pm
		111	Charges	поѕрі таі	Costs	
Cost Center Description	Cost to Charge	DDS Doimburged		Cost	PPS Services	
COST Center Description	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(See Hist.)	
	Part I, col. 9		Subject To	Subject To		
	rait i, coi. 7		Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00 05000 OPERATING ROOM	0. 306258	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 247088	l .		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 441996			0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0	Ö	53.00
53. 01 05301 PALN MANAGEMENT	0. 610842	١		0	Ö	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 279473	١			Ö	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 601964				0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	l .			0	56.00
56. 01 05601 CARDI AC CATH LAB	0. 186238	l e			0	56. 01
60. 00 06000 LABORATORY	0. 206264	0			0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 291745				0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 617295	l e		0	Ö	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 357220	l e		0	Ö	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 438087				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 096844	٥		0	Ö	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 780775			0	Ö	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 448565	l e		0	Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 217615	l e		0 0	Ö	73. 00
OUTPATIENT SERVICE COST CENTERS	0.217010			<u> </u>		70.00
90. 00 09000 CLINIC	0. 527849	0		0 0	0	90.00
90. 01 09001 CLI NI C	0. 000000			0	_	90. 01
90. 02 09002 WOUND CLINIC	0. 475159			0	Ō	90. 02
90. 03 09003 MOBILE CLINIC	0. 000000	l e		0	0	90. 03
91. 00 09100 EMERGENCY	0. 273945	l e		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 196310			0	0	92.00
200.00 Subtotal (see instructions)		ا		0 0	_	200.00
201.00 Less PBP Clinic Lab. Services-Program]		o o		201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202. 00

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der	CCN: 150026	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/29/2015 3:1	
		Ti t	le XIX	Hospi tal	Cost	
	Co	sts				
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.)				
	/ 00	7.00	1			i .

		00.	515	4	
	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		
	NCILLARY SERVICE COST CENTERS		1		4
	5000 OPERATING ROOM	0	0		50. 00
	5100 RECOVERY ROOM	0	0		51. 00
	5200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
	5300 ANESTHESI OLOGY	0	0		53. 00
	5301 PAIN MANAGEMENT	0	0		53. 01
	5400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
	5500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
	5600 RADI OI SOTOPE	0	0		56. 00
	5601 CARDI AC CATH LAB	0	0		56. 01
	6000 LABORATORY	0	0		60. 00
	6500 RESPI RATORY THERAPY	0	0		65. 00
	6600 PHYSI CAL THERAPY	0	0		66. 00
	6700 OCCUPATI ONAL THERAPY	0	0		67. 00
	6800 SPEECH PATHOLOGY	0	0		68. 00
69.00 0	6900 ELECTROCARDI OLOGY	0	0		69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
OI	UTPATIENT SERVICE COST CENTERS				
	9000 CLI NI C	0	0		90.00
	9001 CLI NI C	0	0		90. 01
90. 02 0	9002 WOUND CLINIC	0	0		90. 02
	9003 MOBILE CLINIC	0	0		90. 03
91.00 0	9100 EMERGENCY	0	0		91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	,	92. 00
200.00	Subtotal (see instructions)	0	0	,	200. 00
201.00	Less PBP Clinic Lab. Services-Program	0)		201. 00
	Only Charges				1
202.00	Net Charges (line 200 +/- line 201)	0	0	ı	202. 00

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150026	From 01/01/2014	Worksheet D-1 Date/Time Preps/29/2015 3:1	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			4 00	

		Ti +l o VVIII	Hocni tal	5/29/2015 3:1	7 pm
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	oust deficer beschiption			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS			00.400	4 00
1.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			20, 109 20, 109	1. 00 2. 00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed days	<i>y</i> ,	vate room dave	833	2. 00 3. 00
3.00	do not complete this line.). It you have only pri	vate 100m days,	033	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		16, 610	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December .	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
7.00	reporting period	aayo, tiii oagii boooiiiboi	0. 0. 1 0001	· ·	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	6, 966	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Join days)	· ·	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private r	oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, ent			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar yea			· ·	10.00
14.00	Medically necessary private room days applicable to the Program			0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 of	f the cost	0.00	17. 00
17.00	reporting period	through becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	tne cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost reporti	ng poriod (line	16, 536, 932 0	
22.00	5 x line 17)	31 of the cost reporti	ng perrou (Trie	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reportion	ng period (line	0	24. 00
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)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		16, 536, 932	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	47, 007, 488	28. 00
29. 00	Private room charges (excluding swing-bed charges)		g/	19, 742, 961	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			27, 264, 527	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 351794	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			23, 701. 03	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			1, 641. 45	
34. 00	Average per diem private room charge differential (line 32 minu		tions)	22, 059. 58	
35. 00	Average per diem private room cost differential (line 34 x line	31)		7, 760. 43	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an	d private room cost di	Fforontial (line	6, 464, 438 10, 072, 494	
57.00	27 minus line 36)	a private room cost ar	recentral (IIIIe	10, 072, 494	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i			822.36	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	•		5, 728, 560 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	•		5, 728, 560	
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	/	l	2, .20, 000	

Heal th	Financial Systems	IU HEALTH GOSH	IEN HOSPITAL		In Lie	eu of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1		
					From 01/01/2014 To 12/31/2014	Date/Time Pre		
-			Ti tl	e XVIII	Hospi tal	5/29/2015 3: 1° PPS	/ pm	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.		
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00		
42. 00	NURSERY (title V & XIX only)	0	2.00				42. 00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3, 855, 595	2, 626	1, 468. 2	4 1, 085	1, 593, 040		
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
46. 00	1						46. 00	
	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1.00		
48. 00	Program inpatient ancillary service cost (Wk	ct D 2 col 2	lino 200)			1. 00 16, 234, 559	48. 00	
	Total Program inpatient costs (sum of lines			ons)		23, 556, 159		
	PASS THROUGH COST ADJUSTMENTS	g, (
50.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	378, 496	50. 00	
51. 00	<pre> </pre>	ationt ancillar	v sorvicos (fr	com Wkst D s	um of Darte II	578, 038	51. 00	
51.00	and IV)	atrent anciriar	y services (11	OIII WKSt. D, S	um or Farts II	378,038	31.00	
52.00	Total Program excludable cost (sum of lines					956, 534		
53.00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	22, 599, 625	53. 00	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54. 00	Program di scharges					0	54.00	
55.00	Target amount per discharge					0.00	55. 00	
56. 00	Target amount (line 54 x line 55)				50)	0		
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	ine 56 minus	11 ne 53)	0		
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	updated and co	mpounded by the			
	market basket							
60.00	Lesser of lines 53/54 or 55 from prior year				the amount by	0.00		
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00	
	amount (line 56), otherwise enter zero (see							
	2.00 Relief payment (see instructions)							
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00		ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00	
	instructions) (title XVIII only)	S		·				
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	l only). For	0	66. 00	
	CAH (see instructions)							
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	porting period	0	67. 00	
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00	
00.00	(line 13 x line 20)	0 00010 4.10. 0	0.00	3551 . 565	. cring por rou		00.00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil					I	70.00	
71.00	Adjusted general inpatient routine service c	-					71.00	
72.00	Program routine service cost (line 9 x line	71)		ŕ			72. 00	
73.00	Medically necessary private room cost applic						73.00	
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II column		74. 00 75. 00	
73.00	26, line 45)	routine service	COSTS (TIOIII V	ioi käneet b, T	art II, corumii		73.00	
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00	
77. 00	Program capital -related costs (line 9 x line	,					77. 00	
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi den record	ds)			78. 00 79. 00	
	Total Program routine service costs for comp				us line 79)		80.00	
81. 00	Inpatient routine service cost per diem limi						81.00	
82.00	Inpatient routine service cost limitation (I		* .				82.00	
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00	
85. 00	Utilization review - physician compensation		ns)				85. 00	
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00	
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					2 ///	07.00	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			2, 666 822. 36		
	Observation bed cost (line 87 x line 88) (se	•				2, 192, 412		
		•					•	

Health Financial Systems	IU HEALTH GOSI	HEN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
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	759, 579	16, 536, 932	0. 04593	2, 192, 412	100, 702	90.00
91.00 Nursing School cost	0	16, 536, 932	0.00000	2, 192, 412	0	91.00
92.00 Allied health cost	0	16, 536, 932	0.00000	2, 192, 412	0	92.00
93.00 All other Medical Education	0	16, 536, 932	0.00000	2, 192, 412	0	93. 00

Health Financial Systems	IU HEALTH GOSHEN H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150026	Peri od: From 01/01/2014	Worksheet D-1	
				Date/Time Prep 5/29/2015 3:1	
		Title XIX	Hospi tal	Cost	
Cost Center Description					
·				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room da	ys and swing-bed days,	excluding newborn)		20, 109	1.00
2 00 I posti ont days (i poludi na pri vata room da	un avaludina awina ba	ا معمل ممسلموسم مامیرم		20 100	2 00

PART I. ALL PROVIDER CONCENDENTS Next Let No Description		IITIE XIX HOSPITAI	Cost	
IRBATILE ILMS IRBATILE ILM		Cost Center Description	1 00	
Impatient days (including private room days and seing-bed days, excluding newborn)		PART I - ALL PROVIDER COMPONENTS	1.00	
Inpatient days (including private room days, excluding swing-bed and newborn days) 20,109 20,009				
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 8,333 3.00				
do not complete this line. 4. 00 Semi-private room days (sectualing swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7. 00 Iotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 8. 00 Iotal swing-bed Nr type inpatient days (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 9. 00 Iotal swing-bed Nr type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and noxidor days) 10. 00 Swing-bed SNF type inpatient days applicable to the swing-bed in the swing-bed swing-bed swing-bed swing-bed SNF type inpatient days applicable to the swing-bed swing-bed swing-bed swing-bed SNF type inpatient days applicable to the swing-bed swing-bed SNF type inpatient days applicable to the swing-bed SNF type inpatient days applicable to swing-bed SNF type inpatient days app				
Semi-private room days (excluding swing-bed and observation bed days) Total sing-bed SRF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 10. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 11. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12. 00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 14. 00 Nover and the private room days applicable to services after December 31 of the cost reporting period (including private room days) 15. 00 Nover and the private room da	3.00		0, 333	3.00
reporting period (1º calendar year, enter 0 on this line) 7.00 Total swing-bed SWT type inpatient days (including private room days) after December 31 of the cost 1 period (1º calendar year, enter 0 on this line) 8.00 7.00 Total swing-bed Nr type inpatient days (including private room days) through December 31 of the cost 1 period (1º calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost 1 period (1º calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost 1 period (1º calendar year, enter 0 on this line) 9.00 Swing-bed SWT type inpatient days applicable to the Program (excluding private room days) 11.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWT period (1º calendar year, enter 0 on this line) 13.00 Swing-bed Nr type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (1º calendar year, enter 0 on this line) 14.00 Modically nocessary private room days applicable to title XVIII only (including private room days) 2.0 14.00 Swing-bed Mr type inpatient days applicable to title XVIII only (including private room days) 3.0 14.00 Swing-bed Mr type inpatient days applicable to title XVIII only (including private room days) 3.0 14.00 Swing-bed Wr type protect on days applicable to services through December 31 of the cost reporting period (1º calendar year, enter 0 on this line) 4.0 Modically nocessary private room days applicable to services through December 31 of the cost reporting period (1º calendar year, enter 0 on this line	4.00	· ·	9, 110	4. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 7.	5.00		0	5. 00
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swin, bed M Trype Inpatient days (Including private room days) through December 31 of the cost 1 on 1,00 Total Inpatient days (Including private room days) after December 31 of the cost 1 on 1,171 on 1,00 Total Inpatient days Including private room days) after December 31 of the cost 1 on 1,171 on 1,00 Mills of 1,00 Mills				4 00
7.00 Total sain_bed MF type inpatient days (including private room days) through December 31 of the cost proporting period (if calendar year, enter 0 on this line) 10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1.1717 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1.1717 9.00 Swing-bed SNF type larght ent days applicable to 1 tile XVIII only (including private room days) 10.00 Through December 31 of the cost reporting period (see Instructions) 10.00 Swing-bed SNF type inpatient days applicable to 1 tile XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed MF type inpatient days applicable to tiles V or XIX only (including private room days) 12.00 Swing-bed MF type inpatient days applicable to tiles V or XIX only (including private room days) 12.00 Swing-bed MF type inpatient days applicable to tiles V or XIX only (including private room days) 13.00 Swing-bed MF type inpatient days applicable to the Program (excluding swing-bed days) 14.00 Swing-bed MF type inpatient days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Swing-bed MF type inpatient days applicable to services through December 31 of the cost 10.00 Program (excluding swing-bed days) 17.00 Program (excluding excluding swing-bed excluding swing-bed excluding excluding excluding excluding excluding excluding	0.00		٥	0.00
10 Total swing-bed NF type inpatient days (including private room days) arter December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.777 9.00 1.777 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 1.779 9.00 9.0	7.00		0	7. 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 newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 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 through December 31 of the cost reporting period on this line) 12.00 Swing-bed SNF type inpatient days applicable to title X or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title X or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title X or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title X or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title X or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nedically necessary private room days applicable to services through December 31 of the cost 17.00 New SNM SED AUDISTRIENT 17.00 Necessary days (title V or XIX only) 17.00 Necessary days (title	0.00			0.00
1.171 1.00	8.00		U	8.00
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through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Bedical in precessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 15.00 Total nursery days (title V or XIX only) 16.00 Nedical room of the voice of		, , , , , , , , , , , , , , , , , , ,	_	
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery day	10. 00		0	10.00
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through December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Novery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to the Program (excluding swing-bed days) 18.00 Mind GBED ADJUSTMENT 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost oreporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost oreporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost oreporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost oreporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Total swing-bed cost (see instructions) 29.00 Total swing-bed cost (see instructions) 29		December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 0 13.00	12. 00		0	12. 00
after December'31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 15.00 10.01 10	13 00		0	13 00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00	10.00			10.00
16.00 Nursery days (title V or XIX only) SIMD RED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (local drate for swing-bed SNF services applicable to services after December 31 of the cost (local drate for swing-bed SNF services applicable to services after December 31 of the cost (local drate for swing-bed SNF services applicable to services after December 31 of the cost (local drate for swing-bed NF services applicable to services after December 31 of the cost (local drate for swing-bed NF services applicable to services after December 31 of the cost (local drate for swing-bed NF services applicable to services after December 31 of the cost (local drate for swing-bed SNF type services after December 31 of the cost reporting period (local drate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line (local drate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line (local drate) (line (li		Medically necessary private room days applicable to the Program (excluding swing-bed days)	- 1	
SWING BED ADJUSTNENT 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18. 00 reporting period 19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19. 00 reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20. 00 reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29. 00 Private room charges (excluding swing-bed charges) 20. 00 Private room charges (excluding swing-bed charges) 21. 26. 44. 80 22. 40. 62. 40 23. 40. 63. 40 24. 40. 64. 60 25. 40. 60 26. 60 27. 40. 60 28. 60 29.				
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost periting period 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00	10.00		374	16.00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 19.	17. 00		0.00	17. 00
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28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 47,007,448 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 536, 932) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 47,007,448 29.00 29.00 27,264,487 30.00 27,369,25 32.00 32,369,25 32.00 33.00 34.00 35.00 Average private room per diem charge (line 27 ÷ line 28) 36.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0 .00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0 .00 35.00 36.00 37.00 General inpatient routine service cost per diem (see instructions) 822.36 38.00 39.00 Average per diem private room cost applicable to the Program (line 14 x line 35)	27. 00		16, 536, 932	27. 00
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 822.36 38.00 902.984 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
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	39. 00	Program general inpatient routine service cost (line 9 x line 38)	962, 984	39. 00
41.00 Iotal Program general inpatient routine service cost (line 39 + line 40) 962,984 41.00				
	41. 00		962, 984	41.00

	Financial Systems	IU HEALTH GOSE				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
					To 12/31/2014	Date/Time Pre 5/29/2015 3:1	pared:
			Ti t	le XIX	Hospi tal	Cost	7 piii
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		Impatrent cost	liipatient bays	col. 2)	.	4)	
40.00	NUDGEDY (1) II WA WAY IN	1.00	2.00	3.00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	558, 071	2, 315	241.0	7 374	90, 160	42.00
43. 00	INTENSIVE CARE UNIT	3, 855, 595	2, 626	1, 468. 2	4 O	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46.00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			2, 321, 524	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ons)		3, 374, 668	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	n Wkst D sum	of Parts I and	0	50.00
30.00						Ĭ	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	sician anesth	etist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54. 00
	Target amount per discharge					l e	55. 00
56. 00 57. 00	, ,	ing cost and ta	rget amount (1	ine 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	rng cost and ta	inger amount (i	THE 30 III HUS	11116 33)	Ö	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, เ	pdated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of		0	1
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	na period (See	0	64. 00
	instructions)(title XVIII only)	Ü		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decemb	er 31 of the c	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through	Docombon 21 o	of the cost re	parting pariod	0	67. 00
67.00	(line 12 x line 19)	e costs till ough	i beceiliber 31 c	or the cost re	boiling period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting 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	URSING FACILITY	, AND ICF/MR C	NLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
72. 00			THE 70 + TIME	2)			72.00
73. 00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II column		74. 00 75. 00
70.00	26, line 45)	routine service		ior Rondoc D, Tr	art II, corumi		70.00
76. 00	Per diem capital related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79. 00
	Total Program routine service costs for comp		cost limitation	ı (line 78 min	us line 79)		80. 00 81. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81.00
83. 00	Reasonable inpatient routine service costs (see instruction	* .				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in		une)				84. 00 85. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	J /				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			2, 666 822 36	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•				2, 192, 412	1
	,	,				•	•

