PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH PAOLI HOSPITAL (151306) for the cost reporting period beginning 01/01/2014 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 Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	245, 025	46, 172	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	4, 357	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	249, 382	46, 172	0	0	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENIIFICATIO	ON DATA	Prov	ider CCN:		Peri od: From 01/01, To 12/31,		Workshe Part I Date/Ti		
	1.00		2. 00		3. 00			4. 00	5/28/20		
	Hospital and Hospital Health Care Co		s:		0.00						
	Street: 642 WEST HOSPITAL ROAD City: PAOLI	PO E Sta	Box: te: IN	Zip Cod	e: 47454	Count	y: ORANGE				1.0
00	10. cy. 17102.	Componer		CCN	CBSA	Provi der	Date		ent Syst		2.0
				Number	Number	Туре	Certi fi ed	V T	, 0, or		-
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	Hospital and Hospital-Based Componer										
. 00		IU HEALTH PA HOSPITAL	OLI	151306	99915	1	07/01/2001	N	0	Р	3.00
1. 00	Subprovi der - IPF	11001 1 1712									4.00
	Subprovi der - IRF										5.0
	Subprovi der – (Other) Swing Beds – SNF	IUHP SWING B	FDS	15Z306	99915		07/01/2001	N	0	N	6.0
	Swing Beds - NF	I OIII SWING B	LDS	132300	,,,,,		0770172001	"		"	8.0
	Hospital-Based SNF										9.0
	Hospi tal -Based NF Hospi tal -Based OLTC										10.0
	Hospi tal -Based HHA										12.0
	Separately Certified ASC										13.0
	Hospi tal -Based Hospi ce										14.0
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15. 0 16. 0
	Hospital -Based (CMHC) I										17. 0
	Hospital-Based (CORF) I										17. 1
	Renal Dialysis Other										18.0
7. 00	o their						From:		То):	17.0
0.00	Cook Demonting Demind (my/dd/my/)						1.00		2. (20.0
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/2	2	12/31/	/2014	20.0
	Inpatient PPS Information]
	Does this facility qualify and is it								N	Į.	22.0
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en				12.00(0)	,2) (11 CK1 C					
	Did this hospital receive interim un						N		N	Į.	22. 0
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)										
	Is this a newly merged hospital that determined at cost report settlement						N N		N	l .	22.0
	or "N" for no, for the portion of th	e cost repor	ting period	prior to	October	1. Enter					
	in column 2, "Y" for yes or "N" for	no, for the	portion of t	he cost	reporti no	period c و	on				
	or after October 1. Did this hospital receive a geograph	ic reclassif	ication from	urhan t	o rural a	as a resul	t N				1
	of the OMB standards for delineating	stati sti cal							N	1	22 0
				ed by CM	S in FY20	015? Enter			N	l	22. 0
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care or general surgery. (see instructions)

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)

in column 1 and termination date, if applicable, in column 2.

ılth Financial Systems	U HEALTH PAOL ION DATA		CCN: 15130		ri od:		worksheet S-	
				To		/01/2014 /31/2014	Part I Date/Time Pr 5/28/2015 11	epareo
				-		1.00	2.00	_
3.00 f this is a Medicare certified liver transplar	nt center, ent	er the certif	ication da	ite		1.00	2.00	128.
in column 1 and termination date, if applicable 9.00 If this is a Medicare certified lung transplant	center, ente		cation dat	ein				129.
column 1 and termination date, if applicable, i 0.00lf this is a Medicare certified pancreas transp	olant center,		ti fi cati or	ı				130.
date in column 1 and termination date, if appli 1.00 If this is a Medicare certified intestinal tran- date in column 1 and termination date, if appli	nsplant center	, enter the d	erti fi cati	on				131.
2.00 f this is a Medicare certified islet transplar in column 1 and termination date, if applicable	nt center, ent	er the certif	ication da	ite				132.
3.00 f this is a Medicare certified other transplar in column 1 and termination date, if applicable	e, in column 2	<u>)</u> .						133.
4.00 If this is an organ procurement organization ((and termination date, if applicable, in column		ne OPO number	in column	1				134.
All Providers 0.00 Are there any related organization or home offi	ce costs as d	defined in CMS	S Pub. 15-1	,		Υ	15H059	140.
chapter 10? Enter "Y" for yes or "N" for no in are claimed, enter in column 2 the home office				sts				
1.00	2. 00		1.110.11			3. 00	. 6. 11	
If this facility is part of a chain organization office and enter the home office contractor name of the contractor of t	me and contrac	ctor number.						
.00 Name: INDIANA UNIVERSITY HEALTH Contract 2.00 Street: 340 WEST TENTH STREET PO Box:	or's Name: WIS SER	RVICES	IAN CONTR	actor	s Nun	nber: U810	11	141
8.00 Ci ty: INDI ANAPOLI S State:	18		Zip Co	ode:		4620	6	143
							1.00	
			costs for	innat	ient	servi ces	Y	
			costs for	i npat	i ent	servi ces	Y	
5.00 f costs for renal services are claimed on Work			costs for	i npat			Y N	
only? Enter "Y" for yes or "N" for no.	sheet A, line	e 74, are the	st report?			servi ces	Y	145
5.00 If costs for renal services are claimed on Work only? Enter "Y" for yes or "N" for no. 5.00 Has the cost allocation methodology changed from Enter "Y" for yes or "N" for no in column 1. (S	sheet A, line	e 74, are the	st report?			1.00	Y N	145
only? Enter "Y" for yes or "N" for no. Only? Enter "Y" for yes or "N" for no. Only? Enter "Y" for yes or "N" for no in column 1. (State of the approval date (mm/dd/yyyy) in column 2.	om the previou See CMS Pub. 1	e 74, are the usly filed cos (5-2, § 4020)	st report? If yes, er			1. 00 N	Y N	145
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Health Financial Systems	IU HEALTH PAOLI H	OSPI TAL	In Lie	u of Form Cl	MS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provi der CCN: 151306	Peri od:	Worksheet	S-2
			From 01/01/2014		
			To 12/31/2014		
				5/28/2015	11:53 am
				1. 00	
Health Information Technology (HIT) incent	ive in the American R	Recovery and Reinvestme	ent Act		
167.00 Is this provider a meaningful user under Se	ection §1886(n)? Ent	er "Y" for yes or "N"	for no.	N	167.00
168.00 If this provider is a CAH (line 105 is "Y")) and is a meaningful	user (line 167 is "Y"), enter the		d168. 00
reasonable cost incurred for the HIT assets		•	, .		
169.00 If this provider is a meaningful user (line	,	not a CAH (line 105 is	"N") enter the	(0. 00169. 00
transition factor. (see instructions)		(// 0		,, 00, 07, 00
transition ractors (eee thetraetrans)			Begi nni ng	Endi ng	
			1.00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning	date and ending date	for the reporting			170.00
period respectively (mm/dd/yyyy)	<u> </u>				
				1. 00	
171.00 If line 167 is "Y", does this provider have	e any days for indivi	duals enrolled in sect	i on 1876	N	171.00
Medicare cost plans reported on Wkst. S-3,	Pt. I. line 2. col.	6? Enter "Y" for ves a	nd "N" for no.		
(see instructions)	, , , , , , , , , , , , , , , , , , , ,	,			
(000 11.01. 001. 01.0)					1

Ν

Ν

20.00

the other adjustments:

If line 16 or 17 is yes, were adjustments

made to PS&R Report data for Other? Describe

Health Financial Systems	IU HEALTH PAOLI HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provi der		Peri od: From 01/01/2014	Worksheet S-2	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 HOSPI	TALS ONLY (EXCEPT C	HILDRENS F	HOSPI TALS)			
Capital Related Cost						
22.00 Have assets been relifed for Medicare purpos	es? If yes, see ins	tructions			N	22. 00
23.00 Have changes occurred in the Medicare deprec	iation expense due	to apprais	sals made dur	ina the cost	N	23.00

		Descr	iption	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			N		N	21.00
	i nstructi ons.						
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPI	TALS ONLY (EVO	PEDT CHILDDENS I	JOSDI TALS)		1.00	
	Capital Related Cost	TALS UNLY (EXC	LEPT CHILDRENS I	103P1 TALS)			
22. 00	Have assets been relifed for Medicare purpos	es? If yes se	e instructions			l N	22. 00
23. 00	Have changes occurred in the Medicare deprec			sals made duri	na the cost	l N	23. 00
20.00	reporting period? If yes, see instructions.	. att on oxponor	ado to app. a	sar o mado dar r	g : 0001		20.00
24. 00	Were new leases and/or amendments to existin lf yes, see instructions	g Leases enter	red into during	this cost rep	orting period?	N	24. 00
25. 00	Have there been new capitalized leases enter	ed into durino	the cost repo	rting period?	If ves. see	l N	25. 00
	i nstructi ons.		,	g p	,		
26. 00	Were assets subject to Sec. 2314 of DEFRA acq instructions.	uired during 1	the cost reporti	ng period? If	yes, see	N	26. 00
27. 00	Has the provider's capitalization policy cha	naed durina th	ne cost reporti:	na period? If	ves. submit	l N	27. 00
	copy.			.5	<i>J</i> ,		
	Interest Expense						
28.00	Were new Loans, mortgage agreements or Lette	rs of credit e	entered into du	ring the cost	reporti ng	N	28. 00
	period? If yes, see instructions.						
29. 00	Did the provider have a funded depreciation treated as a funded depreciation account? If			ebt Service Re	serve Fund)	Y	29. 00
30.00	Has existing debt been replaced prior to its			debt? If yes,	see	N	30.00
21 00	instructions.			-1-1-10 1.6		, .	21 00
31. 00	Has debt been recalled before scheduled matu instructions.	rity without i	ssuance or new	debt? IT yes,	see	N	31.00
	Purchased Services						
32. 00	Have changes or new agreements occurred in p	atient care se	ervices furnishe	ed through con	tractual	N	32.00
	arrangements with suppliers of services? If	yes, see instr	ructions.				
33.00	If line 32 is yes, were the requirements of			ng to competit	ive bidding? If		33.00
	no, see instructions.						
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facil	ity under an a	arrangement with	n provi der-bas	ed physicians?	Y	34.00
35. 00	If yes, see instructions.	or omandad as	doting ograsma	a+a wi+b +ba n	rouldor boood	Y	25.00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			its with the p	r ovi der -based	, r	35.00
					Y/N	Date	
					1. 00	2. 00	
	Home Office Costs						
36. 00	Were home office costs claimed on the cost r				Υ		36. 00
37. 00	If line 36 is yes, has a home office cost st	atement been p	prepared by the	home office?	Υ		37. 00
20.00	If yes, see instructions.	. 6 . 11	56, !! 66 !	6			20.00
38. 00	If line 36 is yes, was the fiscal year end				N		38. 00
39. 00	the provider? If yes, enter in column 2 the If line 36 is yes, did the provider render s				N		39. 00
07.00	see instructions.	0. 1. 000 10 01.	ioi onarii oompoi	.oo.			07.00
40. 00	If line 36 is yes, did the provider render s instructions.	ervices to the	e home office?	If yes, see	N		40. 00
	THST uctions.						
			1.	00	2.	00	_
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the titl	•	STEVE		HOWELL		41.00
	held by the cost report preparer in columns respectively.	i, 2, and 3,					
42. 00	Enter the employer/company name of the cost	report	INDIANA UNIVER	SLTY HEALTH			42.00
00	preparer.	- 1					
43.00	Enter the telephone number and email address		317. 962. 1035		SHOWELL7@I UHEA	LTH. ORG	43.00
	report preparer in columns 1 and 2, respecti	vel y.					