Health Financial Systems	IU HEALTH GOSI	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/29/2015 3:1	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	759, 579	16, 536, 932	0. 04593	2, 192, 412	100, 702	90.00
91.00 Nursing School cost	0	16, 536, 932	0.00000	0 2, 192, 412	0	91.00
92.00 Allied health cost	0	16, 536, 932	0.00000	0 2, 192, 412	0	92.00
93.00 All other Medical Education	0	16, 536, 932	0.00000	0 2, 192, 412	0	93.00

llool th	Financial Cystems	III UEALTU COCUEN HOCDITAL		la lia	u of Form CMC	2552 10
	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	IU HEALTH GOSHEN HOSPITAL Provi der	CCN: 150026	Peri od: From 01/01/2014 To 12/31/2014	worksheet D-3 Date/Time Pre 5/29/2015 3:1	pared:
		Ti tl	e XVIII	Hospi tal	PPS	7 piii
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				0.00	
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNIT 04300 NURSERY			14, 898, 035 5, 093, 530		30. 00 31. 00 43. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM		0. 3062 0. 2470		1, 624, 736 140, 462	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 4419	·	· ·	1
53. 00	05300 ANESTHESI OLOGY		0.0000		l .	1
53. 01	05301 PAI N MANAGEMENT		0. 6219			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2811			
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 6019	64 0	0	55. 00
56.00	05600 RADI OI SOTOPE		0.0000	00 0	0	56. 00
56. 01	05601 CARDI AC CATH LAB		0. 1862		502, 665	56. 01
60.00	06000 LABORATORY		0. 2062			
65.00	06500 RESPI RATORY THERAPY		0. 2917			1
66. 00	06600 PHYSI CAL THERAPY		0. 6172			1
67. 00	06700 OCCUPATI ONAL THERAPY		0. 3572	·		1
68.00	06800 SPEECH PATHOLOGY		0. 4380			
69. 00 71. 00	06900 ELECTROCARDI OLOGY		0.0968	·		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7807 0. 4485			
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 4465		2, 878, 279	
73.00	OUTPATIENT SERVICE COST CENTERS		0.2170	15 15, 220, 472	2,010,217	73.00
90.00	09000 CLI NI C		0. 5278	49 0	0	90.00
90. 01	09001 CLI NI C		0.0000		0	90. 01
90. 02	09002 WOUND CLINIC		0. 4777	44 0	0	90. 02
90. 03	09003 MOBILE CLINIC		0.0000		0	
91. 00	09100 EMERGENCY		0. 2750			
			0. 1963			
200.00				48, 916, 468	16, 234, 559	
201.00		ogram only charges (line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)		I	48, 916, 468	I	202. 00

Heal th	Financial Systems	J HEALTH GOSHEN HOSPITAL		In lie	eu of Form CMS-	2552_10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150026	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 3:1	
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1. 00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS		1	2, 263, 243		30.00
31. 00	03100 INTENSIVE CARE UNIT			191, 468		31.00
43. 00	04300 NURSERY			128, 925		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS			1207720		1 .0.00
50.00	05000 OPERATI NG ROOM		0. 3062	58 841, 942	257, 851	50.00
51.00	05100 RECOVERY ROOM		0. 2470	88, 735	21, 925	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 4419	96 690, 806	305, 333	52.00
53.00	05300 ANESTHESI OLOGY		0.0000	00 0	0	53.00
53. 01	05301 PAI N MANAGEMENT		0. 6108		0	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2794			
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 6019			
56. 00	05600 RADI OI SOTOPE		0.0000		0	
56. 01	05601 CARDI AC CATH LAB		0. 1862			1
60.00	06000 LABORATORY		0. 2062			
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 2917			1
66. 00 67. 00	06700 OCCUPATIONAL THERAPY		0. 6172 0. 3572			
68. 00	06800 SPEECH PATHOLOGY		0. 3372		20, 936	1
69. 00	06900 ELECTROCARDI OLOGY		0. 0968			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7807			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4485			1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 2176			
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0. 5278	49 0	0	90.00
90. 01	09001 CLI NI C		0.0000	00	0	90. 01
	09002 WOUND CLINIC		0. 4751		0	
90. 03	09003 MOBILE CLINIC		0.0000		0	
91.00	09100 EMERGENCY		0. 2739			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1963		0	
200.00				7, 460, 953	2, 321, 524	
201.00	, ,	am only charges (line 61)		7 440 053		201. 00
202. 00			I	7, 460, 953	I	202. 00

			Т	o 12/31/2014	Date/Time Pre 5/29/2015 3:1	
		Ti tl	e XVIII	Hospi tal	PPS	7 piii
			0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2. 00	
1.00	DRG Amounts Other than Outlier Payments			0		1. 00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior		11, 115, 355		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		3, 705, 118		1. 02
1.02	after October 1 (see instructions)	9 011 01		0, 700, 110		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1. 04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
1.04	discharges occurring on or after October 1 (see instructions)					1.04
2.00	Outlier payments for discharges. (see instructions)			719, 939		2. 00
2. 01	Outlier reconciliation amount	,		0		2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructio Managed Care Simulated Payments	ns)		0		2. 02 3. 00
4. 00	Bed days available divided by number of days in the cost report	i ng		114. 56		4. 00
	peri od (see i nstructi ons)					
F 00	Indirect Medical Education Adjustment			0.00		- 00
5.00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instr			0.00		5. 00
6.00	FTE count for allopathic and osteopathic programs which meet th			0.00		6.00
	criteria for an add-on to the cap for new programs in accordance	e with 42				
7. 00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un	dor 12		0.00		7. 00
7.00	CFR §412. 105(f)(1)(iv)(B)(1)	uei 42		0.00		7.00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7. 01
	CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July	1, 2011				
8. 00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8. 00
0.00	osteopathic programs for affiliated programs in accordance with			0.00		0.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67	FR 50069				
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s undor		0.00		8. 01
0.01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.01
	instructions.	011, 000				
8. 02	The amount of increase if the hospital was awarded FTE cap slot			0.00		8. 02
9. 00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
7. 00	and 8,02) (see instructions)	(0, 0,01		0.00		7.00
10. 00	FTE count for allopathic and osteopathic programs in the curren	t year		0.00		10.00
11. 00	from your records FTE count for residents in dental and podiatric programs.			0.00		11. 00
	Current year allowable FTE (see instructions)			0.00		12.00
13.00	Total allowable FTE count for the prior year.			0.00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
15. 00	or after September 30, 1997, otherwise enter zero. Sum of Lines 12 through 14 divided by 3.			0.00		15. 00
16. 00	Adjustment for residents in initial years of the program			0.00		16.00
17. 00	Adjusment for residents displaced by program or hospital closur	е		0.00		17. 00
18. 00	Adjusted rolling average FTE count			0.00		18. 00
	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000		19. 00 20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000		21. 00
	IME payment adjustment (see instructions)			0		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0		22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		he MMA	0.00		23. 00
23.00	slots under 42 Sec. 412.105 $(f)(1)(iv)(C)$.	т сар		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo	wer of		0.00		25. 00
26. 00	line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
	IME payments adjustment factor. (see instructions)			0. 000000		27. 00
	IME add-on adjustment amount (see instructions)			o		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 00 29. 01
۷. ۵۱	Di sproporti onate Share Adjustment		1	, O		1 2 / . 0 1
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	i ent days		1. 63		30. 00
21 00	(see instructions)			10.04		21 00
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			18. 94 20. 57		31. 00 32. 00
	Allowable disproportionate share percentage (see instructions)			6. 19		33. 00
	Di sproporti onate share adjustment (see instructions)			229, 347		34.00

Qualify for adjustment	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prep	
			Title XVIII	Hospi tal		/ piii
Discomposited Care Adjustment See Instructions S. De See			,tig xviii			
Incomposated Carra Adjustment						
2.00 3.00 Total uncompressed care securit (see instructions) 2.04 (3.80 148) 7 (.47 0.44 885) 35.00 Total of a Cee instruction payagener (if Files 44 is zero,			0	1. 00	2. 00	
3.0.0	25 00			0.04/ 200 142	7 (47 (44 005	25 00
Section Sect		,				
### Uniform Zerro on this Line) (see instructions) ### Add to compare the compare of the hospital uncompensated care payment ### Add to compare the compare of the compare		1				
35.03 Pro rate share of the hospital uncoepensated care payment 909, 609 240,817 35.03	00.02			1, 552,	7007 110	00.02
Total uncorporated care (sum of column 1 and 2 on line S.0.00	35. 03	Pro rata share of the hospital uncompensated care payment		809, 609	240, 817	35. 03
35.03)						
Additional payment for high percentage of ESBD beneficiary of scharges (Lines 40 through 46) 40 00 Total Wedicare discharges on Worksheet S-3, Part I. 41 00 41 00 42 00 43 00 44 00	36.00			1, 050, 426		36.00
10 10 10 10 10 10 10 10			scharges (lines 40 throug	h 46)		
excluding discharges for MS-IRGs 652, 682, 683, 684 and 685	40.00		sonal gos (Timos To timoag	0		40. 00
1.00 10 10 10 10 10 10 1		excluding discharges for MS-DRGs 652, 682, 683, 684 and				
62, 683, 684 an 685. (see instructions)		l '				
1.0 Total ENRO Medicare covered and paid discharges excluding NS-DRSS 652, 602, 603, 604 an 608, 50e instructions) 0.00 42.0	41.00			0		41.00
MS-DRGS 652, 692, 693, 694 an 695. (see Instructions) 42,00 24,0	41 01			0		41 01
quality for adjustment						
43.00 Total Medicare ESRD inpatient days excluding MS-PRGs 652, 682, 683, 684 and 685, (see instructions) 43.00	42.00			0.00		42. 00
682, 683, 684 an 685. (see instructions) 44.00 4	40.00					40.00
44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 1 for 41 di	43.00			٩		43.00
divided by line at divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions) 46.00 Total additional payment (line 45 times line 44 times line 41.01) 47.00 Average weekly cost for dialysis treatments (see instructions) 48.00 Total additional payment (line 45 times line 44 times line 41.01) 47.00 Average weekly cost for dialysis treatments (see instructions) 48.00 Average weekly cost for dialysis treatments (see instructions) 48.00 Average weekly cost for dialysis treatments (see instructions) 48.00 Average weekly cost for dialysis treatments (see instructions) 48.00 Average weekly cost for dialysis treatments (see instructions) 49.00 Total payment for instructions) 49.00 Average weekly cost for see instructions) 40.00 Average weekl for see instructions) 40.00 Average weekl for see instructions)	44 00			0 000000		44 00
instructions						
46.00 Total additional payment (line 45 times line 44 times line 41.101)	45.00			0.00		45. 00
41.01 1.00	47.00					47.00
47.00 Subtotal (see instructions) 48.00 Mobil small rural hospitals only (see instructions) 48.00 Mobil small rural hospitals only (see instructions) 48.00 49.00 Total payment for inpatient operating costs (see instructions) 49.00 Total payment for inpatient operating costs (see instructions) 1.,258,449 50.00 Payment for inpatient program capital (from Wkst. L, Pt. II and Pt. II. as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, Pt. III., see instructions) 52.00 Direct graduate medical education payment (from Wkst. E-4, III. see instructions) 52.00 Direct graduate medical education payment (from Wkst. E-4, III. see instructions) 53.00 Special advoice payment for inpatient program capital (Wkst. D. Pt. III. see instructions) 53.00 Special advoice payment for inpatient program capital (Wkst. D. Pt. III. see instructions) 54.00 55.00 Special advoice payment for inpatient for new technologies 54.00 55.	46. 00			0		46. 00
48.00	47 00	· ·		16 820 185		47 00
49.00 Total payment for inpatient operating costs (see 16,820,185 49.00 1.50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II., as applicable) 5.0.00 Exception payment for inpatient program capital (Wkst. L, Pt. II.) 5.0.00 5.0.0				0		48. 00
instructions						
50.00 Payment for inpatient program capital (From Wkst. L, Pt. I and Pt. II. as applicable) 50.00 51.00 51.00 52.00 51.00 52.00 51.00 52.0	49. 00			16, 820, 185		49. 00
and Pt. II, as applicable	EO 00			1 250 440		EO 00
51.00 Exception payment for inpatient program capital (Wkst. L, P. P. III, see instructions) 52.00 Pr. III, see instructions) 52.00 52.00 52.00 52.00 52.00 53.00 54.00 55.00	50.00			1, 258, 449		50.00
Pt. 111, see instructions 52.00 5	51.00			0		51. 00
Iline 49'see instructions).						
53.00 Nursing and Allied Health Managed Care payment 54.00 55.00 54.00 55.00 54.00 55.00 Net organ acquisition cost (Wkst. D. 4 Pt. III., col. 1, line 69) 55.00 Net organ acquisition cost (Wkst. D. 4 Pt. III., col. 1, line 69) 55.00 Secondary of the contractions 55.00 Secondary of the contractio	52. 00			0		52. 00
54.00 Special add-on payments for new technologies 0 54.00 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, III	E2 00					F2 00
55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 55.00 1 10 69) 56.00 56.00 56.00 56.00 56.00 56.00 57.				0		
56.00 Cost of physicians' services in a teaching hospital (see intructions) 0 56.00 56.00 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 0 75.00 19,984 58.00 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 19,984 58.00 59.00 Total (sum of amounts on lines 49 through 58) 18,098,618 59.00 60.00 Primary payer payments 5,000 60.00 61.00 Total amount payable for program beneficiaries 18,098,618 61.00 62.00 Deductibles billed to program beneficiaries 1,780,960 62.00 63.00 Coinsurance billed to program beneficiaries 0 63.00 64.00 Allowable bad debts (see instructions) -10,642 64.00 65.00 Allowable bad debts for dual eligible beneficiaries (see instructions) -6,917 65.00 66.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGS (see instructions) 0 68.00 69.00 Officer Sch see instructions) 0 69.00 <td< td=""><td></td><td></td><td></td><td>0</td><td></td><td>55. 00</td></td<>				0		55. 00
Intructions S7.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). S7.00 Pt. III, column 9, lines 30 through 35). S8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) S8.00 Total (sum of amounts on lines 49 through 58) S8.00 Total (sum of amounts on lines 49 through 58) S9.00 G0.00 G0.		line 69)				
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	70. 95	kecovery of accelerated depreciation		0		70. 95

	Financial Systems IU HEALTH GOS	HEN H				eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150026	F	eriod: rom 01/01/2014 o 12/31/2014		pared: 7 pm
		_	Title XVIII		Hospi tal	PPS	
					Prior to	On/After	
					October 1	October 1	
			0		1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)			0	0		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)			0	0		70. 97
70. 98	Low Volume Payment-3	İ			0		70. 98
70. 99	HAC adjustment amount (see instructions)	İ			0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)				16, 247, 514		71. 00
71. 01	Sequestration adjustment (see instructions)				324, 950		71. 01
72.00	Interim payments				15, 966, 890		72. 00
73.00	Tentative settlement (for contractor use only)				0		73.00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)				-44, 326		74. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				766, 948		75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				1	1	
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see				0		90. 00
	instructions)						
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)				0		92.00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)				0		93. 00
94. 00	The rate used to calculate the time value of money (see instructions)				0.00		94. 00
95. 00	Time value of money for operating expenses (see instructions)				0		95. 00
96. 00	Time value of money for capital related expenses (see instructions)				0		96. 00
						0- /15 10 /1	

[Instructions]			
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100.00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0	0	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 00

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150026 Period: From 01/01/2014 To 12/31/2014 To 12/31/2014 From 01/01/2014 To 12/31/2014 To 12/31/2014 From 01/01/2014 To 12/31/2014 Health Financial Systems	IU HEALTH GOSHEN HOS	SPITAL	In Lie	u of Form CMS-2552-10	
	CALCULATION OF REIMBURSEMENT SETTLEMENT	F	Provi der CCN: 150026	From 01/01/2014	Part B Date/Time Prepared:

PAPE B - NSDICAL AND DIREC HEALTH SERVICES 1.00				To 12/31/2014	Date/Time Pre 5/29/2015 3:1		
MAT B - MEDICAL AND OTHER REALTH SERVICES 1,000			Title XVIII	Hospi tal		, p	
MAT B - MEDICAL AND OTHER REALTH SERVICES 1,000					1 00		
Medical and other services (see instructions) 19,19 21,00 22,880,252 2.00 Medical and other services reimbroad under OPPS (see instructions) 12,880,252 2.00 22,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 20,880,252 2.00 2		PART R - MEDICAL AND OTHER HEALTH SERVICES			1.00		
PS payments	1.00				19, 919	1.00	
Dutiler payment (see Instructions)		,	ons)		22, 840, 252	•	
Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 5.00 1.00 2.10 5.00 1.00 5.00	3.00	PPS payments			17, 120, 558	3. 00	
Line 2 times line 5 0 0.00 0.	4.00	Outlier payment (see instructions)			106, 544	4. 00	
2.00 3.mg of line 3 plus line 4 divided by line 6 0.00 7.00 8.00 1.00 9.00 4.00 1.00 9.00 4.00 1.00 9.00 3.1.543 9.00 9.00 3.1.543 9.00 1.00 0.0	5.00	Enter the hospital specific payment to cost ratio (see instruct		0. 000	5. 00		
Transitional corridor payment (see Instructions) 0 8.00						1	
9.00 Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200 31, 543 9.00		,				1	
10.00 organ acquisitions 10.00						1	
1.00 Total cost (sum or lines 1 and 10) (see instructions) 19, 919 10, 00			/, col. 13, line 200			1	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Service charges		9					
Reasonable charges 12.00 Ancil Tary service charges 12.00 Ancil Tary service charges 17.500 13.0	11.00				19, 919	11.00	
12.00 Ancil lary service charges 91,530 12.00 12.10 12.10 10.11 12.10							
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4) 0 13.00 0 13.00 0 13.00 0 15.00	12 00				01 530	12 00	
14.00 Total reasonable charges (sum of lines 12 and 13)			1 4)				
Customery charges			· · · · · · · · · · · · · · · · · · ·			ł	
15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0.16.00 Anounts that would have been realized from patients liable for payment for services on a chargebasis 0.16.00 1.00	00				7.1,000		
16.00 Amounts that would have been realized from patients Iable for payment for services on a chargebasis Nature	15. 00		yment for services on	a charge basis	0	15. 00	
17. 00	16.00				0	16. 00	
18.00 Total customary charges (see instructions)		had such payment been made in accordance with 42 CFR §413.13(e)	. ,	Ü			
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 71, 611 19. 00	17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00	
instructions	18.00	Total customary charges (see instructions)			91, 530	18. 00	
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00 Instructions) 10,919 21. 00 22. 00	19. 00		if line 18 exceeds li	ne 11) (see	71, 611	19. 00	
Instructions			_				
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0.20.00 22.00 23.00 20.00 20.00 20.00 22.00 23.00 20.00 20.00 22.00 23.00 20.00 20.00 20.00 22.00 20.	20.00		0	20.00			
22.00 Interns and residents (see instructions) 0.22.00 23.00	21 00	1	10 010	21 00			
23.00 Cost of physicians' services in a teaching hospital (see instructions) 17,258,645 24.00 24.00 24.00 24.00 24.00 25.00 24.00 25.00		, ,		ł			
Total prospective payment (sum of lines 3, 4, 8 and 9) 17, 258, 645 24. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25. 00 Deductibles and coinsurance (for CAH, see instructions) 3, 477, 744 26. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 3, 477, 744 26. 00 Deductibles and Coinsurance relating to amount on line 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 13, 800, 820 27. 00 CAH, see instructions) 0 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29. 00 Direct graduate medical education payments (from Wkst. E-4, line 36) 13, 800, 820 30. 00 Subtotal (sum of lines 27 through 29) 13, 800, 820 30. 00 Divoltotal (sum of lines 27 through 29) 13, 800, 820 30. 00 20. 00		1	ictions)			ł	
COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions) 0 25. 00 25. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 3, 477, 744 26. 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) 0 28. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 29. 00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29. 00 30. 00 Subtotal (sum of lines 27 through 29) 13, 800, 820 30. 00 31. 00 Primary payer payments 2, 791 31. 00 32. 00 Subtotal (ine 30 minus line 31) 13, 798, 029 32. 00 33. 00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33. 00 34. 00 Allowable bad debts (see instructions) 203, 207 34. 00 35. 00 Allowable bad debts (see instructions) 203, 207 34. 00 36. 00 Allowable bad debts (see instructions) 55, 271 36. 00 37. 00 Subtotal (see instructions) 13, 930, 114 37. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 99 40. 00 Subtotal (see instructions) 0 39. 99 40. 00 Subtotal (see instructions) 0 39. 99 40. 00 Subtotal (see instructions) 0 39. 99 40. 00 Subtotal (see instructions) 0 39. 99 40. 00 Subtotal (see instructions) 0 39. 90 40. 00 Sequestration adjustment (see instructions) 0 39. 90 40. 00 Total in each of the subtraction of the subtract			1011 0113)			ł	
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CAH, see instructions	26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		3, 477, 744	26. 00	
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Composite rate costs (from Wkst. E-4, line 36) Composite rate ESRD (from Wkst. Intervited in a cost of the cost	27. 00		us the sum of lines 22	and 23} (for	13, 800, 820	27. 00	
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93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,					
94.00 Total (sum of lines 91 and 93)		· ·					
	94.00	IOTAL (SUM OT LINES 91 AND 93)			0	94.00	