Health Financial Systems	IU HEALTH PAOLI	I HOSPITAL	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provi der CCN: 151306	From 01/01/2014	Worksheet S-2 Part II Date/Time Pre 5/28/2015 11:	pared:
	Part B				
	Date				
	4. 00				
PS&R Data					
16.00 Was the cost report prepared using the PS&R		-			16.00

					3/20/2013 11.3	33 aiii
		Part B				
		Date				
		4. 00				
	PS&R Data					
16.00	Was the cost report prepared using the PS&R					16.00
	Report only? If either column 1 or 3 is yes,					
	enter the paid-through date of the PS&R					
	Report used in columns 2 and 4 (see					
	instructions)					
17. 00		04/24/2015			İ	17.00
17.00	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	` ,					18. 00
10.00	made to PS&R Report data for additional					10.00
	claims that have been billed but are not					
	included on the PS&R Report used to file					
	this cost report? If yes, see instructions.					
19. 00						19. 00
17.00	made to PS&R Report data for corrections of					17.00
	other PS&R Report information? If yes, see					
	instructions.					
20. 00						20.00
20.00	made to PS&R Report data for Other? Describe					20.00
	the other adjustments:					
21 00	Was the cost report prepared only using the				1	21. 00
21.00	provider's records? If yes, see					21.00
	instructions.					
	That detrois.					
			3.00			
	Cost Report Preparer Contact Information			<u>'</u>		
41.00	Enter the first name, last name and the title	e/position	MANAGER			41.00
	held by the cost report preparer in columns	1, 2, and 3,				
	respectively.	•				
42.00	Enter the employer/company name of the cost	report			1	42.00
	preparer.	•				
43.00	Enter the telephone number and email address	of the cost				43.00
	report preparer in columns 1 and 2, respecti					

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA

					T-	12/31/2014	Date/Time Pre 5/28/2015 11:	
							1/P Days /	JJ alli
							0/P Visits /	
							Trips	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			25		26, 184. 00	0.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	00.00		20	7, 120	20, 101.00	0	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			25	9, 125	26, 184. 00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		0	_	0. 00	0	8.00
9. 00	CORONARY CARE UNIT	32. 00		0	_	0. 00	0	9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00		0	_	0. 00	0	10. 00
11. 00	SURGI CAL INTENSI VE CARE UNI T	34. 00		0	0	0. 00	0	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43.00					0	13.00
14.00	Total (see instructions)			25	9, 125	26, 184. 00	0	14.00
15.00	CAH visits	40.00		0			0	15.00
16.00	SUBPROVIDER - I PF	40.00		0			0	16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER	41. 00 42. 00		0			0	17. 00 18. 00
19.00	SKILLED NURSING FACILITY	44. 00		0			0	19. 00
20.00	NURSING FACILITY	45. 00		0			0	20.00
21. 00	OTHER LONG TERM CARE	46. 00		0	_		U	21. 00
22. 00	HOME HEALTH AGENCY	101.00		O	J		0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					· ·	23. 00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30.00		· ·	Ĭ			24. 10
25. 00	CMHC - CMHC	99. 00					0	25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			25				27.00
28.00	Observation Bed Days						0	28.00
29.00	Ambul ance Tri ps							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
00.05	outpatient days (see instructions)							00.00
33.00	LTCH non-covered days							33. 00