Health Financial Systems IU FANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 150026

					5/29/2015 3: 16	5 pm
		Ti	tle XVIII	Hospi tal	PPS	
		Inpati	ent Part A	Pai	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		15, 900, 7	90	13, 658, 125	1. 00
2.00	Interim payments payable on individual bills, either			0	o	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	ı		07/10/0011		
3. 01	ADJUSTMENTS TO PROVIDER	07/40/004		0 07/18/2014	44, 900	3. 01
3. 02		07/18/2014	66, 1		0	3. 02
3. 03				0	0	3. 03
3. 04				0	0	3. 04
3. 05				0	0	3. 05
0 50	Provi der to Program					0 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0	0	3. 50 3. 51
				-		
3. 52				0	1	3. 52
3.53				0	0	3. 53
3. 54 3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines		// 1	0	1	3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		66, 1	00	44, 900	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		15, 966, 8	90	13, 703, 025	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		13, 700, 0	70	13, 703, 023	4.00
	appropriate)					
	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	•	•	<u>.</u>		
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 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
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)				_	,
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		44, 3		51, 513	6. 02
7. 00	Total Medicare program liability (see instructions)		15, 922, 5		13, 651, 512	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		0	1.00	2.00	8. 00
0.00	Thame of Softi dotor	I		I	1 1	0.00

Heal th	Financial Systems IU HEALTH GOSHEN	I HOSPITAL	In Lie	u of Form CMS-2	2552-10			
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150026	Peri od: From 01/01/2014 To 12/31/2014					
		Title XVIII	Hospi tal	PPS				
				1. 00				
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS							
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION							
1.00								
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12		8, 051	2. 00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2, 311	3. 00			
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		20, 069	4. 00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			497, 017, 150	5. 00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l			8, 715, 405	6. 00			
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I	0	7. 00			
8.00	Calculation of the HIT incentive payment (see instructions)			833, 548	8. 00			
9.00	Sequestration adjustment amount (see instructions)			16, 671	9. 00			
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		816, 877	10. 00			
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH							
	Initial/interim HIT payment adjustment (see instructions)			849, 892	30.00			
	Other Adjustment (specify)			0	31. 00			
22 00	00 Polance due provider (line 0 (or line 10) minus line 20 and line 21) (occine trustians)							

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

-33, 015 32. 00

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150026	Period: Worksheet E-3 From 01/01/2014 Part VII
		To 12/31/2014 Date/Time Prepared:

PART VII _ CALCULATION OF RETIBURSEMENT ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				To 12/31/2014		
PART VII - CALCULATION OF REINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		
PART VII - CALCULATION OF RETINDENSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				I npati ent	Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.0				1. 00	2.00	
Impatient hospital/SNF/NF services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
Medical and other services 0 2 0.00 3.00 0 cgran acquisition (certified transplant centers only) 3.374,668 0 4.00 5.00		COMPUTATION OF NET COST OF COVERED SERVICES				1
0	1.00	Inpatient hospital/SNF/NF services		3, 374, 668		1.00
Organ acquisition (certified transplant centers only)	2.00				0	2.00
A.00 Subtotal (sum of lines 1, 2 and 3) 3,374,668 0 4,00 0 0 0 0 0 0 0 0 0	3.00			o		3.00
Inpatient primary payer payments 0 0 5.00 0.00	4.00			3, 374, 668	0	4.00
0.00 Outpatient primary payer payments 0.0 6.00	5.00			0		5. 00
1.00 Subtotal (line 4 less sum of lines 5 and 6) 7, 00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 2,583,637 8,00 Routine service charges 7,460,953 0,9,00 10.00 00 and charges, net of revenue 7,460,953 0,9,00 10.00	6.00				0	6.00
Reasonable Charges 2,583,637 8.00 8.00 Ancillary service charges 2,583,637 8.00 9,00 Ancillary service charges 7,460,953 0.9,00 10.00 Incentive from target amount computation 0.00 10.0	7.00	Subtotal (line 4 less sum of lines 5 and 6)		3, 374, 668	0	7. 00
Routine service charges		COMPUTATION OF LESSER OF COST OR CHARGES				
9,00 Ancillary service charges 7, 460, 953 0 9,00		Reasonabl e Charges				
10.00 Organ acquisition charges, net of revenue 0 10.0	8.00	Routine service charges		2, 583, 637		8. 00
11.00	9.00	Ancillary service charges		7, 460, 953	0	9. 00
12.00 Total reasonable charges (sum of lines 8 through 11) 10,044,590 0 12.00	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOWARY CHARGES	11.00	Incentive from target amount computation		0		11. 00
13. 00 Amount actually collected from patients liable for payment for services on a charge basis 14. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 0.000000 15. 00 15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 0.000000 0.000000 15. 00 16. 00 Total customary charges (see instructions) 10.044,590 0.000000 16. 00 17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 6, 669, 922 0.17. 00 17. 00 18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0.000000 0.00000 18. 00 19. 00	12.00	Total reasonable charges (sum of lines 8 through 11)		10, 044, 590	0	12.00
basis 14.00 Amounts that would have been realized from patients liable for payment for services on 0 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000)		CUSTOMARY CHARGES				
14.00 Amounts that would have been realized from patients Liable for payment for services on a large basis had such payment been made in accordance with 42 CFR §413. 13(e) 0.000000 0.000000 15.00 16.00 101d icustomary charges (see instructions) 10.044.590 0.16.00 16.00 101d icustomary charges over reasonable cost (complete only if line 16 exceeds 6.669,922 0.17.00 11ne 4) (see instructions) 0.00000 0.00000 15.00 16	13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16. 00 Total customary charges (see instructions) 17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 6, 669, 922 0 17. 00						
15.00	14. 00		0	0	14. 00	
16. 00 Total customary charges (see instructions) 10,044,590 10,044,590 10,044,590 10,044,590 10,044,590 10,044,590 17,00 10,00						
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 6,669,922 0 17.00		,			•	
Iine 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 18.00 16) (see instructions) 0 0 19.00 10 10 10 10 10 10 10		,			_	
18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19. 00 18. 00 19. 00	17. 00	, , ,	6, 669, 922	0	17. 00	
16) (see instructions)	10.00		: £ ; 4		0	10.00
19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 2	18.00		IT line 4 exceeds line	U	U	18.00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 25. 00 26. 00 27. 0	10 00			0	0	10 00
21.00			ctions)	0	_	•
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	*	3 374 668		
22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capit al payments 0 24. 00 25. 00 Capit al exception payments (see instructions) 0 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 25. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 3, 374, 668 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) 0 0 30. 00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 3, 374, 668 0 31. 00 32. 00 Deductibles 0 0 33. 00 0 0 33. 00 33. 00 Coinsurance 0 0 33. 00 0 0 0 33. 00 34. 00	21.00					21.00
23. 00	22.00		omp. 0.00 10. 110 p. 0.10		0	22.00
24.00 Program capital payments 0 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 0 0 26.00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 3, 374, 668 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT ***********************************				o	0	
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 374, 668 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 42. 00 Bal ance due provi der/program (line 40 minus line 41) 43. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub 15-2, 25. 00 26. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 21. 00 20. 00 21. 00 20. 00 21. 00 22. 00 23. 374, 668 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 27. 00 28. 00 28. 00 29. 00 20				0		24. 00
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 30. 00 Deductibles 30. 00 Coinsurance 40 O 33. 00 34. 00 Allowable bad debts (see instructions) 30. 00 Utilization review 30. 00 Utilization review 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 40. 00 Bal ance due provider/program (line 40 minus line 41) 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 20. 00 Customary charges (title V or XIX PS covered services only) 31. 00 O 28. 00 32. 00 33. 374, 668 34. 00 O 34. 00 35. 00 36. 00 Subtotal (line 36 ± line 37) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 O 36. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				o		25. 00
27. 00 28. 00 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 30. 00 Excess of reasonable cost (from line 18) 30. 00 31. 00 32. 00 32. 00 34. 00 34. 00 34. 00 35. 00 36. 00 36. 00 36. 00 36. 00 37. 00 38. 00 39. 00 30.				o	0	26. 00
Titles V or XIX (sum of lines 21 and 27) 3,374,668 0 29.00	27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 3, 374, 668 0 31.00 32.00 32.00 32.00 32.00 33.00 Coinsurance 0 0 0 32.00 33.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 35.00 Utilization review 0 35.00 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3, 374, 668 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 3, 374, 668 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Interim payments 4, 317, 386 0 40.00 41.00 Interim payments 4, 317, 386 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -942, 778 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Coinsurance 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 38.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Balance due provider/program (line 40 minus line 41) 42.00 Balance due provider (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 30.00 30.00 30.00 30.00 31.00 32.00 0 0 32.00 0 0 33.00 0 0 34.00 0 35.00 0 0 37.00 0 37.00 0 37.00 0 37.00 0 37.00 0 0 0 37.00 0 0 0 37.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00	Titles V or XIX (sum of lines 21 and 27)		3, 374, 668	0	29. 00
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coi nsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 38. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Balance due provider/program (line 40 minus line 41) 42. 00 Balance due provider (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 37. 00 37. 00 37. 00 37. 00 39. 00 43. 00		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
32.00 Deductibles 0 32.00 33.00 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3,374,668 0 36.00 37.00 37.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 Total amount payable to the provider (sum of lines 38 and 39) 3,374,668 0 40.00 41.00 Interim payments 4,317,386 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -942,718 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00	30.00	Excess of reasonable cost (from line 18)		0	0	30.00
33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3, 374, 668 0 36.00 37.00 37.00 38.00 Subtotal (line 36 ± line 37) 0 0 0 37.00 38.00 0 0 0 0 0 0 0 0 0	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 374, 668	0	31. 00
34.00 Allowable bad debts (see instructions) 0 34.00 35.00 0 0 0 0 0 0 0 0 0	32.00	Deducti bl es		0	0	32. 00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 35.00 36.00 37.4,668 0 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 38.00 38.00 38.00 39.00 40.00 40.00 40.00 41.00 42.00 43.00	33.00			0	0	33. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 37.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	34.00	Allowable bad debts (see instructions)		0	0	34. 00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 37. 00 37.				0		1
38.00 Subtotal (line 36 ± line 37) 3,374,668 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 1.0			33)	3, 374, 668		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 40.00 41.00 41.00 42.00 43.00						1
40.00 Total amount payable to the provider (sum of lines 38 and 39) 3,374,668 0 40.00 41.00 Interim payments 4,317,386 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -942,718 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00					0	1
41.00 Interim payments 4,317,386 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00					_	•
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00 43.00		, , , , , , , , , , , , , , , , , , , ,			•	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00					1	
		, ,	-942, 718			
Chapter 1, 9115.2	43. 00					43.00
		Cnapter 1, 9115.2				I

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

| Period: | Worksheet G | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/29/2015 3:17 pm

					5/29/2015 3:1	7 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	13, 051, 595		0	0	1. 00
2.00	Temporary investments	10, 146, 613	0	0	0	2. 00
3.00	Notes recei vabl e	0	0	0	0	3. 00
4.00	Accounts receivable	66, 114, 087	0	0	0	4. 00
5.00	Other recei vabl e	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-38, 847, 938	0	0	0	6. 00
7.00	Inventory	4, 829, 950	0	0	0	7. 00
8.00	Prepai d expenses	3, 618, 643	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	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	58, 912, 950	0	0	0	11. 00
	FI XED ASSETS		1			
12. 00	Land	3, 883, 887	1		0	
13. 00	Land improvements	2, 988, 795	1	0	0	13. 00
14. 00	Accumulated depreciation	-1, 571, 048	1	0	0	14. 00
15. 00	Bui I di ngs	100, 814, 005	1	0	0	15. 00
16.00	Accumulated depreciation	-35, 353, 705	1	0	0	16.00
17. 00	Leasehold improvements	113, 748	1	0	0	17. 00
18.00	Accumulated depreciation	-106, 769	1	0	0	18. 00
19.00	Fixed equipment	13, 278, 447	1	0	0	19. 00
20.00	Accumulated depreciation	-6, 876, 054	1	0	0	20.00
21. 00	Automobiles and trucks		0	0	0	21. 00
22. 00	Accumulated depreciation		0	0	0	22. 00
23. 00	Maj or movable equipment	100 414 107	0	0	0	23. 00
24. 00	Accumulated depreciation	103, 414, 137	1	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	-77, 198, 676		0	0	25. 00
26. 00 27. 00	Accumulated depreciation			0	0	26. 00 27. 00
28. 00	HIT designated Assets		0	0	0	28. 00
28.00	Accumulated depreciation		0	0	0	28.00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	103, 386, 767		-	0	30.00
30.00	OTHER ASSETS	103, 360, 767	<u> </u>	U	U	30.00
31. 00	Investments		0	0	0	31. 00
32. 00	Deposits on Leases			0	0	32. 00
33. 00	Due from owners/officers			0	0	33. 00
34. 00	Other assets	154, 470, 286	Ö	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	154, 470, 286	1	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	316, 770, 003	1	-	0	36. 00
00.00	CURRENT LI ABI LI TI ES	0.077707000		٥,		00.00
37. 00	Accounts payable	7, 106, 914	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	8, 673, 952	1	0	0	38. 00
39. 00	Payrol I taxes payable	406, 038	1	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	Ō	0	0	40. 00
41. 00	Deferred income	l o	Ō	0	0	41. 00
42.00	Accel erated payments					42.00
43.00	Due to other funds	l o	0	0	0	43.00
44.00	Other current liabilities	2, 344, 309	0	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	18, 531, 213	0	0	0	45. 00
	LONG TERM LIABILITIES		•			
46.00	Mortgage payable	O	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	-33, 187, 032	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	-33, 187, 032	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-14, 655, 819	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	265, 051, 756				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			0		56.00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on	0				E0 -
59.00	Total fund balances (sum of lines 52 thru 58)	265, 051, 756	1	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	250, 395, 937	0	0	0	60. 00
	[59]	I	I	ı		1

					To 12/31/201	14 Date/Time Pre 5/29/2015 3:1	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) LOSS ON INTEREST RATE SWAPS, NET ACT	-123, 340	190, 551, 493 45, 396, 635 235, 948, 128 0 235, 948, 128		0 0 0 0 0 0	0 0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	-123, 340 236, 071, 468 PI ant		0 0 0	0 0 0	15. 00 16. 00
		6. 00	7. 00	8.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) LOSS ON INTEREST RATE SWAPS, NET ACT Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems I STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			To 12/31/2014	Date/Time Pre 5/29/2015 3:1	
	Cost Center Description	I npati ent	Outpati ent	Total	7 piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2. 22	
	General Inpatient Routine Services				
1.00	Hospi tal	32, 404, 54	7	32, 404, 547	1. 00
2.00	SUBPROVIDER - IPF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		o	0	5. 00
6.00	Swing bed - NF		O	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	32, 404, 54	7	32, 404, 547	10. 00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10, 358, 76	3	10, 358, 763	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	10, 358, 76	3	10, 358, 763	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	42, 763, 31		42, 763, 310	
18. 00	Ancillary services	110, 794, 55	8 288, 367, 094	399, 161, 652	
19. 00	Outpati ent servi ces	4, 977, 72	27, 626, 875	32, 604, 597	
20.00	RURAL HEALTH CLINIC		0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		1, 673, 090	1, 673, 090	
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		0 3, 866, 369	3, 866, 369	26. 00
27. 00	NURSERY	13, 016, 66		31, 354, 840	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	171, 552, 25	339, 871, 605	511, 423, 858	28. 00
	G-3, line 1)				
00.00	PART II - OPERATING EXPENSES		400 554 400		00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		190, 551, 490		29. 00
30.00	ADD (SPECIFY)		0		30. 00
31.00			0		31. 00
32.00			0		32. 00 33. 00
33.00			0		34. 00
34. 00			0		35. 00
35. 00	Total additions (our of Lines 20 25)				
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			0		39. 00
			0		
40. 00 41. 00			١		40. 00 41. 00
41.00	Total deductions (sum of lines 37-41)		0		41.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	-	190, 551, 490		42.00
45.00	to Wkst. G-3, line 4)		170, 331, 470		73.00
	10 mot. 0 0, 1110 4)	1	1	I	1

STATE	IENT OF REVENUES AND EXPENSES Pr	rovi der CCN: 150026	Peri od:	Worksheet G-3	
SINIL	ILIVI OF REVENUES AND EXTENSES	OVI GET CON. 130020	From 01/01/2014	WOLKSHEEL G-3	
			To 12/31/2014	Date/Time Prep	
				5/29/2015 3: 1	7 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			511, 423, 858	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			297, 057, 574	
3.00	Net patient revenues (line 1 minus line 2)			214, 366, 284	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			190, 551, 490	
5.00	Net income from service to patients (line 3 minus line 4)		23, 814, 794	5. 00	
	OTHER I NCOME		,		
6. 00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			5, 396, 131	
8.00	Revenues from telephone and other miscellaneous communication serv	ri ces		0	
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			50, 699	
11. 00	Rebates and refunds of expenses			638, 554	
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			867, 554	
15. 00	Revenue from rental of living quarters				15. 00
16.00	Revenue from sale of medical and surgical supplies to other than p	ati ents		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	
18.00	Revenue from sale of medical records and abstracts			50, 530	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			1, 079, 164	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MISC OTHER OPER/NON OPER REVENUE			13, 499, 209	24.00
25.00	Total other income (sum of lines 6-24)			21, 581, 841	25. 00
26.00	Total (line 5 plus line 25)			45, 396, 635	26.00
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			o	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			45, 396, 635	