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 151306

				''	0 12/31/2014	5/28/2015 11:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	00 4
		171 bays	7 071 113113	, 111ps	Turr Trille	_qui vai onto	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II ti C XVIII	TI CIC XIX	Patients	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	381	190	845		10.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	301	170	043			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	26	0				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	7	0	7			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	'	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	388	190	852			7.00
7.00	beds) (see instructions)	300	190	032			7.00
8. 00	INTENSIVE CARE UNIT	0	0	0			8.00
9. 00	CORONARY CARE UNIT	0	0	0			9.00
	BURN INTENSIVE CARE UNIT	0	0	0			
10.00		0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	U	٠	U			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		100	220			12.00
13.00	NURSERY	200	182	239		400.00	13.00
14.00	Total (see instructions)	388	372	1, 091	0. 00	129. 08	1
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVI DER - I PF	0	0	0		0.00	1
17.00	SUBPROVI DER - I RF	0	0	0		0.00	
18.00	SUBPROVI DER	0	0	0		0.00	1
19.00	SKILLED NURSING FACILITY	0	0	0		0.00	1
20. 00	NURSING FACILITY		0	0		0.00	1
21. 00	OTHER LONG TERM CARE	_	_	0		0.00	1
22. 00	HOME HEALTH AGENCY	0	0	0		0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0. 00	0. 00	1
24. 00	HOSPI CE	0	0	0		0. 00	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC	0	0	0		0. 00	
25. 10	CMHC - CORF	0	0	0		0.00	
26. 00	RURAL HEALTH CLINIC	0	0	0			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00		
27. 00	Total (sum of lines 14-26)				0. 00	129. 08	
28. 00	Observation Bed Days		0	880			28. 00
29. 00	Ambulance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 151306

				To	12/31/2014	Date/Time Pre 5/28/2015 11:	
		Full Time		Di scha	arges	, -,,, -, -, -, -, -, -, -, -, -,	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	145	96	386	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)			11	0		2.00
3. 00	HMO IPF Subprovi der						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						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		_				13.00
14.00	Total (see instructions)	0.00	C	145	96	386	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF	0.00	C	1	0	0	16.00
17. 00	SUBPROVI DER - I RF	0.00	C	-	0	0	17.00
18.00	SUBPROVI DER	0.00	C	0	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00				0	20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22. 00	HOME HEALTH AGENCY	0.00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23.00
24. 00	HOSPI CE	0.00					24.00
24. 10 25. 00	HOSPICE (non-distinct part)	0.00					24. 10 25. 00
25. 00	CMHC - CMHC CMHC - CORF	0. 00 0. 00					25.00
26. 00		0.00					26.00
	RURAL HEALTH CLINIC	0.00					26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
28. 00	Total (sum of lines 14-26)	0.00					28.00
29. 00	Observation Bed Days Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32.00
32.01	outpatient days (see instructions)						32.01
33 00	LTCH non-covered days						33. 00
33. 00	Eron non covered days	l l		1	ı		33.00

	Financial Systems IU HEALTH PAOLI HOS				u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der CCN: 1		Peri od:	Worksheet S-1	0
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/28/2015 11:	
					1.00	JJ dill
	Uncompensated and indigent care cost computation				1.00	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line 20	02 column	8)	0. 372617	1.00
0.00	Medicaid (see instructions for each line)				0.010.770	
2.00	Net revenue from Medicaid				3, 318, 662	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplemental payments.	oumanta from	Modiocie	12	Y Y	3.00 4.00
4. 00 5. 00	If line 4 is "no", then enter DSH or supplemental payments from N		wedi cai c	lf	r o	5.00
6. 00	Medicald charges	leui cai u			10, 087, 059	6.00
7. 00	Medicald cost (line 1 times line 6)				3, 758, 610	7.00
8. 00	Difference between net revenue and costs for Medicaid program (li	no 7 minus su	m of lir	as 2 and 5: if	439, 948	
0.00	<pre>< zero then enter zero)</pre>	ile / illi ilus sc	alli Oi TTT	les 2 and 5, 11	437, 740	0.00
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for each L	ine)			
9. 00	Net revenue from stand-alone SCHIP				0	9.00
10.00	Stand-alone SCHIP charges				o	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)				Ö	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 minus	line 9;	if < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see instru	ictions for ea	ach line)			[
13.00	Net revenue from state or local indigent care program (Not include	ded on lines 2	2, 5 or 9)	309, 562	13.00
14.00	Charges for patients covered under state or local indigent care p	orogram (Not i	ncl uded	in lines 6 or	1, 933, 832	14.00
	10)					
15. 00	State or local indigent care program cost (line 1 times line 14)				720, 579	
16.00	Difference between net revenue and costs for state or local indig	gent care prog	gram (lir	e 15 minus line	411, 017	16. 00
	13; if < zero then enter zero)					
17 00	Uncompensated care (see instructions for each line)	li			0	17.00
17. 00 18. 00	Private grants, donations, or endowment income restricted to fund	5			04 004	17. 00 18. 00
19.00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, SCHIP and state and local			s (cum of lines	84, 896 850, 965	
19.00	8, 12 and 16)	Thurgent care	e program	is (Suill Of Titles	650, 965	19.00
			nsured	Insured	Total (col. 1	
			tients	pati ents	+ col . 2)	
			1.00	2.00	3. 00	00.00
20. 00	Total initial obligation of patients approved for charity care (a		2, 709, 70	715, 689	3, 425, 390	20.00
21. 00	charges excluding non-reimbursable cost centers) for the entire 1 Cost of initial obligation of patients approved for charity care		1, 009, 68	266, 678	1, 276, 359	21.00
21.00	times line 20)	(TITIE I	1, 009, 00	200, 070	1, 270, 339	21.00
22. 00	Partial payment by patients approved for charity care		81, 618	5, 209	86, 827	22.00
	Cost of charity care (line 21 minus line 22)		928, 06		1, 189, 532	
20.00	Todat or order ty dar o (Trito 21 million Trito 22)		720,00	2017 107	17 1077 002	20.00
24 00	Deep the amount in line 20 column 2 include charges for nations of	lava bayand a	Longth o	f atou limit	1. 00 N	24.00
24. 00	Does the amount in line 20 column 2 include charges for patient of imposed on patients covered by Medicaid or other indigent care pr		rength C	n stay IIMIT	IN IN	24.00
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		n's Lenat	h of stav limit	0	25. 00
26. 00			9	· · · · ·	Ö	26.00
27. 00	Medicare bad debts for the entire hospital complex (see instructi				799, 177	
	Non-Medicare and non-reimbursable Medicare bad debt expense (line		ne 27)		-799, 177	28.00
28.00						
28. 00 29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper		,	28)	-297, 787	29.00
	1		,	28)	-297, 787 891, 745	

	FINANCIAL SYSTEMS SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	TU HEALTH PAULI		CCN: 151306	Peri od:	Worksheet A	2332-10
NECLAS	STITICATION AND ADJUSTMENTS OF TRIAL DALANCE C	I EXI ENGES	Trovider		From 01/01/2014 Fo 12/31/2014		narod:
						5/28/2015 11:	53 am
	Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
				+ col . 2)	ions (See A-6)	Trial Balance (col. 3 +-	
					7. 0)	col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		200 107	200 10	120 52/	410 (42	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		280, 106 786, 000			419, 642 876, 635	1. 00 2. 00
3. 00	00300 OTHER CAP REL COSTS		39, 021			0,0,033	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	209, 518	2, 116, 405			2, 325, 923	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	623, 890	3, 924, 055				
7. 00 7. 01	OO7OO OPERATION OF PLANT OO7O1 UTI LI TI ES	256, 206 0	560, 180 332, 078			797, 378 332, 078	1
8. 00	00800 LAUNDRY & LINEN SERVICE	Ö	69, 246			69, 246	1
9. 00	00900 HOUSEKEEPI NG	170, 646	50, 691			221, 337	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	182, 413	113, 336	295, 749	-56, 329 54, 920	239, 420 54, 920	1
13. 00	01300 NURSING ADMINISTRATION	515, 716	19, 285	535, 00		466, 964	1
13. 01	01301 HOUSE SUPERVI SORS	327, 413	104	1		327, 517	1
14.00	01400 CENTRAL SERVICES & SUPPLY	99, 958	56, 995			136, 638	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	199, 446 7, 646	1, 197, 657 42, 039			239, 655 49, 685	1
17. 00	01700 SOCIAL SERVICE	0	0	177 33.	o o	0	l
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	(0	0	18. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	329, 297	18, 241	347, 538	0	347, 538 0	19. 00 20. 00
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV		0			0	1
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	Ö	0		0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	892, 311	175, 721	1, 068, 032	-40, 380	1, 027, 652	30.00
31. 00	03100 INTENSIVE CARE UNIT	072, 311	173, 721	1,000,032	0 0	1,027,032	31.00
32.00	03200 CORONARY CARE UNIT	О	0		0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0			0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	o o	0		o o	0	1
42.00	04200 SUBPROVI DER	o	0		0	0	
43. 00 44. 00	04300 NURSERY	65, 834	15, 347	81, 18	-17, 198		1
45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		0			0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	O	0	(0	0	1
FO 00	ANCILLARY SERVICE COST CENTERS	405 222	220 512	(42.74	112.050	F20 704	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	405, 232 0	238, 512 0	643, 74	1 -113, 950 0 0	529, 794 0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	123, 470	Ö	123, 470	13, 708	137, 178	1
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	699, 574	300, 160	999, 734	-922	998, 812 0	l
56. 00	05600 RADI OI SOTOPE		0			0	1
57.00	05700 CT SCAN	O	0		0	0	57.00
58. 00	05800 MRI	0	0		0	0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	659, 861	604, 348	1, 264, 209		0 1, 264, 209	
60. 01	06001 BLOOD LABORATORY	0	0	., 20., 20	o o	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	0	(0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	45, 277	16, 002	61, 27	79, 701	140, 980	1
65. 00	06500 RESPIRATORY THERAPY	277, 358	22, 237			285, 157	1
66.00	06600 PHYSI CAL THERAPY	536, 210	22, 492			550, 628	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY		0			0	
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		252, 494	252, 494	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0		12, 432 1, 063, 098	12, 432 1, 063, 098	
74. 00	07400 RENAL DIALYSIS	o	0		0	0	1
75.00	07500 ASC (NON-DISTINCT PART)	O	0		0	0	
75. 01	07501 CARDI AC REHAB	53, 651	12, 417	66, 068	-249	65, 819	75. 01
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	Ö		o o	0	89. 00
90.00	09000 CLI NI C	0	0		0	0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 104, 750	520, 958	1, 625, 708	-68, 491	1, 557, 217	91. 00 92. 00
72.00	10.200 ODOLANTION DEDO (NON DISTINOTIANI	ı l		I	1	I	1 /2.00