	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	504, 312	0	504, 312		6. 00
7.00	Physical Therapy	0	218, 688	0	218, 688		7. 00
8.00	Occupational Therapy	0	89, 850	0	89, 850		8. 00
9.00	Speech Pathology	o	29, 952	O	29, 952		9. 00
10.00	Medical Social Services	o	56, 038	O	56, 038		10.00
11.00	Home Health Aide	o	38, 995	O	38, 995		11. 00
12.00	Supplies (see instructions)	-21, 083	1, 583	O	1, 583		12. 00
13.00	Drugs	-2, 482	0	O	0		13. 00
14.00	DME	O	0	o	0		14. 00
	HHA NONREI MBURSABLE SERVI CES						
15.00	Home Dialysis Aide Services	0	0	0	0		15. 00
16.00	Respiratory Therapy	o	0	O	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17. 00
18.00	Clinic	0	0	0	0		18. 00
19.00	Health Promotion Activities	0	0	0	0		19. 00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	o	0	O	0		21. 00
22.00	Homemaker Service	o	0	O	0		22. 00
23.00	All Others (specify)	o	0	O	0		23. 00
24.00	Total (sum of lines 1-23)	-23, 565	1, 816, 910	o	1, 816, 910		24. 00
		·	·		·		•

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17.00

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23 00

24.00

15.00

16.00

17.00

18.00

19. 00 20. 00

21.00

22.00

23 00

Clinic

HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Respiratory Therapy

Day Care Program

Homemaker Service

All Others (specify)

24.00 Total (sum of lines 1-23)

Private Duty Nursing

Health Financial Systems		IU HEALTH GOSI	HEN H	OSPI TAL			In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HHA STATISTICAL BAS	SIS			Provi der	CCN: 150026	Peri	i od:	Worksheet H-1	
							m 01/01/2014		
				HHA CCN:	157174	To	12/31/2014	Date/Time Pre	
								5/29/2015 3:1	7 pm
						H	ome Health	PPS	
							Agency I		
	Capi tal	Related Costs							

						Agency I	FF3	
		Capital Pol	ated Costs			Agency I		
		Capital Kei	ateu costs					
		Bl dgs &	Movabl e	PI ant	Transportation	Reconciliation	Admi ni etrativa	
		Fixtures	Equi pment	Operation &	(MI LEAGE)	Reconciliation	& General	
			(DOLLAR VALUE)		(WILLEAGE)		(ACCUM. COST)	
		(SQUARE FEET)	(DULLAR VALUE)	(SQUARE FEET)			(ACCUM. COST)	
		1.00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5A. 00	5.00	
1.00	Capital Related - Bldg. &	2, 563				0		1. 00
1.00	Fixtures	2, 503				U		1.00
2.00	Capital Related - Movable		15, 446			0		2. 00
2.00	Equi pment		13, 440			U		2.00
3.00	Plant Operation & Maintenance	0	0	2, 563		0		3. 00
4.00	Transportation (see	0	0	2,303	106, 622	U		4. 00
4.00	instructions)	٥	U		100, 022			4.00
5.00	Administrative and General	2, 563	15, 446	2, 563	3, 064	-877, 492	939, 418	5. 00
3.00	HHA REIMBURSABLE SERVICES	2, 303	13, 440	2, 303	3,004	-011, 472	737, 410	3.00
6. 00	Skilled Nursing Care	0			61, 763		504, 312	6. 00
7. 00	Physical Therapy	0	0		11, 963		218, 688	
8.00		0	0		5, 048		216, 000 89, 850	
9.00	Occupational Therapy	0	0		956			
	Speech Pathology	0	0				29, 952	
10.00	Medical Social Services	0	0	U	4, 208		56, 038	
11.00	Home Heal th Ai de	0	0	U	19, 620	0	38, 995	
12.00	Supplies (see instructions)	0	0	0	1	0	1, 583	
13.00	Drugs	0	0	0		0	0	13.00
14. 00	DME	0	0	0	0	0	0	14. 00
	HHA NONREIMBURSABLE SERVICES	_	_	_	1 -		_	
15. 00	Home Dialysis Aide Services	0	0	0	0	0	0	15. 00
16. 00	Respiratory Therapy	0	0	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	0	0	0	19. 00
20.00	Day Care Program	0	0	0	0	0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22. 00	Homemaker Service	0	0	0	0	0	0	22. 00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2, 563			106, 622	-877, 492	939, 418	24.00
25.00	Cost To Be Allocated (per	0	2, 812	64, 961	0		877, 492	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 182054	25. 345689	0.000000		0. 934080	26. 00

Peri od: Worksheet H-2
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm HHA CCN: 157174

Home Health PPS

						Home Health Agency I	PPS	
			CAPITAL REI	_ATED COSTS		Agency 1		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	
		0	1. 00	2.00	4.00	5. 01	5A. 01	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 975, 380 422, 960 173, 777 57, 930 108, 382 75, 419 3, 062 0 0 0 0 0 0 0 0 0 0	21, 093 21, 093 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 536 0 0 0 0 0 0 0 0 0 0 0 0 0 0	216, 886 163, 339 70, 830 29, 101 9, 701 18, 150 12, 630 0 0 0 0 0 0 0	7, 999 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	256, 514 1, 138, 719 493, 790 202, 878 67, 631 126, 532 88, 049 3, 062 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
	column 26, line 1, rounded to 6 decimal places. Cost Center Description	OTHER ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 02	6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Administrative and General	60, 926	0.00		0.00		10.00	1.00
2. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	270, 462 117, 282 48, 186 16, 063 30, 053 20, 913 727 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00

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

Health Financial Systems IU FALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: Worksheet H-2
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm

Home Heal th PPS Provi der CCN: 150026 Peri od: HHA CCN: 157174

						Home Health	PPS	
	Cost Contar Doscription	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	Agency I MEDICAL	SOCIAL SERVICE	
	Cost Center Description		ADMI NI STRATI ON		PHARWACT	RECORDS &	SOCIAL SERVICE	
			ADMINI STRATION	SUPPLY		LI BRARY		
		11. 00	13. 00	14.00	15. 00	16.00	17. 00	
1. 00	Administrative and General	10, 649	0		C		0	1. 00
2.00	Skilled Nursing Care	6, 623	105, 666	0	C		0	2. 00
3.00	Physical Therapy	2, 295	0	0	l	0	0	3.00
4.00	Occupational Therapy	999	0	0	l	0	0	4. 00
5.00	Speech Pathology	321	0	0	C	0	0	5. 00
6.00	Medical Social Services	832	0	0	C	0	0	6. 00
7.00	Home Health Aide	1, 353	0	0	C	0	0	7. 00
8.00	Supplies (see instructions)	0	0	510	C	0	0	8. 00
9.00	Drugs	0	0	0	C	1	0	9. 00
10.00	DME	0	0	0	C	1	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	C	0	0	11.00
12. 00 13. 00	Respiratory Therapy	0	0	0			0	12.00
14. 00	Private Duty Nursing Clinic		0	0		,	0	13. 00 14. 00
15. 00	Health Promotion Activities		0	1	· -	-	0	15. 00
16. 00	Day Care Program		0	0		-	0	16. 00
17. 00	Home Delivered Meals Program		0	0		1	0	17. 00
18. 00	Homemaker Service	0	0	0		o o	0	18. 00
19. 00	All Others (specify)	0	0	Ō	C	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	23, 072	105, 666	510	C	14, 176	0	20. 00
21.00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	ALLIED HEALTH	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
	cost center bescription	ALLIED HEALTH		Residents Cost		A&G (see Part	Costs	
				& Post		11)	00313	
				Stepdown				
				Adjustments				
		23. 00	24. 00	25. 00	26. 00	27. 00	28. 00	
1.00	Administrative and General	0	397, 039	l				1.00
2.00	Skilled Nursing Care	0	1, 521, 470	1	.,,		1, 741, 702	2. 00
3.00	Physi cal Therapy	0	613, 367	0	613, 367		702, 151	3.00
4.00	Occupational Therapy	0	252, 063	0	252, 063			4.00
5. 00 6. 00	Speech Pathology Medical Social Services	0	84, 015 157, 417	0	84, 015 157, 417		96, 176	5. 00 6. 00
7. 00	Home Health Aide		110, 315		110, 315	· ·		•
8.00	Supplies (see instructions)		4, 299	0	4, 299		4, 921	8.00
9. 00	Drugs		0	0	7, 277	0	0	1
10. 00	DME	l ő	0	o o	ĺ	o o	Ö	10.00
11. 00	Home Dialysis Aide Services	0	0	0	C	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	C	0	0	12.00
13.00	Private Duty Nursing	0	0	0	C	0	0	13. 00
14.00	Clinic	0	0	0	C	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	[C	0	0	15. 00
16. 00		0	0	0	C	0	0	1 .0.00
17. 00	Home Delivered Meals Program	0	0	0	C	0	0	
18.00	Homemaker Service] 0	0	J 5) 0	0	18.00
19. 00	All Others (specify)	0	3, 139, 985	0	3, 139, 985	207.020	2 120 005	19.00
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column		3, 139, 985	0	3, 139, 985	397, 039 0. 144749		20. 00 21. 00
21.00	26, line 1 divided by the sum					0. 144/49		21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

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

						Home Health Agency I	PPS	
		CAPITAL REL	ATED COSTS			Agency		,
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	CASHI ERI NG/ACC	Reconciliation	OTHER ADMI NI STRATI VE	
		(SQUARL TELT)	(DOLLAR VALUE)	DEPARTMENT	RECEI VABLE		& GENERAL	
				(GROSS	(GROSS		(ACCUM. COST)	
		1 00	0.00	SALARI ES)	CHARGES)	54.00		
1. 00	Administrative and General	1. 00 2, 563	2. 00 15, 446	4. 00 669, 641	5. 01 1, 673, 090	5A. 02	5. 02 256, 514	1. 00
2. 00	Skilled Nursing Care	2, 303	13, 440	504, 312				2. 00
3.00	Physi cal Therapy	0	0	218, 688	1	0		3. 00
4.00	Occupational Therapy	0	0	89, 850	1	_	202, 878	4.00
5.00	Speech Pathology	0	0	29, 952		_	,	5.00
6. 00 7. 00	Medical Social Services Home Health Aide	0	0	56, 038 38, 995	1	_	126, 532 88, 049	6. 00 7. 00
8. 00	Supplies (see instructions)		0	0 30, 773	Ö	0	3, 062	8. 00
9.00	Drugs	0	0	0	0	0		9. 00
10.00	DME	0	0	0	1	_		10.00
11. 00	Home Dialysis Aide Services	0	0	0	1	_	0	11. 00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0	0	_	0	12. 00 13. 00
14. 00	Clinic	0	0	0	Ö	0	l o	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16. 00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	17. 00 18. 00
19. 00	All Others (specify)	0	0	0	0	0		19. 00
20. 00	Total (sum of lines 1-19)	2, 563	15, 446	1, 607, 476	1, 673, 090		2, 377, 175	20.00
21. 00	Total cost to be allocated	21, 093	10, 536	520, 637			564, 612	21. 00
22. 00	Unit cost multiplier Cost Center Description	8. 229809 MAI NTENANCE &	0. 682118 OPERATI ON OF	0. 323885 LAUNDRY &	0. 004781 HOUSEKEEPI NG	DI ETARY	0. 237514 CAFETERI A	22. 00
	Cost Center Description	REPAIRS	PLANT	LI NEN SERVI CE		(MEALS SERVED)	(MANHOURS)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF				
		6.00	7. 00	LAUNDRY) 8.00	9.00	10.00	11.00	
1. 00	Administrative and General	2, 563	2, 563	8.00		10.00		1. 00
2.00	Skilled Nursing Care	0	0	0		0		2. 00
3.00	Physical Therapy	0	0	0	1	_	-,	3.00
4.00	Occupational Therapy	0	0	0	0	_		4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	0	0	0	0	_		5. 00 6. 00
7. 00	Home Heal th Ai de	0	0	0	ő	0	3, 235	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs		0	0	ıl o	0	l ol	9.00
10. 00 11. 00		0	0	-	1	_		
	DME	0	0	0	Ō	0	0	10.00
	DME Home Dialysis Aide Services	0 0	0	-	0	0		10. 00 11. 00
12. 00 13. 00	DME	0 0 0	0	0	0	0	0	10.00
12. 00 13. 00 14. 00	DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 0	0 0 0 0	0	0	0 0 0 0	0	10. 00 11. 00 12. 00 13. 00 14. 00
12. 00 13. 00 14. 00 15. 00	DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	000000000000000000000000000000000000000	0 0 0 0 0	0	000000000000000000000000000000000000000	0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
12. 00 13. 00 14. 00 15. 00 16. 00	DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0	000000000000000000000000000000000000000	0 0 0 0	0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
12. 00 13. 00 14. 00 15. 00	DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0 0 0 0 0 0 0	0 0 0 0 0	0	000000000000000000000000000000000000000	0 0 0 0	0 0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0 0 0 0 0 0	0 0 0 0 0 0	0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19)	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 2, 563	0	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 55,149	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) Total cost to be allocated	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 2, 563 37, 388	0	0 0 0 0 0 0 0 0 0 2, 563 17, 386	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 55, 149 23, 072	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Health Financial Systems	IU HEALTH GOSHEN HO	OSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE CO	TO HHA COST CENTERS STATISTICAL	Provi der CCN: 150026		Worksheet H-2
BASIS			From 01/01/2014	
		HHA CCN: 157174	To 12/31/2014	Date/Time Prepared:

5/29/2015 3:17 pm Home Health PPS Agency I Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ALLIED HEALTH (ASSI GNED ADMI NI STRATI ON SERVICES & (COSTED RECORDS & REQUIS.) (TIME SPENT) TIME) SUPPLY LI BRARY (DI RECT NURS. (COSTED (GROSS CHARGES) HRS.) REQUIS.) 13. 00 14.00 15.00 16.00 17.00 23.00 1.00 Administrative and General 1, 673, 090 1.00 0 0 0 0 0 2.00 17, 948 Ω 0 ol 2.00 Skilled Nursing Care 3.00 Physical Therapy 0 0 0 3.00 4.00 Occupational Therapy 0 0 0 0 4.00 5.00 Speech Pathology 0 5.00 0 0 6.00 Medical Social Services 6.00 7.00 Home Health Aide 7.00 0 0 8.00 Supplies (see instructions) 0 18, 232 8.00 0 0 0 9.00 9.00 Drugs 10.00 DMF 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 0 0 0 0 0 0 0 11.00 12.00 Respiratory Therapy 12.00 0 0 0 Private Duty Nursing 0 13.00 13.00 14.00 Clinic 0 14.00 15.00 Health Promotion Activities 15.00 0 0 Day Care Program 16, 00 16.00 17.00 Home Delivered Meals Program 17.00 0 18.00 Homemaker Service 0 18.00 All Others (specify) 19.00 0 0 0 0 19.00 0 20.00 20.00 Total (sum of lines 1-19) 17, 948 18, 232 0 1, 673, 090 21.00 Total cost to be allocated 105, 666 510 14, 176 21.00 22.00 Unit cost multiplier 5. 887341 0.027973 0.000000 0.008473 0.000000 0.000000 22.00

### APPORTION/ENT OF PATIENT SERVICE COSTS ### COST Center Description From Next	Heal th	Financial Systems		IU HEALTH GOSH	HEN HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
HAR CRO. 157174 70 12/31/2014 Disputation From West. Facility Costs Facility			S				Peri od:	Worksheet H-3	
Cost Center Description					HHA CCN:			Date/Time Pre	pared: 7 pm
Cost Center Description From, Wast. Facility Costs Shared Total HMA Total Visits Average Cost Per Visit Col. 3					Ti tl	e XVIII			
Col. 28, line Hi-Z, Part 1 Costs (From *2) Col. 3 o col.		Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA			
Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Description Part II Part II Description Part I Des						,	1		
PART I - COMPUTATION OF LESSER OF AGRECATE PROGRAM COST, AGSREGATE OF THE PROGRAM LIMITATION COST, OR SERVET CLARY COST LIMITATION			col. 28, line	H-2, Part I)		+ 2)			
PART - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION COST, OR DENNETH AGENCY COST COST COST COST COST COST COST COST			0	1 00		3.00	4 00		
BRIFFICIARY COST LIMITATION		PART I - COMPUTATION OF LESSER							
1.00 Skilled Nursing Care 2.00 1.741, 702 0.1741, 702 5.383 323, 56 1.00 2.00 Physical Therapy 3.00 702, 151 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		BENEFICIARY COST LIMITATION							
2.00 Physical Therapy	1 00		2.00	1 741 702		1 741 70	2 5 383	323 56	1 00
3.00 Occupational Therapy		9							
4.00 Speech Pathology 5.00 96,176 96 1,001.83 4,00				· ·					
Medical Social Services				· ·					
Total (sum of lines 1-6)				· ·				·	
Cost Center Description Cost Limits CBSA No. (1) Part A Part B Not Subject to Deductible & Coinsurance 6.00	Home Health Aide	7.00	126, 283		126, 28	3 1, 143	110. 48	6. 00	
Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to Deductibles & Coinsurance Not Subject to Deductibles Not Subject to Deductible	7.00	Total (sum of lines 1-6)		3, 135, 064	(7.00
Cost Center Description Cost Limits CBSA No. (1) Part A Deductible & Dedu									
Limitation Cost Computation									
		Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Deductibles 8	- J		
8.00 Skil led Nursing Care 22140 0 3,537 8.00 8.01			0	1. 00	2.00		4. 00	5. 00	
Skilled Nursing Care 99915		Limitation Cost Computation				•			
9.00 Physical Therapy 99915 0 0 1,191 99015 0 0 0 9,01 10.00 Occupational Therapy 99915 0 0 0 445 10.00 10.01 Occupational Therapy 99915 0 0 0 445 11.00 10.01 Occupational Therapy 99915 0 0 9,01 11.00 Speech Pathology 22140 0 94 11.00 11.01 Speech Pathology 99915 0 0 0 12.01 Medical Social Services 99915 0 0 0 13.01 Home Health Aide 99915 0 0 0 13.01 Home Health Aide 99915 0 0 0 13.01 Home Health Aide 99915 0 0 0 14.00 Total (sum of lines 8-13) From Wkst. H-2 Pacility Costs Part II, col. 28, line 0 1.00 2.00 3.00 4.00 5.00 Supplies and Drugs Cost Computations Supplies 8.00 4.921 0 0 4.921 36.557 0.036036 15.00 0 0 0 0 0 Cost of Brugs 9,00 0 0 0 0 0 0 0 0 0									
9.01 Physical Therapy 09915 0 0 0 0 0 0 0 0 0						1			
10.00 Occupational Thérapy 09915 0 0 0 0 0 0 0 0 0						1			
10. 01 Occupational Therapy 99915 0 0 0 11. 00					-	1			
11. 00 Speech Pathology 99915 0 0 94 11. 00 11. 01 12. 00 Medical Social Services 22140 0 99915 0 0 0 12. 00 12. 00 Medical Social Services 99915 0 0 0 0 12. 00 12. 00 13. 00 13. 00 14. 00 14. 00 15. 00 14. 00 15. 00					-	1			
11. 01 Speech Pathol of Sp						1			
12.00 Medical Social Services 22140 0 0 97 0 12.00					-				
12. 01			•		-				_
13. 00 Home Heal th Aide 99915 0 0 1,027 0 13. 01 13. 00 13. 00 13. 00 13. 00 14. 00 15. 00		II .				1			
13. 01		II .				1	-		
14.00						1			
Cost Center Description				,,,,,	-		-		
Part I, col. 28, line			From Wkst. H-2	Facility Costs	Shared			Ratio (col. 3	
Supplies and Drugs Cost Computations		'				Costs (cols.			
Supplies and Drugs Cost Computations Supplies and Drugs Cost Computations			28, line	H-2, Part I)		+ 2)	Record)		
Supplies and Drugs Cost Computations 15.00 Cost of Medical Supplies 8.00 4,921 0 4,921 136,557 0.036036 15.00 16.00 Cost of Drugs 9.00 9.00 0 0 0 0 0 0 0 0 0									
15.00 Cost of Medical Supplies 8.00 4,921 0 4,921 136,557 0.036036 15.00				1. 00	2.00	3. 00	4. 00	5. 00	
16.00 Cost of Drugs 9.00 0 0 0 0 0 0 0 0 0	15 00	Cost of Modical Supplies		4 021	(1 02	1 126 557	0.026026	15 00
Program Visits Cost of Services Part B Not Subject to Deductibles & Coinsurance Coinsuranc				· ·					
Part B Not Subject to Deductibles & Coinsurance	10.00	COST OF DEGS	7.00					0.000000	10.00
Cost Center Description									
Deductibles & Coinsurance Deductibles & Coinsurance Coinsurance				Par	t B		Part B		
Coi nsurance Coi nsurance Coi nsurance Coi nsurance Coi nsurance		Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to	Subject to	
Cost Per Visit Computation Cost Per Visit Computation									
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
BENEFICIARY COST LIMITATION Cost Per Visit Computation 1.00 Skilled Nursing Care 0 3,537 0 1,144,432 1.00 2.00 Physical Therapy 0 1,191 0 439,217 2.00 3.00 Occupational Therapy 0 445 0 196,939 3.00 4.00 Speech Pathology 0 94 0 94,172 4.00 5.00 Medical Social Services 0 97 0 153,331 5.00 6.00 Home Health Aide 0 1,027 0 113,463 6.00		DART I COMPUTATION OF LECCER							
1. 00 Skilled Nursing Care 0 3,537 0 1,144,432 1.00 2. 00 Physical Therapy 0 1,191 0 439,217 2.00 3. 00 Occupational Therapy 0 445 0 196,939 3.00 4. 00 Speech Pathology 0 94 0 94,172 4.00 5. 00 Medical Social Services 0 97 0 153,331 5.00 6. 00 Home Heal th Ai de 0 1,027 0 113,463 6.00		BENEFICIARY COST LIMITATION	UF AGGREGATE F	YKUGKAM CUSI, A	GGREGATE UF TH	1E PRUGRAM LIM	LIATION COST, OF	(
2. 00 Physical Therapy 0 1, 191 0 439, 217 2. 00 3. 00 Occupational Therapy 0 445 0 196, 939 3. 00 4. 00 Speech Pathology 0 94 0 94, 172 4. 00 5. 00 Medical Social Services 0 97 0 153, 331 5. 00 6. 00 Home Heal th Ai de 0 1, 027 0 113, 463 6. 00	1 00		_	0 507		1	0 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		1 00
3. 00 Occupational Therapy 0 445 0 196, 939 3. 00 4. 00 Speech Pathology 0 94 0 94, 172 4. 00 5. 00 Medical Social Services 0 97 0 153, 331 5. 00 6. 00 Home Heal th Ai de 0 1, 027 0 113, 463 6. 00						1			
4. 00 Speech Pathology 0 94 0 94,172 4. 00 5. 00 Medical Social Services 0 97 0 153,331 5. 00 6. 00 Home Heal th Aide 0 1,027 0 113,463 6. 00			0			1			
5. 00 Medical Social Services 0 97 0 153, 331 5. 00 6. 00 Home Heal th Aide 0 1, 027 0 113, 463 6. 00			0			1		1	
6. 00 Home Heal th Ai de 0 1, 027 0 113, 463 6. 00		1 ' 33				1		1	
		1				1		1	
7.00 10tai (Suii 01 111163 1-0) 0 0,371 0 2,141,334 7.00			_					1	
	7.00	Total (Sum of Titles 1-0)	1	0, 391	ı	1	2, 141, 334	1	7.00