			To	12/31/2014	Date/Time Pre 5/28/2015 11:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cat	Reclassi fi ed	J
			+ col . 2)	ions (See	Trial Balance	
			,	A-6)	(col. 3 +-	
				,	col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	o	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	0	0	0	0	98. 00
99. 00 09900 CMHC	o	0	0	0	0	99.00
99. 10 09910 CORF	o	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	o	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	o	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	o	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	o	o	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	o	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	o	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE		23, 216	23, 216	-23, 216	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	o	0	0	0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0	0	0	0	115.00
116. 00 11600 HOSPI CE	o	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7, 785, 677	11, 556, 849	19, 342, 526	-21, 561	19, 320, 965	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190.01 19001 VISITING SPECIALTY CLINIC	0	105	105	0		190. 01
190. 02 19002 OUTREACH	100, 073	23, 526	123, 599	14, 979	138, 578	
190. 03 19003 FOUNDATI ON	37, 103	2, 300	39, 403	0	39, 403	190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	14, 507	14, 507	0	14, 507	190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0	134	134	4, 579	4, 713	190. 05
190. 06 19006 OTHER PROPERTY	0	4, 981	4, 981	2, 003	6, 984	190. 06
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
200.00 TOTAL (SUM OF LINES 118-199)	7, 922, 853	11, 602, 402	19, 525, 255	0	19, 525, 255	200. 00

Period: Worksheet A From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/28/2015 11:53 am

				5/28/2015 11:	<u>53 am</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		6. 00	Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	114, 552	534, 194		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-187, 722	688, 913		2.00
3.00	00300 OTHER CAP REL COSTS	0	1	1	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 481, 436			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	79, 362			5.00
7. 00 7. 01	00700 OPERATION OF PLANT 00701 UTILITIES	0	797, 378 332, 078		7. 00 7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	0	69, 246	l control of the cont	8.00
9. 00	00900 HOUSEKEEPI NG	0	221, 337		9.00
10.00		0	239, 420		10.00
11. 00	01100 CAFETERI A	-34, 843	20, 077		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	466, 964		13.00
13. 01	01301 HOUSE SUPERVI SORS	0	327, 517		13. 01
14.00		-7, 624			14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	-9, 896	239, 655 39, 789		15. 00 16. 00
17. 00		-9, 690	37, 787		17. 00
18. 00			l o	·	18.00
19.00		-1, 203	346, 335		19.00
20.00		0	0		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22. 00		0	0	•	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0		23. 00
30.00		-50, 004	977, 648		30.00
31.00		0	0	l control of the cont	31.00
32.00		0	0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0	1	34.00
40.00		0	0	l .	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	1	41.00
42. 00 43. 00	1	0	0 63, 983		42. 00 43. 00
44. 00		0	05, 705		44. 00
45. 00		0	Ö	1	45.00
46.00	04600 OTHER LONG TERM CARE	0	0		46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	1	F20 704	I	F0 00
50. 00 51. 00		0	529, 794 0	l control of the cont	50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	137, 178	•	52.00
53. 00		0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-9, 166	989, 646		54.00
55.00		0	0		55.00
56. 00		0	0	·	56.00
57.00	05700 CT SCAN	0	0	l .	57.00
	05800 MRI 05900 CARDI AC CATHETERI ZATI ON		0		58. 00 59. 00
60.00		0	1	•	60.00
60. 01	06001 BLOOD LABORATORY	0	0		60.01
61.00	1 1	0	0		61.00
62.00		0	0		62.00
63.00		0	0		63.00
64. 00		0	140, 980	•	64.00
65. 00 66. 00		0	285, 157 550, 628		65. 00 66. 00
67.00	1	0	550, 626	l .	67.00
68. 00		0	ĺ	•	68.00
69.00	1	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
		0	252, 494		71.00
		0	12, 432		72.00
		-9, 783			73. 00 74. 00
74. 00 75. 00			0	1	75. 00
75. 00		0	65, 819	l .	75. 00
. 0. 01	OUTPATIENT SERVICE COST CENTERS		, 30,017] . 3. 3.
88. 00	08800 RURAL HEALTH CLINIC	0	1	·	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	•	89. 00
		0	1 444 140	·	90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	106, 931	1, 664, 148		91. 00 92. 00
7Z. UU	101200 ODDERANTION DEDO (NOM-DISTINCI LAKI	I	I	1	72. UU

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

			То	12/31/2014	Date/Time Prepared: 5/28/2015 11:53 am
Cost Center Description		Net Expenses	'		0, 20, 20 10 111 00 dill
	(See A-8)	For			
	4.00	Allocation			
OTHER REIMBURSABLE COST CENTERS	6. 00	7. 00			
94. 00 09400 HOME PROGRAM DIALYSIS	0	0			94.00
95. 00 09500 AMBULANCE SERVICES	0	0			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0			97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0			98.00
99. 00 09900 CMHC	0	o			99.00
99. 10 09910 CORF	O	O			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0			100.00
101.00 10100 HOME HEALTH AGENCY	0	0			101.00
SPECIAL PURPOSE COST CENTERS					
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0			106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0			107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0			108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0			109.00
110. 00 11000 INTESTINAL ACQUISITION	0	0			110.00
111.00 11100 SLET ACQUISITION	0	0			111. 00 113. 00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0			114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0			115.00
116. 00 11600 HOSPI CE		0			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 472, 040	20, 793, 005			118.00
NONREI MBURSABLE COST CENTERS	1, 172, 010	20, 770, 000			110.00
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	0	105			190. 01
190. 02 19002 OUTREACH	0	138, 578			190. 02
190. 03 19003 FOUNDATI ON	0	39, 403			190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	14, 507			190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0	4, 713			190. 05
190. 06 19006 OTHER PROPERTY	0	6, 984			190. 06
191. 00 19100 RESEARCH	0	0			191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0			192. 00
193. 00 19300 NONPALD WORKERS	1 472 242	0 007 205			193. 00
200.00 TOTAL (SUM OF LINES 118-199)	1, 472, 040	20, 997, 295			200.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 151306

Cost Center	me Prepared: 015 11:53 am
A - INSURANCE RECLASS	10 111 00 4
A - INSURANCE RECLASS Company	
1.00 CAP REL COSTS-MINISTER EQUIP 2.00 0 26,965	
2. 00 O DOBLITY TAX RECLASS 1. 00 E PROPERTY TAX RECLASS 0	1.00
O	2.00
1.00	
1.00 C 1.05 Section Sectio	
C - INTEREST RECLASS 2.00 2.00 CAP REL COSTS-MVBLE EQUIP	1.00
1.00	
2. 00	1.00
O	2.00
D - LEASE RECLASS	2.00
2.00 3.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 7.00 7.00 7	
3.00	1. 00
4. 00	2. 00
5.00	3.00
6.00 O O O O O O O O O O O O O O O O O O	4. 00 5. 00
C	6.00
E - CHARGEABLE MEDI CAL SUPPLI ES MEDI CAL SUPPLI ES CHARGED TO 71.00 0 264, 926 PATI ENT 0.00 0 0 0 4.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0 5.00 0.00 0	0.00
PATI ENT 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 9. 00 10. 00 9. 00 11. 00 12. 00 1. 148, 845 1. 00 1. 00 2. 00 2. 00 3. 00 1. 148, 845 1. 00 2. 00 3. 00 1. 00 3. 00 3. 00 1. 00 3. 00 3. 00 0. 00	1.00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 10. 00 9. 00 10. 00 9. 00 11. 00 12. 00 0 12. 00 0 13. 00 0 14. 00 0 15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00
5. 00 6. 00 7. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00
6. 00 7. 00 8. 00 9. 00 0. 00	4. 00 5. 00
7. 00 8. 00 9. 00 10. 00 9. 00 10. 00 10. 00 10. 00 11. 00 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00
8. 00 9. 00 10. 00 10. 00 11. 00 11. 00 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00
10. 00 11. 00 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00
11. 00 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00
12. 00	10.00
1.00 CAFETERI A RECLASS 1.00 CAFETERI A	11.00
F - CAFETERI A RECLASS 1. 00 CAFETERI A 11. 00 33, 874 21, 046 0 33, 874 21, 046 0 33, 874 21, 046 0 33, 874 21, 046 0 33, 874 21, 046 0 33, 874 21, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 046 0 37, 047, 047, 047, 047, 047, 047, 047, 04	12.00
1. 00	
1. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 1, 148, 845 0 0 1, 148, 845 0 0 1, 148, 845 0 0 0 1, 148, 845 0 0 0 0 0 0 0 0 0	1.00
G - PHARMACY RECLASS 1. 00 DRUGS CHARGED TO PATLENTS 73. 00 0 1,148,845 0 1,1	
1.00 1,148,845 H - COO RECLASS 190.02 14,979 0	
H - COO RECLASS 1. 00 OUTREACH 190. 02 14, 979 0 2. 00 ADMI NI STRATI VE & GENERAL 5. 00 53, 058 0 0 68, 037 0 1 - NON-ALLOWABLE DEPRECIATION RECLASS 1. 00 PAOLI FAMILY PRACTICE 190. 05 0 4, 579 2. 00 0 0 0 0 0 3. 00 0 0 4, 579 0 0 4, 579	1.00
1. 00 OUTREACH 190. 02 14, 979 0 2. 00 ADMINISTRATIVE & GENERAL 5. 00 53, 058 0 0 68, 037 0 1 - NON-ALLOWABLE DEPRECIATION RECLASS 1. 00 PAOLI FAMILY PRACTICE 190. 05 0 4, 579 2. 00 0 0 0 0 0 3. 00 0 0 4, 579	
2. 00 ADMI NI STRATI VE & GENERAL 5. 00 53, 058 0 0 1 - NON-ALLOWABLE DEPRECIATION RECLASS 1. 00 PAOLI FAMILY PRACTICE 190. 05 0 4, 579 2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00
0 68, 037 0 1 - NON-ALLOWABLE DEPRECIATION RECLASS 1. 00 PAOLI FAMILY PRACTICE 190. 05 0 4, 579 0 0 0 0 0 0 0 0 0	1.00 2.00
1 - NON-ALLOWABLE DEPRECIATION RECLASS	2.00
1. 00 PAOLI FAMILY PRACTICE 190. 05 0 4, 579 2. 00 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00
0 4,579	2. 00
	3.00
J - IV MEDICINE RECLASS 1. 00 INTRAVENOUS THERAPY 64. 00 0 85, 747	1 00
1. 00 INTRAVENOUS THERAPY	1.00
K - AMBULANCE DEPRECITION RECLASS	
1. 00 OTHER PROPERTY 190. 06 0 2, 003	1.00
0 2,003	
L - OB OTHER EXPENSE RECLASS	
1. 00 DELIVERY ROOM & LABOR ROOM 52. 00 0 13, 708	1.00
2.00	2. 00
0 0 13,708	
N - I MPLANTABLE DEVI CE RECLASS 1.00 IMPL. DEV. CHARGED TO 72.00 0 12,432	1.00
PATI ENTS 12, 432	1.00
0 12,432	
500.00 Grand Total: Increases 101,911 1,791,166	500.00