	Financial Systems TIONMENT OF PATIENT SERVICE COST	S	TU HEALTH GOSE		CCN: 150026 157174	Peri od: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet H-3 Part I Date/Time Pre	}
							5/29/2015 3:1	7 pm
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	6. 00	7. 00	8.00	9.00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	0.00	7.00	10.00	11.00	
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00
13. 01 14. 00	Home Health Aide Total (sum of lines 8-13)							13. 01 14. 00
14.00	Total (Suil Of Titles 0-13)	Prog	ram Covered Cha	arges	Cost of Services			14.00
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Deductibles & Coinsurance	
	Supplies and Drugs Cost Computa	6.00	7. 00	8.00	9. 00	10.00	11. 00	
	Cost of Medical Supplies Cost of Drugs	0	90, 870 0	l		0	0	15. 00 16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	MITATION COST, OF	2	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	1, 144, 432 439, 217 196, 939 94, 172 153, 331 113, 463 2, 141, 554						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Limitation Cost Computation							
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01

Heal th	Health Financial Systems IU HEALTH GOSHEN HOSPITAL In Lieu of Form CMS-2552-10							2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provi der		Peri od:	Worksheet H-3	
						From 01/01/2014	Part II	
				HHA CCN:	157174	To 12/31/2014	Date/Time Pre	
							5/29/2015 3:1	7 pm
				Ti tl	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 617295	(D	0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67. 00	0. 357220	(D	0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68. 00	0. 438087	(D	0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 780775	(0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 217615	(0 col. 2, line 1	6. 00	5. 00

CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150026	Peri od:	u of Form CMS-2 Worksheet H-4	
	HHA CCN:	157174	From 01/01/2014 To 12/31/2014	Part I-II Date/Time Pre 5/29/2015 3:1	
	Titl	e XVIII	Home Health Agency I	PPS	
		Part A	Not Subject to Deductibles & Coinsurance		
		1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOR	MARY CHARGE	S			
Reasonable Cost of Part A & Part B Services		I		0	-
Reasonable cost of services (see instructions) Total charges			0 0 0 960, 629	0	
Customary Charges		l	0 700, 027	0	4
Amount actually collected from patients liable for payment for on a charge basis (from your records)	servi ces		0 0	0)
Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0 0	0	
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000			- 1
Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (complete		0 960, 629 0 960, 629	0	
only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	yifline		0 0	0	
Primary payer amounts			0 0	0	
			Part A Services	Part B Services	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1. 00	2. 00	+
700 Total reasonable cost (see instructions)			0	0	1
00 Total PPS Reimbursement - Full Episodes without Outliers			0	953, 357	
OO Total PPS Reimbursement - Full Episodes with Outliers			0	4, 886	5 1
Total PPS Reimbursement - LUPA Episodes			0	28, 142	2 1
OO Total PPS Reimbursement - PEP Episodes			0	7, 064	
70 Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	444	
00 Total PPS Outlier Reimbursement - PEP Episodes 00 Total Other Payments			0	91 0	
00 DME Payments			0	0	
O Oxygen Payments			0	0	
00 Prosthetic and Orthotic Payments			0	0	
Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	
OO Subtotal (sum of lines 10 thru 20 minus line 21)			0	993, 984	
DO Excess reasonable cost (from line 8)			0	0	
O Subtotal (line 22 minus line 23)			0	993, 984	- 1
00 Coinsurance billed to program patients (from your records) 00 Net cost (line 24 minus line 25)			0	0 993, 984	- -
00 Reimbursable bad debts (from your records)				773, 704	1 2
Reimbursable bad debts for dual eligible beneficiaries (see in	structions)				2
Total costs - current cost reporting period (line 26 plus line			0	993, 984	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	·		0	0	
Pioneer ACO demonstration payment adjustment (see instructions)		0	0	
O Subtotal (see instructions)			0	993, 984	
Ol Sequestration adjustment (see instructions)			0	19, 881	
			1	974, 103	
On Interim payments (see instructions)			^	^	כור
no Interim payments (see instructions) 00 Tentative settlement (for contractor use only) 10 Balance due provider/program (line 31 minus lines 31.01, 32, a	nd 33)		0	0	

PROGRAM BENEFICIARIES

HHA CCN: 157174

				Agency I	PPS	
		I npati en	t Part A		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		(974, 103	1.00
2.00	Interim payments payable on individual bills, either		C)	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	1 Togram to 11 ovi dei		1 0)	0	3. 01
3. 02			Ì		Ö	3. 02
3.03			C		0	3. 03
3.04			C		0	3. 04
3. 05			C)	0	3. 05
3. 50	Provider to Program	T	1 0	\	0	3. 50
3. 50						3. 50
3. 52					0	3. 52
3.53			C)	0	3. 53
3.54			C)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		,		974, 103	4. 00
4.00	(transfer to Wkst. H-4, Part II, column as appropriate,			,	774, 103	4.00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR	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		l .			
5. 01	- regression and research		C)	0	5. 01
5.02			(0	5. 02
5. 03			C)	0	5. 03
5. 50	Provider to Program		1 0	\	0	5. 50
5. 51						5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		c)	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER)	0	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	6. 02
7. 00	Total Medicare program liability (see instructions)		d		974, 103	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8. 00
0.00	Indine of contractor	I		I	1 1	0.00

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	SPITAL In Lieu of Form CMS-2552-10				
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150026	Period: Worksheet K From 01/01/2014				

Hospice CCN: 150026 Period: From 01/01/2014 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm

			nospi ce (JON. 151527 1	0 12/31/2014	5/29/2015 3:1	
					Hospi ce I	0,2,,2010 011	, p
		Salaries (from	Employee	Transportation		Other	
			Benefits (from		Services (from		
			Wkst. K-2)	(000 111001)	Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1. 00
2.00	Capital Related Costs-Movable Equip.			0		0	2. 00
3.00	Plant Operation and Maintenance	0	0	0	519	0	3. 00
4.00	Transportation - Staff	0	0	0	o	0	4. 00
5.00	Volunteer Service Coordination	0	0	0	o	0	5. 00
6.00	Administrative and General	0	0	0	20, 072	164, 212	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	723, 837	0	0	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	0	o	0	8. 00
	VI SI TI NG SERVI CES		<u> </u>				
9.00	Physi ci an Servi ces	0	0	0	0	0	9. 00
10.00	Nursing Care	0	0	0	o	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	o	0	11. 00
12.00	Physical Therapy	0	0	0	o	0	12.00
13.00	Occupational Therapy	0	0	0	o	0	13. 00
14.00	Speech/ Language Pathology	0	0	0	o	0	14.00
15.00	Medical Social Services	0	0	0	o	0	15. 00
16.00	Spiritual Counseling	0	0	0	o	0	16. 00
17.00	Di etary Counseling	0	0	0	o	0	17. 00
18.00	Counseling - Other	0	0	0	o	0	18. 00
19.00	Home Health Aide and Homemaker	0	0	0	o	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	o	0	20. 00
21.00	Other	0	0	0	o	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	185, 847	22. 00
23.00	Anal gesi cs	0	0	0	o	0	23. 00
24.00	Sedatives / Hypnotics	0	0	0	o	0	24. 00
25.00	Other - Specify	0	0	0	o	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0	0	o	0	26. 00
27.00	Patient Transportation	0	0	0	o	0	27. 00
28.00	I maging Services	0	0	0	o	0	28. 00
29.00	Labs and Diagnostics	0	0	0	o	0	29. 00
30.00	Medical Supplies	0	0	0	o	29, 387	30. 00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	o	0	31. 00
32.00	Radi ati on Therapy	0	0	0	o	0	32.00
33.00	Chemotherapy	0	0	0	o	0	33. 00
34.00	Other	0	0	0	o	407, 480	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35. 00
36.00	Volunteer Program Costs	0	0	0	o	0	36. 00
37.00	Fundrai si ng	0	0	0	o	0	37. 00
38. 00	Other Program Costs	0	0	0	o	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	723, 837	0	0	20, 591	786, 926	39. 00

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150026				
	Hospi ce CCN: 15152	From 01/01/2014 To 12/31/2014 Date/Time Prepared:			

			Hospi ce (rom 01/01/2014 o 12/31/2014	Date/Time Pre	nared·
			110361 66 (7014. 101027	12/01/2011	5/29/2015 3:1	
					Hospi ce I		
				Subtotal (col.	Adjustments	Total (col. 8	
		1-5)	on	6 ± col . 7)		± col. 9)	
	DENERAL DERIVERS DOOT DENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	_		1 .	ما		
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	519	0	519	0	519	
4.00	Transportation - Staff	0	0	0	0	0	
5.00	Volunteer Service Coordination	104 204	0	104 204	0	104 204	5.00
6. 00	Administrative and General INPATIENT CARE SERVICE	184, 284	U	184, 284	υ	184, 284	6. 00
7. 00		723, 837	0	723, 837	ol	723, 837	7.00
8.00	Inpatient - General Care Inpatient - Respite Care	723, 637	0		ol Ol	723, 637	
0.00	VI SI TI NG SERVI CES	U	0	0	<u> </u>	0	0.00
9. 00	Physi ci an Servi ces	0	0	0	ol	0	9. 00
10. 00	Nursing Care	0	0	0	0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11.00
12. 00	Physical Therapy	0	0	0	0	0	12.00
13. 00	Occupational Therapy	0	0	0	0	0	13. 00
14. 00	Speech/ Language Pathology	0	0	o o	0	0	14. 00
	Medical Social Services	0	0	Ŏ	0	0	15. 00
	Spiritual Counseling	0	0	0	0	0	16. 00
	Di etary Counsel i ng	0	0	0	0	0	17. 00
18. 00	Counseling - Other	0	0	o	o	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	0	o	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	o	0	20.00
21. 00	Other	0	0	0	О	0	21. 00
	OTHER HOSPICE SERVICE COSTS						1
22. 00	Drugs, Biological and Infusion Therapy	185, 847	-185, 847	0	0	0	22. 00
23.00	Anal gesi cs	0	0	0	0	0	23. 00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24. 00
25.00	Other - Specify	0	0	0	0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26. 00
27. 00	Patient Transportation	0	0	0	0	0	27. 00
28. 00	I maging Services	0	0	0	0	0	
29. 00	Labs and Diagnostics	0	0	0	0	0	29. 00
30. 00	Medical Supplies	29, 387	-29, 387	0	0	0	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31. 00
32. 00	Radiation Therapy	0	0	0	0	0	32. 00
33. 00	Chemotherapy	0	0	0	0	0	33. 00
34. 00	Other	407, 480	0	407, 480	0	407, 480	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35. 00	Bereavement Program Costs	0	0	0	0	0	
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37. 00		0	0	0	0	0	37. 00
38. 00	Other Program Costs	1 521 254	0	1 21/ 120	0	0	
39.00	Total (sum of lines 1 thru 38)	1, 531, 354	-215, 234	1, 316, 120	이	1, 316, 120	J 39. UU

			nospi ce v	JCN. 151527	10 12/31/2014	5/29/2015 3:1	
					Hospi ce I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	<u>. </u>					
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance	0	C		0 0	0	3. 00
4.00	Transportation - Staff	0	C)	0 0	0	4. 00
5.00	Volunteer Service Coordination	0	C)	0	0	5. 00
6.00	Administrative and General	0	C		0 0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	723, 837	C	1	0		
8.00	Inpatient - Respite Care	0	C		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	C	1	0		9. 00
10.00	Nursi ng Care	0	C	1	0		10.00
11. 00	Nursing Care-Continuous Home Care	0	C	1	0		11. 00
12.00	Physi cal Therapy	0	C)	0	0	12. 00
13.00	Occupational Therapy	0	C)	0	0	
14. 00	Speech/ Language Pathology	0	C)	0	0	14. 00
15. 00	Medical Social Services	0	C)	0	0	15. 00
16. 00	Spiritual Counseling	0	C		0	0	16. 00
17. 00	Di etary Counsel i ng	0	C		0	0	17. 00
18. 00	Counseling - Other	0	C		0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	C		0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	C	1	0		20. 00
21. 00	Other	0	C		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS			T		Г	
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Pati ent Transportation	0	C	1	0 0	0	
28. 00	I maging Services	0	C		0 0	0	
29. 00	Labs and Diagnostics	0	C		0 0	0	
30.00	Medical Supplies	0	C		0	0	
31. 00	Outpatient Services (including E/R Dept.)	0	C	1	0 0	0	
32. 00	Radiation Therapy	0	C		0 0	0	32.00
33. 00	Chemotherapy	0	C	1	0 0		33. 00
34. 00	Other	l U	C	1	0 0	0	34. 00
35. 00	HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs	0	C	J	0 0	0	35. 00
36. 00	Volunteer Program Costs		C	1	0 0		
36.00	Fundrai si ng		(0 0		
38.00	Other Program Costs		(0 0		
	Total (sum of lines 1 thru 38)	723, 837	C	J	0 0		
37.00	Trotal (Sum of Trines I till a So)	125,057	C	Т	σ ₁ 0	1	1 37.00

Health Financial Systems	IU HEALTH GOSHEN HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CCN	: 150026	Peri od: From 01/01/2014	Worksheet K-1
	Hospi ce CCN:	151527		Date/Time Prepared: 5/29/2015 3:17 pm

			Hospi ce (CCN: 151527	To 12/31/2014	Date/Time Prepared:
					Hospi ce I	5/29/2015 3:17 pm
		Total	Ai des	All-Other	Total (1)	
		Therapists	Ai des	Ai i -otilei	10(a) (1)	
		6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS			•		
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance		0		0 0	3. 00
4.00	Transportation - Staff		0		0 0	4. 00
5.00	Volunteer Service Coordination		0		0 0	5. 00
6.00	Administrative and General		0		0 0	6. 00
	I NPATI ENT CARE SERVI CE					
7. 00	Inpatient - General Care		0		0 723, 837	7. 00
8.00	Inpatient - Respite Care		0		0 0	8. 00
	VI SI TI NG SERVI CES					
9. 00	Physi ci an Servi ces		0		0 0	9. 00
10.00	Nursing Care		0		0 0	10.00
11. 00	Nursing Care-Continuous Home Care		0		0 0	11. 00
12.00	Physical Therapy	0	0		0 0	12.00
13. 00	Occupational Therapy	0	0		0 0	13.00
14. 00	Speech/ Language Pathology Medical Social Services	U	0		0 0	14. 00 15. 00
15. 00 16. 00	Spiritual Counseling		0			16. 00
17. 00	Dietary Counseling		0			17. 00
18. 00	Counseling - Other		0			18.00
19. 00	Home Health Aide and Homemaker		0			19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care		0			20.00
21. 00	Other		0			21. 00
211.00	OTHER HOSPICE SERVICE COSTS				<u> </u>	2 00
22. 00	Drugs, Biological and Infusion Therapy					22. 00
23. 00	Anal gesi cs					23. 00
24.00	Sedatives / Hypnotics					24. 00
25.00	Other - Specify					25. 00
26.00	Durable Medical Equipment/Oxygen					26. 00
27.00	Patient Transportation		0		0 0	27. 00
28.00	I maging Services		0		0 0	28. 00
29. 00	Labs and Diagnostics		0		0 0	29. 00
30.00	Medical Supplies		0		0 0	30.00
31. 00	Outpatient Services (including E/R Dept.)		0		0 0	31.00
32.00	Radiation Therapy		0		0 0	32. 00
33.00	Chemotherapy		0		0 0	33. 00
34. 00	Other		0		0 0	34.00
	HOSPICE NONREIMBURSABLE SERVICE			1		
35. 00	Bereavement Program Costs		0		0 0	35. 00
36. 00	Volunteer Program Costs		0	•	0 0	36. 00
37. 00	Fundrai si ng		0		0 0	37. 00
38. 00	Other Program Costs		0		0 0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	I	0 723, 837	39.00

Health Financial Systems

IU HEALTH GOSHEN HOSPITAL

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 150026
Hospice CCN: 151527

Hospice CCN: 151527

Hospice CCN: 151527

Bate/Time Prepared: 5/29/2015 3:17 pm

				70111	10 12,01,2011	5/29/2015 3: 1	7 pm
					Hospi ce I		
		Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
		1.00	2.00	Servi ces 3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Brug and Trxt.						2.00
3.00	Plant Operation and Maintenance		0		0 0	0	
4. 00	Transportation - Staff		0		0 0		
5.00	Volunteer Service Coordination		0		0 0		
6.00	Administrative and General		0	1	0 0	-	
0.00	I NPATI ENT CARE SERVI CE	J U		1	0 0	U	0.00
7. 00	Inpatient - General Care	0	0		0 0	0	7. 00
8. 00	Inpatient - General Care		0		0 0		1
0.00	VISITING SERVICES	J U		1	0 0	U	0.00
9. 00		0	0	ı	0 0	0	9.00
	Physician Services		0				
10.00	Nursing Care	0	0		0 0	0	
11.00	Nursing Care-Continuous Home Care	0	0		-	-	
12.00	Physical Therapy	0	U		0 0	_	
13.00	Occupational Therapy	0	U	1	0 0	0	
14. 00	Speech/ Language Pathology	0	U		9	0	
15. 00	Medical Social Services	0	U		0 0	0	
16.00	Spiritual Counseling	0	Ü		0 0	0	
17. 00	Di etary Counsel i ng	0	Ü		0 0	0	
18.00	Counseling - Other	0	Ü		0 0	0	
19. 00	Home Health Aide and Homemaker	0	Ü		0 0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	1	0 0		
21. 00	Other	0	0	1	0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS			T			
	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Pati ent Transportation	0	Ü		0 0	0	
28. 00	I maging Services	0	0	1	0	0	
29. 00	Labs and Diagnostics	0	0	1	0	0	
30. 00	Medical Supplies	0	0	1	0	0	
31. 00	Outpatient Services (including E/R Dept.)	0	0	1	0	0	
32. 00	Radiation Therapy	0	0	1	0	0	
33.00	Chemotherapy	0	0	1	0	-	
34.00	Other	0	0		0 0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
	Bereavement Program Costs	0	0	1	0	-	
36.00	Volunteer Program Costs	0	0	1	0	-	
37.00	Fundrai si ng	0	0	1	0	-	
38. 00	Other Program Costs	0	0	l .	0		1
39. 00	Total (sum of lines 1 thru 38)	0	0	1	0 0	0	39. 00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES Provider CCN: 150026 Peri od: Worksheet K-3 From 01/01/2014 Hospi ce CCN: 151527 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm Hospi ce I Total Ai des All-Other Total (1) Therapi sts 7.00 8.00 9. 00 6 00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 3 00 Plant Operation and Maintenance 519 519 4.00 Transportation - Staff 0 0 0 4.00 5.00 Volunteer Service Coordination 5.00 6.00 Administrative and General 0 20.072 20, 072 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 7.00 8.00 Inpatient - Respite Care 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 9.00 10.00 Nursing Care 0 0 0 10.00 0 Nursing Care-Continuous Home Care 0 11.00 0 11.00 0 12.00 Physical Therapy 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 0 0 0 13.00 Speech/ Language Pathology 0 14.00 14.00 0 Medical Social Services 0 15.00 15.00 0 0 16.00 Spiritual Counseling 16.00 17.00 Dietary Counseling 0 17.00 0 0 18.00 Counseling - Other 18.00 Home Health Aide and Homemaker 0 19.00 19.00 0 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 20.00 21.00 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesi cs 23.00 Sedatives / Hypnotics 24.00 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26,00 27.00 Patient Transportation 27.00 0 28.00 Imaging Services 0 0 28.00 29 00 Labs and Diagnostics 0 0 29 00 0 0 30.00 Medical Supplies 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 0 31.00 Radiation Therapy 0 32.00 0 0 32.00 0 0 33.00 Chemotherapy 33.00 34.00 0ther 0 0 0 34.00

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36.00

37.00

38.00

39.00

HOSPICE NONREIMBURSABLE SERVICE

Bereavement Program Costs

Volunteer Program Costs

39.00 Total (sum of lines 1 thru 38)

Other Program Costs

Fundrai si ng

35 00

36.00

37.00

38.00

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150026
 Period: From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm

						5/29/2015 3:1	7 pm
					Hospi ce I		
			CAPITAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1.00	2.00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	Capital Related Costs-Bldg and Fixt.	0	0				1. 00
2.00	Capital Related Costs-Movable Equip.	0			0		2. 00
3. 00	Plant Operation and Maintenance	519	0		0		3. 00
4.00	Transportation - Staff	0	0		0	1	4. 00
5.00	Volunteer Service Coordination	104 004	0		0	1	5.00
6. 00	Administrative and General	184, 284	0		0 (0	6. 00
7. 00	INPATIENT CARE SERVICE Inpatient - General Care	723, 837	0	Ι	0 0	0	7. 00
7. 00 8. 00	Inpatient - General Care	723, 837	0		0 0		8.00
6.00	VISITING SERVICES	l o			U C) U	0.00
9. 00	Physician Services	0	0		0 0	0	9. 00
10. 00	Nursing Care	0	0		0		10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	_	11.00
12. 00	Physical Therapy	0	0		0	1	12.00
13. 00	Occupational Therapy	0	0		0		13. 00
14. 00	Speech/ Language Pathology	0	0		o d		14. 00
15. 00	Medical Social Services	0	0		0	o	15. 00
16.00	Spiritual Counseling	0	0		0 0	o	16. 00
17.00	Di etary Counseling	0	0		0	o	17. 00
18.00	Counseling - Other	0	0		0	0	18. 00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	20. 00
21. 00	Other	0	0		0 (0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0		0	1	22. 00
23. 00	Anal gesi cs	0	0	ł	0	1	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	1	24. 00
25. 00	Other - Specify	0	0		0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0	1	26. 00
27. 00	Patient Transportation	0	0		0 0	1	27. 00
28. 00 29. 00	I maging Services	0	0		0 0	1	28. 00 29. 00
30.00	Labs and Diagnostics Medical Supplies	0	0		0 (30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0 0		31.00
32. 00	Radiation Therapy	0	0		0		32.00
33. 00	Chemotherapy	0	0		0		33.00
34. 00	Other	407, 480	0		0		34.00
5 1. 00	HOSPI CE NONREI MBURSABLE SERVI CE	707, 700	0		<u> </u>	. 0	3 1. 00
35. 00	Bereavement Program Costs	0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs		0		0		36.00
37. 00	Fundrai si ng		0		0		37. 00
38. 00	Other Program Costs	l ol	0		0	1	38. 00
39. 00	Total (sum of lines 1 thru 38)	1, 316, 120	0		0	0	39. 00
					•		

Heal th Financial	Systems		IU HEALTH GOSHEN H	OSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION	- HOSPICE GENERAL	SERVICE COST		Provi der CCN:	150026	Peri od:	Worksheet K-4

From 01/01/2014 151527 To 12/31/2014 Part I Date/Time Prepared: Hospi ce CCN: 5/29/2015 3:17 pm Hospi ce I VOLUNTEER SUBTOTAL ADMINISTRATIVE TOTAL (col. 5A SERVI CES (cols. 0 - 5) & GENERAL ± col. 6) COORDI NATOR 5A 6.00 7. 00 5.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 Plant Operation and Maintenance 3.00 4.00 Transportation - Staff 4.00 5.00 Volunteer Service Coordination 5.00 Administrative and General 0 184, 284 184, 284 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 723, 837 117, 908 841, 745 7.00 8.00 8.00 0 0 VISITING SERVICES 9.00 Physician Services 0000000000000 0 9.00 0 10.00 Nursing Care 0 10.00 0 0 11.00 Nursing Care-Continuous Home Care 11.00 0 0 12.00 Physical Therapy 12.00 13.00 Occupational Therapy 13.00 0 0 0 0 0 0 Speech/ Language Pathology Medical Social Services 0 0 14.00 14.00 0 15.00 0 15.00 16.00 Spiritual Counseling 0 16.00 17.00 Dietary Counseling 0 0 17.00 0 0 18.00 Counseling - Other 18.00 OI 0 Home Health Aide and Homemaker 19.00 19.00 0 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 0 0 21.00 0ther 0 21.00 OTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy 0 0 22.00 0 0 22.00 0 23.00 Anal gesi cs 0 0 0 0 0 0 0 0 0 0 0 0 23.00 0 0 24.00 Sedatives / Hypnotics 0 0 24.00 25.00 Other - Specify 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 26.00 Patient Transportation 0 0 27.00 0 0 27.00 28 00 Imaging Services 0 0 28.00 Labs and Diagnostics 0 29.00 29.00 0 30.00 Medical Supplies 0 0 30.00 Outpatient Services (including E/R Dept.) 0 31.00 0 31.00 0 32 00 Radiation Therapy Ω 0 32.00 33.00 33.00 Chemotherapy C 0 0 34.00 407, 480 66, 376 473, 856 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 35.00 Bereavement Program Costs 0 0 0 0 0 0 36.00 Volunteer Program Costs 0 0 36.00 0 37.00 Fundrai si ng 0 0 37.00

0

1, 315, 601

0

1, 315, 601

38.00

39.00

38.00 Other Program Costs

39.00 Total (sum of lines 1 thru 38)

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150026
 Period: From 01/01/2014 Part II

 Hospice CCN: 151527
 To 12/31/2014 Date/Time Prepared: 5/29/2015 3:17 pm

						5/29/2015 3:1	7 pm
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.	, ,	COORDI NATOR	
		,		FT.)		(HOURS)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	00	0.00	
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2. 00	Capital Related Costs-Movable Equip.						2.00
3. 00	Plant Operation and Maintenance				o		3. 00
4. 00	Transportation - Staff	0		1	0		4.00
		0				0	
5.00	Volunteer Service Coordination	0	0	1	0	0	5. 00
6. 00	Administrative and General	0	0	1	0 0	0	6. 00
	I NPATI ENT CARE SERVI CE	1	1	1			
7. 00	Inpatient - General Care	0		1	0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0	0	8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	1	1	0 0	0	9. 00
10. 00	Nursing Care	0	0	l .	0	0	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0)	0	0	11. 00
12.00	Physi cal Therapy	0	0)	0	0	12.00
13.00	Occupational Therapy	0	0)	0	0	13.00
14.00	Speech/ Language Pathology	0)	0	0	14. 00
15. 00	Medical Social Services	0	1)	0	0	15. 00
16. 00	Spiritual Counseling	0			0	0	16. 00
17. 00	Di etary Counsel i ng	0			0	0	17. 00
18. 00	Counseling - Other	1 0			0	0	18. 00
19. 00	Home Health Aide and Homemaker	0		l .	0	0	19.00
20. 00	HH Aide & Homemaker - Cont. Home Care	0			0	0	20.00
21. 00			1	l .	0	0	21.00
21.00	Other OTHER HOSPICE SERVICE COSTS	0		1	J U	0	21.00
22.00		1 0		I	0 (0	22.00
22. 00	Drugs, Biological and Infusion Therapy	0		1			22. 00
23. 00	Anal gesi cs	0	0	1	0	0	23. 00
24. 00	Sedatives / Hypnotics	0	0	1	0	0	24. 00
25. 00	Other - Specify	0	0	1	0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0	1	0 0	0	26. 00
27. 00	Patient Transportation	0	0		0 0	0	27. 00
28. 00	I maging Services	0	0)	0	0	28. 00
29.00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	0	0)	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0)	0	0	31.00
32.00	Radi ati on Therapy	0	l 0		0	0	32.00
33.00	Chemotherapy	0)	0	0	33.00
34. 00	Other	0		,	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						1
35. 00	Bereavement Program Costs	0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs	0		1	0	0	36.00
37. 00	Fundrai si ng	1 0		1	0	0	37. 00
38. 00	Other Program Costs			1	0	0	38.00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)			1	0	0	39.00
	Unit Cost Multiplier	0. 000000	0. 000000		٥	0. 000000	1
40.00	John C 003C Wal Cipinel	0.00000	0.000000	0.00000	0.00000	0.000000	1 +0.00

RECONCILIATION ADMIN IN STRATI VE & GENERAL SERVICE COST CENTES						5/29/2015 3:1	17 pm
Benefield Service Cost Centers Capital Related Costs-Bild and First. O					Hospi ce I		
CACC. COST) CAPITAL SERVICE COST CENTERS CAPITAL SERVICE COST CENTERS CAPITAL SERVICE COST CENTERS CAPITAL SERVICE COSTS CENTERS CAPITAL SERVICE COSTS CENTERS CAPITAL SERVICE COSTS CENTERS CAPITAL SERVICE COSTS CENTERS CAPITAL SERVICE COSTS CENTER SERVICE COSTS CAPITAL SERV			RECONCILIATION				
CENERAL SERVICE COST CENTERS							
1.00			6A	6. 00			
2.00 Capit fall Related Costs-Movable Equip. 0 3.00 4.00 Transportation - Staff 0 4.00 5.00 Volunteer Service Coordination 5.00 1.00 Nurtier Service Coordination 5.00 1.00 Nurtier Service Coordination 5.00 1.00 Nurtier Service Coordination 5.00 1.00 Nursing Care 0 723,837 7.00 1.00 Nursing Care 0 0 0 8.00 1.00 Nursing Care 0 0 0 0 1.00 Nursing Care							
1.00			0				
4.00			0				
5.00 Volunteer Service Coordination -184, 284 1, 131, 317 6.00			0				
Administrative and General			0				
IMPATIENT CARE SERVICE		1					
Type Type	6.00		-184, 284	1, 131, 317			6.00
R. 00 Inpatient - Respite Care 0 0 0 8. 00				700 007			
VISITING SERVICES		, ·					
9.00 Physician Services	8.00		0	0			8.00
10.00 Nursing Care							
11.00 Nursing Care-Continuous Home Care 0 0 11.00 12.00 Physical Therapy 0 0 0 13.00 Occupational Therapy 0 0 0 14.00 Speech/ Language Pathology 0 0 0 15.00 Medical Social Services 0 0 0 16.00 Spiritual Counseling 0 0 0 16.00 Spiritual Counseling 0 0 0 17.00 Dietary Counseling 0 0 0 18.00 Counseling - Other 0 0 0 19.00 Home Heal th Aide and Homemaker 0 0 0 19.00 Hith Aide & Homemaker - Cont. Home Care 0 0 0 21.00 Other 0 0 0 21.00 Other 0 0 0 22.00 Other 0 0 0 23.00 Analgesics 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 25.00 Other - Specify 0 0 0 26.00 Urable Medical Equipment/Oxygen 0 0 0 27.00 Patient Transportation 0 0 0 28.00 Care 29.00 Labs and Diagnostics 0 0 0 0 30.00 Medical Supplies 0 0 0 31.00 Outpatient Services (including E/R Dept.) 0 0 0 33.00 Other Program Costs 0 0 0 34.00 Other Program Costs 0 0 0 35.00 Other Program Costs 0 0 0 36.00 Other Program Costs 0 0 0 37.00 Cost to be Allocated (per Wkst. K-4, Part I) 184, 284 39.00							
12.00 Physical Therapy 0 0 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 13.00 0 13.00 1							
13.00			0				
14. 00 Speech Language Pathol ogy 0 0 0 14. 00 15. 00 Medical Social Services 0 0 0 16. 00 Spiritual Counseling 0 0 0 17. 00 Dietary Counseling 0 0 0 18. 00 Counseling - Other 0 0 0 19. 00 Home Heal th Aide and Homemaker 0 0 0 19. 00 Hi Aide & Homemaker - Cont. Home Care 0 0 0 19. 00 Other 0 0 0 22. 00 Other 0 0 0 23. 00 Other Specify 0 0 0 24. 00 Sedatives / Hypnotics 0 0 0 25. 00 Other - Specify 0 0 0 26. 00 Durable Medical Equipment/Oxygen 0 0 0 27. 00 Patient Transportation 0 0 0 28. 00 Imaging Services 0 0 0 29. 00 Labs and Diagnostics 0 0 0 30. 00 Medical Supplies 0 0 0 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 32. 00 Radiation Therapy 0 0 0 33. 00 Other Homemaker - Cont. Home Care 0 0 34. 00 Other Homemaker - Cont. Home Care 0 0 35. 00 Bereavement Program Costs 0 0 0 36. 00 Volunteer Program Costs 0 0 0 37. 00 Fundral sing 0 0 0 39. 00 Other Program Costs 0 0 0 39. 00 Otst to be Ailocated (per Wkst. K-4, Part I) 184, 284 39.00			0	ŭ			
15. 00 Medical Social Services 0 0 0 15. 00 16. 00 Spiritual Counseling 0 0 0 16. 00 17. 00 Dietary Counseling 0 0 0 0 18. 00 Counseling - Other 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 18. 00 19. 00 Counseling - Other 0 0 0 19. 00 Counseling - Other Counsel			0	- 1			
16. 00 Spiritual Counseling 0			0	- 1			
17. 00 Di etary Counseling 0 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 0 19. 00 Home Heal th Aide and Homemaker 0 0 0 20. 00 HH Aide & Homemaker - Cont. Home Care 0 0 0 21. 00 Other 0 0 0 0 22. 00 Other 0 0 0 23. 00 Other 0 0 0 23. 00 Anal gesics 0 0 0 24. 00 Sedatives / Hypnotics 0 0 0 25. 00 Other - Specify 0 0 0 26. 00 Durable Medical Equipment/Oxygen 0 0 0 28. 00 Imaging Services 0 0 0 29. 00 Labs and Di agnostics 0 0 0 29. 00 Labs and Di agnostics 0 0 0 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 32. 00 Radiation Therapy 0 0 0 33. 00 Other - Specify 0 0 0 34. 00 Homeficial Supplies 0 0 0 35. 00 Radiation Therapy 0 0 0 36. 00 Otherapy 0 0 0 37. 00 Otherapy 0 0 0 38. 00 Otherapy 0 0 0 38. 00 Otherapy 0 0 0 37. 00 Fundraising 0 0 0 38. 00 Other Program Costs 0 0 0 38. 00 Other Program Costs 0 0 38. 00 Other Program Costs 0 0 39. 00 Cost to be Allocated (per Wkst. K-4, Part i) 184,284 39. 00		4	0				•
18.00 Counseling - Other 0 0 0 18.00 19.00			0	٥,			•
19.00 Home Heal th Aide and Homemaker			0	- 1			
20.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 0			0	ŭ,			
21.00 Other			0	- 1			
DTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy O O O O O O O O O							1
22. 00 Drugs, Biological and Infusion Therapy 0 0 23. 00 23. 00 Anal gesics 0 0 0 23. 00 24. 00 Sedatives / Hypnotics 0 0 0 24. 00 25. 00 Other - Specify 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 25. 00 26. 00 Patient Transportation 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 28. 00 29. 00 Labs and Di agnostics 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 33. 00 34. 00 Other 0 0 33. 00 35. 00 Bereavement Program Costs 0 0 0 35. 00 <tr< td=""><td>21. 00</td><td></td><td>0</td><td>0</td><td></td><td></td><td>21. 00</td></tr<>	21. 00		0	0			21. 00
23. 00							
24. 00 Sedatives / Hypnotics 0 0 24. 00 25. 00 Other - Specify 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 26. 00 27. 00 28. 00 27. 00 27. 00 28. 00 27. 00 28. 00 29. 00 28. 00 28. 00 29. 00 28. 00 29. 00 29. 00 30. 00 29. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 31. 00 31. 00 31. 00 32. 00 32. 00 32. 00 33. 00 32. 00 33. 00 32. 00 33. 00 34. 00 34. 00 34. 00 34. 00 35. 00 36. 00 36. 00 36. 00 36. 00 37. 00 36. 00 37. 00 38. 00 39. 00 38. 00 39. 00 30. 00 39. 00 39. 00 30. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
25. 00 Other - Specify 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 27. 00 Patient Transportation 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 29. 00 Labs and Diagnostics 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 32. 00 33. 00 Other 0 0 0 0 33. 00 34. 00 Other 0 0 407, 480 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 36. 00 37. 00 Fundraising 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 38. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 184, 284			0	- 1			
26. 00 Durable Medical Equipment/Oxygen 0 0 27. 00 Patient Transportation 0 0 28. 00 Imaging Services 0 0 29. 00 Labs and Diagnostics 0 0 30. 00 Medical Supplies 0 0 31. 00 Outpatient Services (including E/R Dept.) 0 0 32. 00 Radiation Therapy 0 0 33. 00 Chemotherapy 0 0 34. 00 Other 0 407, 480 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 37. 00 Fundraising 0 0 38. 00 Other Program Costs 0 0 37. 00 38. 00 38. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 184, 284 39. 00		7.	0				
27. 00 Pati ent Transportation 0 0 27. 00 28. 00 Imaging Services 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 29. 00 30. 00 Medical Supplies 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 33. 00 34. 00 Other 0 407, 480 34. 00 HOSPICE NONREI MBURSABLE SERVI CE 35. 00 36. 00 Vol unteer Program Costs 0 0 35. 00 37. 00 Fundraising 0 0 37. 00 38. 00 Other Program Costs 0 0 0 38. 00 Other Program			0	ŭ			
28. 00 Imaging Services 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 32. 00 Radiation Therapy 0 0 0 33. 00 Chemotherapy 0 0 0 34. 00 Other 0 407, 480 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 36. 00 Volunteer Program Costs 0 0 37. 00 Fundraising 0 0 38. 00 Other Program Costs 0 0 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 184, 284 39. 00			0	0			
29. 00 Labs and Diagnostics 0 0 29. 00 30. 00 Medical Supplies 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 33. 00 34. 00 Other 0 407, 480 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 36. 00 37. 00 Fundraising 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 38. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 184, 284 39. 00		•	0	0			•
30.00 Medical Supplies 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 32.00 Radiation Therapy 0 0 0 33.00 Chemotherapy 0 0 0 34.00 Other HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 36.00 Volunteer Program Costs 0 0 37.00 Fundraising 0 0 38.00 Other Program Costs 0 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 184, 284 39.00			0	0			
31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 33.00 Chemotherapy 0 0 0 0 0 33.00 Chemotherapy 0 0 0 0 0 0 0 0 0		Labs and Diagnostics	0	0			
32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 0 33. 00 34. 00 Other 0 407, 480 34. 00 HOSPI CE NONREI MBURSABLE SERVI CE 35. 00 Bereavement Program Costs 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 36. 00 37. 00 Fundrai si ng 0 0 37. 00 38. 00 Other Program Costs 0 0 38. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 184, 284 39. 00	30.00	Medical Supplies	0	0			30.00
33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 407, 480 34.00 HOSPICE NONREIMBURSABLE SERVICE	31.00	Outpatient Services (including E/R Dept.)	0	0			31.00
34. 00 Other	32.00	Radiation Therapy	0	0			32. 00
HOSPICE NONREIMBURSABLE SERVICE	33.00	Chemotherapy	0	0			33. 00
35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 184,284 39.00	34.00		0	407, 480			34. 00
36.00 Volunteer Program Costs 0 0 0 37.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 Cost to be Allocated (per Wkst. K-4, Part I) 184,284 39.00		HOSPICE NONREIMBURSABLE SERVICE					
37.00 Fundraising 0 0 38.00 Other Program Costs 0 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 184,284 39.00	35.00	Bereavement Program Costs	0	0			35. 00
38.00 Other Program Costs 0 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 38.00 39.00	36.00	Volunteer Program Costs	0	0			36.00
39.00 Cost to be Allocated (per Wkst. K-4, Part I) 184,284 39.00	37.00	Fundrai si ng	o	o			37. 00
	38.00	Other Program Costs	o	o			38. 00
40.00 Unit Cost Multiplier 0.162893 40.00	39.00	Cost to be Allocated (per Wkst. K-4, Part I)		184, 284			39. 00
	40.00	Unit Cost Multiplier		0. 162893			40.00

Health Financial Systems IU HEALT ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						3/29/2013 3.1	/ pili
					Hospice I		
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Hospice Trial	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	CASHI ERI NG/ACC	
		Bal ance (1)			BENEFI TS	OUNTS	
					DEPARTMENT	RECEI VABLE	
		0	1.00	2. 00	4. 00	5. 01	
1.00	Administrative and General		21, 084	0	234, 440	0	1. 00
2.00	Inpatient - General Care	841, 745	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursi ng Care	0	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	O	0	0	0	0	15. 00
16.00	Other	O	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	0	0	0	0	17. 00
18.00	Anal gesi cs	o	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	o	0	0	0	0	19. 00
20.00	Other - Specify	o	0	0	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Patient Transportation	0	0	0	0	0	22. 00
23. 00	I maging Services	0	0	0	0	0	23. 00
24. 00	Labs and Diagnostics	0	0	0	0	0	24. 00
25. 00	Medical Supplies	0	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	Ō	28. 00
29. 00	Other	473, 856	0	0	0	0	29. 00
30. 00	Bereavement Program Costs	0	0	0	0	0	30.00
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00
32. 00	Fundrai si ng	0	n	l o	n	Ö	32. 00
33. 00	Other Program Costs	l o	n	ا م	0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	1, 315, 601	21, 084	ا م	234, 440		34. 00
	Unit Cost Multiplier (see instructions)	., 5.5, 661	2.,001		20., 110		35. 00
55.50	12 1 2222a. 1. p. 1. 0. (000 1.1.01. 4011 0110)	1 1	ı	I	II	ı	

Cost Center Description							5/29/2015 3: 1	/ pili
ADMINISTRATIVE REPAIRS PLANT LINEN SERVICE						Hospi ce I		
SA.01 S.02 6.00 7.00 8.00		Cost Center Description	Subtotal	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	
SA. 01 S. 02 6. 00 7. 00 8. 00					REPAI RS	PLANT	LINEN SERVICE	
1.00 Administrative and General 255,524 61,425 0 0 0 1.00 2.00 Inpatient - General Care 841,745 202,344 0								
2.00 Inpatient - General Care 841,745 202,344 0 0 0 0 3.00 3.00 Inpatient - Respite Care 0 0 0 0 0 0 3.00 4.00 Physician Services 0 0 0 0 0 0 0 0 4.00 5.00 Nursing Care 0<						7. 00	8. 00	
3.00 Inpatient - Respite Care 0 0 0 0 0 0 3.00 4.00 4.00 Physician Services 0 0 0 0 0 0 0 0 4.00 5.00 Nursing Care 0 0 0 0 0 0 0 5.00 6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 6.00 7.00 Physical Therapy 0 0 0 0 0 0 0 0 7.00 8.00 Occupational Therapy 0 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 9.00						0	0	1. 00
4.00 Physician Services 0 0 0 0 4.00 5.00 Nursing Care 0 0 0 0 0 5.00 6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 6.00 7.00 Physical Therapy 0		Inpatient - General Care	841, 745	202, 344	0	0	0	2. 00
5.00 Nursing Care 0 0 0 0 0 5.00 6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 6.00 7.00 Physical Therapy 0 9.00 9.00 Speech/ Language Pathology 0 <td>3.00</td> <td>Inpatient - Respite Care</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>3. 00</td>	3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
6.00 Nursi ng Care-Conti nuous Home Care 0 0 0 0 6.00 7.00 Physi cal Therapy 0 0 0 0 0 7.00 8.00 Occupati onal Therapy 0 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathol ogy 0 0 0 0 0 9.00	4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
7.00 Physical Therapy 0 0 0 0 7.00 8.00 Occupational Therapy 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 0 9.00	5.00	Nursing Care	0	0	0	0	0	5. 00
8.00 Occupational Therapy 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 9.00	6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
9.00 Speech/ Language Pathol ogy 0 0 0 0 9.00	7.00	Physi cal Therapy	0	0	0	0	ol	7. 00
	8.00	Occupational Therapy	0	0	0	0	ol	8. 00
10 00 Medical Social Services 0 0 0 0 0 10 0	9.00	Speech/ Language Pathology	0	0	0	0	ol	9. 00
	10.00	Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling 0 0 0 11.00	11.00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00 Dietary Counseling 0 0 0 0 12.00	12.00	Di etary Counsel i ng	0	0	0	0	ol	12.00
13.00 Counsel i ng - Other 0 0 0 13.00	13.00	Counseling - Other	0	0	0	0	ol	13.00
14.00 Home Health Aide and Homemaker 0 0 0 0 0 14.00	14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 15.00	15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00 Other 0 0 0 0 0 16.00	16.00	0ther	0	0	0	0	ol	16.00
17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00	17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	ol	17. 00
18.00 Anal gesi cs 0 0 0 0 18.00	18.00	Anal gesi cs	0	0	0	0	ol	18. 00
19.00 Sedatives / Hypnotics 0 0 0 19.00	19.00	Sedatives / Hypnotics	0	0	0	0	ol	19. 00
20.00 Other - Specify 0 0 0 0 0 20.00	20.00	Other - Specify	0	0	0	0	ol	20. 00
21.00 Durable Medical Equipment/Oxygen 0 0 0 21.00	21.00	Durable Medical Equipment/Oxygen	0	0	0	0	ol	21. 00
22.00 Patient Transportation 0 0 0 0 0 22.00	22. 00	Patient Transportation	0	0	0	0	ol	22. 00
23.00 Imaging Services 0 0 0 0 0 0 23.00	23.00	I maging Services	0	0	0	0	0	23. 00
24.00 Labs and Diagnostics 0 0 0 0 0 24.00	24.00	Labs and Diagnostics	0	0	0	0	0	24. 00
25.00 Medical Supplies 0 0 0 0 25.00	25. 00	Medi cal Supplies	0	0	0	0	0	25. 00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 26.00	26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27.00 Radiation Therapy 0 0 0 0 0 27.00	27. 00	Radi ati on Therapy	0	0	0	0	0	27. 00
28.00 Chemotherapy 0 0 0 0 28.00	28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00 Other 473, 856 113, 909 0 0 0 29. 00	29. 00	0ther	473, 856	113, 909	0	0	ol	29. 00
30.00 Bereavement Program Costs 0 0 0 0 0 30.00	30.00	Bereavement Program Costs	0	0	0	0	ol	30. 00
31.00 Volunteer Program Costs 0 0 0 0 0 31.00	31.00	Volunteer Program Costs	0	0	0	0	ol	31.00
32.00 Fundrai si ng 0 0 0 0 0 32.00	32.00	Fundrai si ng	0	0	0	0	ol	32.00
33.00 Other Program Costs 0 0 0 0 0 33.00	33.00	Other Program Costs	0	0	0	0	ol	33. 00
34.00 Total (sum of lines 1 thru 33) (2) 1,571,125 377,678 0 0 34.00	34.00	Total (sum of lines 1 thru 33) (2)	1, 571, 125	377, 678	0	0	ol	34.00
35.00 Unit Cost Multiplier (see instructions) 0.000000 35.00	35. 00	Unit Cost Multiplier (see instructions)	0. 000000					35. 00

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150026
 Period: From 01/01/2014
 Worksheet K-5 Part I Date/Time Prepared: 5/29/2015 3:17 pm
 Health Financial Systems IU HEALT ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						5/29/2015 3:1	7 pm
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
					ADMI NI STRATI ON		
						SUPPLY	
		9. 00	10. 00	11. 00	13. 00	14. 00	
1.00	Administrative and General	0	0	(63, 442	14, 478	1. 00
2.00	Inpatient - General Care	0	0	(0	0	2. 00
3.00	Inpatient - Respite Care	0	0	(0	0	3. 00
4.00	Physi ci an Servi ces	0	0	(0	0	4. 00
5.00	Nursi ng Care	0	0	(0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	(0	0	6. 00
7.00	Physi cal Therapy	0	0	(0	0	7. 00
8.00	Occupational Therapy	0	0	(0	0	8. 00
9.00	Speech/ Language Pathology	0	0	(0	0	9. 00
10.00	Medical Social Services	0	0	(0	0	10. 00
11. 00	Spiritual Counseling	0	0	(0	0	11. 00
12.00	Di etary Counsel i ng	0	0	(0	0	12. 00
13.00	Counseling - Other	0	0	(0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0	(0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	(0	0	15. 00
16.00	0ther	0	0	(0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	(0	0	17. 00
18.00	Anal gesi cs	0	0	(0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	(0	0	19. 00
20.00	Other - Specify	0	0	(0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0	(0	0	21. 00
22. 00	Patient Transportation	0	0	(0	0	22. 00
23.00	I maging Services	0	0	(0	0	23. 00
24.00	Labs and Diagnostics	0	0	(0	0	24. 00
25.00	Medi cal Supplies	0	0	(0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	(0	0	26. 00
27. 00	Radi ati on Therapy	0	0	(0	0	27. 00
28. 00	Chemotherapy	0	0	(0	0	28. 00
29.00	Other	0	0	(0	0	29. 00
30.00	Bereavement Program Costs	0	0	(0	0	30.00
31.00	Volunteer Program Costs	0	0	(0	0	31.00
32.00	Fundrai si ng	0	0	(0	0	32. 00
33.00	Other Program Costs	0	0	(0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	(63, 442	14, 478	34. 00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

OSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150026 | Period: From 01/01/2014 | Part I |

Hospice CCN: 151527 | To 12/31/2014 | Part I |

Date/Time Prepared: 5/29/2015 3:17 pm

						5/29/2015 3:1	7 pm
					Hospi ce I		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	E ALLI ED HEALTH	Subtotal	
			RECORDS &			(cols. 4A-23)	
			LI BRARY				
		15. 00	16. 00	17. 00	23. 00	24. 00	
1.00	Administrative and General	0	(0	394, 869	1. 00
2.00	Inpatient - General Care	0	(0	1, 044, 089	2. 00
3.00	Inpatient - Respite Care	0	(0 0	0	3. 00
4.00	Physi ci an Servi ces	0	(0 0	0	4. 00
5.00	Nursing Care	0	(0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	(0 0	0	6. 00
7.00	Physi cal Therapy	0	(0 0	0	7. 00
8.00	Occupational Therapy	0	(0 0	0	8. 00
9.00	Speech/ Language Pathology	0	(0 0	0	9. 00
10.00	Medical Social Services	0	(0 0	0	10.00
11.00	Spiritual Counseling	0	(0 0	0	11. 00
12.00	Di etary Counsel i ng	0	(0 0	0	12. 00
13.00	Counseling - Other	0	(0 0	0	13. 00
14.00	Home Health Aide and Homemaker	0	(0 0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	(0 0	0	15. 00
16.00	Other	0	(0 0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	(0 0	0	17. 00
18.00	Anal gesi cs	0	(0 0	0	18. 00
19.00	Sedatives / Hypnotics	0	(0 0	0	19. 00
20.00	Other - Specify	0	(0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	(0 0	0	21. 00
22.00	Patient Transportation	0	(0 0	0	22. 00
23.00	I maging Services	0	(0 0	0	23. 00
24.00	Labs and Diagnostics	0	(0 0	0	24. 00
25.00	Medical Supplies	0	(0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	(0 0	0	26. 00
27. 00	Radi ati on Therapy	0	(0 0	0	27. 00
28. 00	Chemotherapy	0	(0 0	0	28. 00
29.00	Other	0	(0 0	587, 765	29. 00
30.00	Bereavement Program Costs	0	(0 0	0	30. 00
31.00	Volunteer Program Costs	0	(0 0	0	31.00
32.00	Fundrai si ng	0	(0 0	0	32. 00
33.00	Other Program Costs	O	(0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	(0	2, 026, 723	34.00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150026
 Period: From 01/01/2014
 Worksheet K-5 Part I Date/Time Prepared: 5/29/2015 3:17 pm

						5/29/2015 3:17 pm	_
					Hospi ce I		_
	Cost Center Description	Intern &	Subtotal	Allocated	Total Hospice		
		Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.		
		& Post	25)	(See Part II)	26 ± 27)		
		Stepdown					
		Adjustments					
		25. 00	26.00	27. 00	28. 00		
1.00	Administrative and General					1.00	
2.00	Inpatient - General Care	0	1, 044, 089	252, 644	1, 296, 733	2.00)
3.00	Inpatient - Respite Care	0	0	C	0	3.00)
4.00	Physician Services	0	0	C	0	4.00	
5.00	Nursi ng Care	0	0	C	0	5. 00)
6.00	Nursing Care-Continuous Home Care	0	0	C	0	6. 00)
7.00	Physi cal Therapy	0	0	C	0	7.00)
8.00	Occupational Therapy	0	0	C	0	8. 00)
9.00	Speech/ Language Pathology	0	0	C	0	9. 00)
10.00	Medical Social Services	0	0	C	0	10. 00)
11.00	Spiritual Counseling	O	0	C	o	11. 00)
12.00	Di etary Counsel i ng	0	0	C	o	12. 00)
13.00	Counseling - Other	0	0	C	o	13. 00)
14.00	Home Health Aide and Homemaker	0	0	C	o	14. 00)
15.00	HH Aide & Homemaker - Cont. Home Care	O	0	C	o	15. 00)
16.00	Other	O	0	C	o	16. 00)
17.00	Drugs, Biological and Infusion Therapy	O	0	C	o	17. 00)
18.00	Anal gesi cs	O	0	C	o	18. 00)
19.00	Sedatives / Hypnotics	O	0	C	o	19. 00)
20.00	Other - Specify	O	0	C	o	20.00)
21.00	Durable Medical Equipment/Oxygen	O	0	C	o	21. 00)
22. 00	Patient Transportation	O	0	C	o	22. 00)
23.00	I maging Services	O	0	C	o	23. 00)
24.00	Labs and Diagnostics	o	0	C	o	24. 00)
25.00	Medical Supplies	o	0	C	o	25. 00)
26.00	Outpatient Services (including E/R Dept.)	o	0	C	o	26. 00)
27.00	Radi ati on Therapy	O	0	C	o	27. 00)
28. 00	Chemotherapy	o	0	l	ol	28. 00)
29. 00	Other	o	587, 765	142, 225	729, 990	29. 00)
30.00	Bereavement Program Costs	o	0	ĺ	o	30.00	
31.00	Volunteer Program Costs	o	0	l d	ol	31.00	
32.00	Fundrai si ng	o	0		ol	32. 00)
33. 00	Other Program Costs	l	0		ol	33.00	
34.00	Total (sum of lines 1 thru 33) (2)	o	2, 026, 723		2, 026, 723	34.00	
	Unit Cost Multiplier (see instructions)			0. 241976		35. 00)
	• • • • • • • • • • • • • • • • • • • •			•		'	

STATISTICAL BASIS

						5/29/2015 3:1	/ pm
					Hospi ce I		
	·	CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	CASHI ERI NG/ACC	Reconciliation	
	, and the second		(DOLLAR VALUE)	BENEFITS	OUNTS		
		(()	DEPARTMENT	RECEI VABLE		
				(GROSS	(GROSS		
				SALARI ES)	CHARGES)		
		1.00	2.00	4. 00	5. 01	5A. 02	
1.00	Administrative and General	2, 562	2.00				1. 00
2.00	Inpatient - General Care	0				0	2.00
3.00	Inpatient - Respite Care			1		0	3. 00
		0	,	1		_	1
4.00	Physi ci an Servi ces	0	0	1		0	
5.00	Nursing Care	0	0	1	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	1	0	0	6. 00
7.00	Physi cal Therapy	0	0	(0	0	7. 00
8.00	Occupational Therapy	0	0	(0	0	8. 00
9. 00	Speech/ Language Pathology	0	0	(0	0	9. 00
10.00	Medical Social Services	0	0		0	0	10. 00
11. 00	Spiritual Counseling	0	0		0	0	11. 00
12.00	Di etary Counsel i ng	0	0	· C	0	0	12.00
13.00	Counseling - Other	0	O		0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0		0	0	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	Ó	1	0	0	15. 00
16. 00	Other	0	Ó		0	0	16, 00
17. 00	Drugs, Biological and Infusion Therapy	0	Ö		0	0	17. 00
	Anal gesi cs	i o	Ö	1	_	0	18. 00
	Sedatives / Hypnotics	0	Ö	1	1	0	19. 00
20. 00	Other - Specify	0	Ö	1	1	0	20.00
	Durable Medical Equipment/Oxygen	0		1	_	0	21.00
22. 00	Patient Transportation	0		1	1	0	22.00
	Imaging Services	0		1	_	0	23. 00
	Labs and Diagnostics	0		1	_	0	24.00
25. 00		0		1	_	0	25. 00
	Medical Supplies	0	ı	1		1	•
26. 00	Outpatient Services (including E/R Dept.)	0	0	_	0	0	26. 00
27. 00	Radi ati on Therapy	0	0	1	0	0	27. 00
28. 00	Chemotherapy	0	0	1	0	0	28. 00
29. 00	Other	0	0	(0	0	29. 00
30. 00	Bereavement Program Costs	0	0	(0	0	30. 00
31. 00	Volunteer Program Costs	0	0	(0	0	31. 00
32.00	Fundrai si ng	0	0		0	0	32. 00
33.00	Other Program Costs	0	0	(0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	2, 562	0	100	0		34.00
35.00	Total cost to be allocated	21, 084	0	234, 440	18, 485		35. 00
36. 00	Unit Cost Multiplier (see instructions)	8. 229508	0. 000000	1			36.00
	1 (3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.					1	

OSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150026 | Period: From 01/01/2014 | Part II |
Hospice CCN: 151527 | To 12/31/2014 | Part II |
Date/Time Prepared: 5/29/2015 3:17 pm STATISTICAL BASIS

						5/29/2015 3:1	7 pm
					Hospi ce I		
	Cost Center Description	OTHER	MAINTENANCE 8	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	
		& GENERAL	(SQUARE FEET)	(SQUARE FEET	(POUNDS OF		
		(ACCUM. COST)			LAUNDRY)		
		5. 02	6.00	7.00	8. 00	9. 00	
1.00	Administrative and General	255, 524		0	0 0	0	1. 00
2.00	Inpatient - General Care	841, 745		0	0 0	0	2. 00
3.00	Inpatient - Respite Care	0		0	0 0	0	3. 00
4.00	Physi ci an Servi ces	0		0	0 0	0	4. 00
5.00	Nursing Care	0		0	0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0		0	0 0	0	6. 00
7.00	Physical Therapy	0		o	0 0	0	7. 00
8.00	Occupational Therapy	0		o	0 0	0	8. 00
9.00	Speech/ Language Pathology	0		o	0 0	0	9. 00
10.00	Medical Social Services	0		o	0 0	0	10.00
11. 00	Spiritual Counseling	0		o	0 0	0	11. 00
12.00	Dietary Counseling	0		o	0 0	0	12.00
13.00	Counseling - Other	0		o	0 0	0	13.00
14.00	Home Health Aide and Homemaker	0		o	0 0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0		o	0 0	0	15. 00
16.00	Other	0		o	0 0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0		o	0 0	0	17. 00
18.00	Anal gesi cs	0		o	0 0	0	18. 00
19. 00	Sedatives / Hypnotics	0		o	0 0	0	19. 00
20.00	Other - Specify	0		o	0 0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0		ol	0 0	0	21. 00
22. 00	Patient Transportation	0		o	0 0	0	22. 00
23. 00	Imaging Services	0		o	0 0	0	23. 00
24.00	Labs and Diagnostics	0		o	0 0	0	24. 00
25. 00	Medical Supplies	0		o	0 0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0		o	0 0	0	26. 00
27. 00	Radi ati on Therapy	0		o	0 0	0	27. 00
28. 00	Chemotherapy	0		ol	0 0	0	28. 00
29. 00	Other	473, 856		ol	0 0	0	1
30.00	Bereavement Program Costs	0		ol	0 0	0	30.00
31. 00	Volunteer Program Costs	0		o	0	0	31.00
32. 00	Fundrai si ng	0		ol	0 0	0	32. 00
33. 00	Other Program Costs	0		ol	o	Ō	1
34. 00	Total (sum of lines 1 thru 33) (2)	1, 571, 125		ol	o	ő	1
35. 00	Total cost to be allocated	377, 678		37, 37	4	17, 379	1
	Unit Cost Multiplier (see instructions)	0. 240387					1
55.50	12 1 2222a. 1. p. 1 0. (000 1ot. 4011 0110)	5.2.3007		-, 5. 55000	5. 550000		, 50.00

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provi der CCN: 150026
 Peri od: From 01/01/2014
 Worksheet K-5

 Hospi ce CCN: 151527
 To 12/31/2014
 Date/Time Prepared: 5/29/2015 3: 17 pm
 STATISTICAL BASIS

						5/29/2015 3:17	/ pm
					Hospi ce I		
	Cost Center Description	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	The second secon	(MEALS SERVED)	(MANHOURS)	ADMINISTRATIO		(COSTED	
		()	(SUPPLY	REQUIS.)	
				(DIRECT NURS.	(COSTED	1 112010.)	
				HRS.)	REQUIS.)		
		10.00	11.00	13. 00	14. 00	15.00	
1. 00	Administrative and General	27, 674	0			0	1. 00
2.00	Inpatient - General Care		0	1	0	ol	2. 00
3.00	Inpatient - Respite Care		0		0	o	3. 00
4. 00	Physician Services		0			Ö	4. 00
5. 00	Nursing Care		0			l ől	5. 00
6. 00	Nursing Care-Continuous Home Care		0		0	l ol	6. 00
7. 00	Physical Therapy		0				7. 00
8. 00	Occupational Therapy		0		0		8. 00
9. 00		0	0		0		9. 00
	Speech/ Language Pathology	0	0		0		
10.00	Medical Social Services	0	0		0	0	10.00
11.00	Spiritual Counseling	0	U		0	0	11. 00
12.00	Di etary Counsel i ng	0	Ü		0	0	12.00
13. 00	Counseling - Other	0	0		0	0	13. 00
14. 00	Home Health Aide and Homemaker	0	O		0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15. 00
16. 00	Other	0	0		0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	19.00
20.00	Other - Specify	0	0		0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	21.00
22.00	Pati ent Transportation	o	0		o o	o	22.00
23.00	I maging Services	o	0		0 0	o	23.00
24.00	Labs and Diagnostics	ol	0		o o	l ol	24.00
25. 00	Medical Supplies	0	0		0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
27. 00	Radi ati on Therapy	o	0		0	ol	27. 00
28. 00	Chemotherapy		0		0	ol	28. 00
29. 00	Other		0		0	0	29. 00
30. 00	Bereavement Program Costs		0			Ö	30. 00
31. 00	Volunteer Program Costs		0				31. 00
32. 00	Fundrai si ng		0				32. 00
33. 00	Other Program Costs		0				33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	27, 674	0	10, 77	6 518, 001	0	34. 00
		27,074	11, 577		·		35. 00
35. 00	Total cost to be allocated	0 000000					
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	5. 88734	2 0. 027950	0.000000	36. UU

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150026
 Period: From 01/01/2014
 Worksheet K-5 Part II Date/Time Prepared: 5/29/2015 3: 17 pm
 Health Financial Systems IU HEALT ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS IU HEALTH GOSHEN HOSPITAL

STATISTICAL BASIS

					Heeni ee I	3/27/2013 3.1	7 piii
	C+ C+ D -+	MEDLON	COCLAL CEDVICE	ALLED HEALTH	Hospi ce I		
	Cost Center Description		SOCIAL SERVICE				
		RECORDS &	(TIME CDENT)	(ASSI GNED			
		LI BRARY	(TIME SPENT)	TIME)			
		(GROSS					
		CHARGES)					
		16. 00	17. 00	23. 00			
1. 00	Administrative and General	0	1	_			1. 00
2.00	Inpatient - General Care	0	0	0			2. 00
3. 00	Inpatient - Respite Care	0	0	0			3. 00
4.00	Physi ci an Servi ces	0	0	0			4. 00
5.00	Nursing Care	0	0	0			5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0			6. 00
7.00	Physi cal Therapy	0	0	0			7. 00
8.00	Occupational Therapy	0	0	0			8. 00
9.00	Speech/ Language Pathology	0	0	0			9. 00
10.00	Medical Social Services	0	0	0			10.00
11. 00	Spiritual Counseling	0	0	0			11. 00
	Di etary Counsel i ng	0	0	0			12.00
	Counseling - Other	0	0	0			13.00
	Home Health Aide and Homemaker	0	0	0			14.00
	HH Aide & Homemaker - Cont. Home Care	0	0	0			15. 00
16. 00	Other	0	0	_			16. 00
	Drugs, Biological and Infusion Therapy	0	0	_			17. 00
	Anal gesi cs	0	0	_			18. 00
	Sedatives / Hypnotics	0	Ö	·			19. 00
	Other - Specify	0	Ö	_			20.00
	Durable Medical Equipment/Oxygen	0	0	_			21.00
	Patient Transportation	0	0	Ĭ			22. 00
	Imaging Services	0	0	_			23. 00
	Labs and Diagnostics	0		_			24.00
	Medical Supplies	0		Ĭ			25. 00
	Outpatient Services (including E/R Dept.)	0	0	ľ			26. 00
	Radi ati on Therapy	0	0	_			27. 00
28. 00	Chemotherapy	0	0	Ĭ			28.00
	Other	0					29.00
		0	0	0			
	Bereavement Program Costs	0	0	0			30.00
	Volunteer Program Costs						31.00
	Fundrai si ng						32.00
	Other Program Costs						33.00
	Total (sum of lines 1 thru 33) (2)	0	ļ	0			34.00
35. 00	Total cost to be allocated	32, 760		0 000000			35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.000000			36. 00

Heal th	Financial Systems	IU HEALTH GOSHEN	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150026	Peri od:	Worksheet K-5	
			Hospi ce (CCN: 151527	From 01/01/2014 To 12/31/2014		pared:
						5/29/2015 3:1	
					Hospi ce I		
	Cost Center Description				ge Total Hospice		
			, col . 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS			,			
1. 00	PHYSI CAL THERAPY		66.00	1		0	1. 00
2.00	OCCUPATI ONAL THERAPY		67. 00			0	2. 00
3.00	SPEECH PATHOLOGY		68. 00	1		0	3. 00
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 2176 ⁻	15 0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	1			5. 00
6.00	LABORATORY		60.00	0. 2062	64 0	0	6. 00
6.01	BLOOD LABORATORY		60. 01				6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0. 7807	75 0	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00)			8. 00
9.00	RADI OLOGY-THERAPEUTI C		55.00	0. 6019	64 0	0	9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76.00)			10.00
11. 00	Totals (sum of lines 1-10)					0	11. 00

Heal th	Financial Systems IU HEALTH GOSI	HEN HO	OSPI TAL			In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST	Provi der CCN: 150026			Peri od:	Worksheet K-6		
			Hosni ce (CN: 1515		From 01/01/2014 To 12/31/2014	Date/Time Pre	nared:
			поэргос	7014. 1010.	-	10 12/01/2011	5/29/2015 3: 1	
						Hospi ce I		
		Ti tl	e XVIII	Title X	I X	0ther	Total	
			1.00	2.00		3. 00	4. 00	
1.00	Total cost (see instructions)						2, 026, 723	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)						0	2. 00
3.00	Average cost per diem (line 1 divided by line 2)						0. 00	3. 00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)		0					4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)		0					5. 00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)					D		6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)					O		7. 00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)		0					8. 00
9.00	Aggregate SNF cost (line 3 time line 8)		0					9. 00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)					O		10.00
11.00	Aggregate NF cost (line 3 times line 10)					O		11. 00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)					0		12.00
13. 00	Aggregate cost for other days (line 3 times line 12)					0		13. 00

Heal th	Financial Systems IU HEALTH GOSHEN	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150026	Peri od: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Pre 5/29/2015 3:1	pared:
		Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			1, 176, 972	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			1, 170, 372	1. 00
2. 00	Capital DRG outlier payments			31, 338	
2. 01	Model 4 BPCI Capital DRG outlier payments			0.7000	2. 01
3. 00				55. 81	3. 00
4.00				0.00	4. 00
5.00	Indirect medical education percentage (see instructions)				5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)				6. 00
7.00					7. 00
8.00	Percentage of Medicaid patient days to total days (see instruc	tions)		18. 94	
9.00	Sum of lines 7 and 8			20. 57	
10. 00	Allowable disproportionate share percentage (see instructions)			4. 26	
11. 00	Disproportionate share adjustment (line 10 times the sum of li			50, 139	
12. 00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2	.01, 6 and 11)		1, 258, 449	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0	3. 00 4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	
3.00	Total Tripatrent program capital cost (Trie 3 x Trie 4)			0	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	s (see instructions)		0	2.00
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0 0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see ins	tructions)		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary	,	line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	circulistances (iiile 2 x	. Title 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as applic	ahl e)		0	
10.00	Current year comparison of capital minimum payment level to ca		less line 9)	0	10.00
	Carryover of accumulated capital minimum payment level over ca			0	
11. 00	IWORKSheet L. Part III. IIhe 14)			_ 1	12. 00
11. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay	ments (line 10 plus lin	e 11) I	0	12.00
	Net comparison of capital minimum payment level to capital pay			0	
12. 00		the amount on this line)	-	13. 00
12. 00 13. 00	Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over ca	the amount on this line pital payment for the f)	0	13. 00 14. 00
12. 00 13. 00 14. 00 15. 00	Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over ca (if line 12 is negative, enter the amount on this line)	the amount on this line pital payment for the f)	0	13. 00 14. 00 15. 00

	Financial Systems IU HEALTH GOSHE			u of Form CMS-2	2552-10
CALCUI	LATION OF CAPITAL PAYMENT	Provi der CCN: 150026	Peri od: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Pre 5/29/2015 3:1	
		Title XIX	Hospi tal	Cost	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			0	1.00
1.01	Model 4 BPCI Capital DRG other than outlier				1. 01
2.00	Capital DRG outlier payments			0	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments				2. 01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			0. 00 0. 00	3. 00
4.00	Number of interns & residents (see instructions)				4. 00
5.00	Indirect medical education percentage (see instructions)				5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)				6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			0.00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	uctions)		0.00	8. 00
9.00	Sum of lines 7 and 8	-)		0.00	9.00
10.00				0.00	
11.00	Disproportionate share adjustment (line 10 times the sum of Total prospective capital payments (sum of lines 1, 1.01, 2,			0	11. 00 12. 00
12.00	Trotal prospective capital payments (sum of fines 1, 1.01, 2,	2.01, 6 and 11)	,	U	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
4.00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0	3. 00 4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
0.00	Total Tipation program capital cost (Time o x Time 1)			0	0.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
0 00	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	2.00
2.00	Not program impationt conital costs (line 1 minus line 2)			0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0 00	3.00
3. 00 4. 00	Applicable exception percentage (see instructions)			0. 00	4. 00
3. 00 4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	nstructions)		0.00	4. 00 5. 00
3. 00 4. 00 5. 00 6. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i		line 6)	0. 00 0 0. 00	4. 00 5. 00 6. 00
3. 00 4. 00 5. 00 6. 00 7. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar		line 6)	0. 00 0 0. 00 0	4. 00 5. 00 6. 00 7. 00
3.00 4.00 5.00 6.00 7.00 8.00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7)	y circumstances (line 2 x	line 6)	0. 00 0 0. 00 0	4. 00 5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl	y circumstances (line 2 x icable)	,	0. 00 0 0. 00 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	y circumstances (line 2 x icable) capital payments (line 8	less line 9)	0. 00 0. 00 0. 00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri	less line 9) or year	0.00 0.00 0.00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lin	less line 9) or year e 11)	0.00 0.00 0.00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lin r the amount on this line	less line 9) or year e 11)	0.00 0.00 0.00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lin r the amount on this line capital payment for the f	less line 9) or year e 11)	0.00 0.00 0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lin r the amount on this line capital payment for the f	less line 9) or year e 11)	0.00 0.00 0.00 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00