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 151306

					То		me Prepared: 15 11:53 am
		Decreases				37 207 20	15 11. 55 dill
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
1 00	A - INSURANCE RECLASS	2 00	ما	20.000	10		1.00
1.00	OTHER CAP REL COSTS	3.00	0	28, 092			1.00
2. 00		0.00		<u> 0</u> 28, 092			2.00
	B - PROPERTY TAX RECLASS		U	20, 092			
1. 00	OTHER CAP REL COSTS	3. 00	O	10, 929	13		1.00
	0			10, 929			
	C - INTEREST RECLASS	,	-,				
1.00	INTEREST EXPENSE	113. 00	0	13, 877			1.00
2.00	INTEREST EXPENSE	1 <u>13.</u> 00	0	<u>9, 3</u> 39			2. 00
	0		0	23, 216			
	D - LEASE RECLASS	7 00	ما	10.000			
1.00	OPERATION OF PLANT	7.00	0	19, 008			1.00
2. 00 3. 00	DI ETARY CENTRAL SERVI CES & SUPPLY	10. 00 14. 00	0	1, 409 5, 156			2. 00 3. 00
4. 00	CENTRAL SERVICES & SUPPLY	14.00	0	14, 763			4.00
5. 00	ADMINISTRATIVE & GENERAL	5. 00	Ö	135, 189			5.00
6. 00	RESPI RATORY THERAPY	65. 00	ő	118			6.00
	0		 	175, 643			
	E - CHARGEABLE MEDICAL SUPPLI	ES					
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	396	0		1. 00
2.00	PHARMACY	15. 00	0	8, 603			2. 00
3.00	ADULTS & PEDIATRICS	30. 00	0	34, 710			3. 00
4.00	NURSERY	43. 00	0	9, 160			4.00
5. 00	OPERATING ROOM	50.00	0	113, 950			5. 00
6.00	I NTRAVENOUS THERAPY	64.00	0	6, 046	1		6.00
7. 00 8. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	U O	14, 320 8, 074			7. 00 8. 00
9. 00	CARDI AC REHAB	75. 01	0	249			9. 00
10. 00	EMERGENCY	91.00	0	68, 491	1		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	922	1		11.00
12. 00	ADMINISTRATIVE & GENERAL	5. 00	o	5	o o		12.00
	0 — — — —		0	264, 926			
	F - CAFETERIA RECLASS						
1. 00	DI ETARY	10.00	3 <u>3, 8</u> 74	2 <u>1, 0</u> 46			1. 00
	0		33, 874	21, 046			
1 00	G - PHARMACY RECLASS	15.00	ما	1 140 045			1.00
1. 00	PHARMACY	1500	0	<u>1, 148, 845</u> 1, 148, 845			1.00
	H - COO RECLASS		U	1, 140, 043			
1. 00	NURSI NG ADMINI STRATI ON	13. 00	14, 979	0	0		1.00
2. 00	NURSING ADMINISTRATION	13. 00	53, 058	0			2. 00
			68, 037				
	I - NON-ALLOWABLE DEPRECIATION	N RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	4, 579			1.00
2. 00		0. 00	0	0	9		2. 00
3. 00		0.00	0	0	9 — 9		3.00
	U LV MEDICINE DECLACE		0	4, 579			
1. 00	J - IV MEDICINE RECLASS DRUGS CHARGED TO PATIENTS	73. 00	ما	85, 747	, O		1.00
1.00	O PATTEINTS		0	85, 747			1.00
	K - AMBULANCE DEPRECITION REC	1 ΔSS	<u> </u>	05, 747			
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	2, 003	9		1.00
	0		 	2, 003			
	L - OB OTHER EXPENSE RECLASS	<u> </u>	<u>'</u>				
1.00	ADULTS & PEDI ATRI CS	30. 00	0	5, 670	0		1. 00
2.00	NURSERY	43.00	0	<u>8, 0</u> 38	<u> </u>		2.00
	0		0	13, 708	8		
	N - IMPLANTABLE DEVICE RECLAS		_1		.1		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	12, 432	<u>.</u> 0		1.00
	PATI ENT	+	+		 		
500 00	Grand Total: Decreases		101, 911	1, 791, 166			500.00
555.00	jo. aa Total . Deel cases		101, 711	1, , , 1, 100	1		1 300. 00

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

					Γο 12/31/2014		pared:
						5/28/2015 11:	53 am
		D	D	Acqui si ti ons		D:	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	0.00	0.00	4.00	Retirements	
	DART	1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE					00.400	
1.00	Land	78, 263	0	9	0	20, 420	1.00
2. 00	Land Improvements	508, 587	0	(0	0	2.00
3.00	Buildings and Fixtures	6, 548, 210	0	(0	2, 562, 036	3.00
4.00	Building Improvements	0	2, 247, 042		2, 247, 042		4.00
5.00	Fixed Equipment	5, 755, 515	428, 256	(428, 256		5.00
6.00	Movable Equipment	4, 904, 794	0		0	343, 370	6. 00
7.00	HIT designated Assets	0	0	(0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17, 795, 369	2, 675, 298	(2, 675, 298	2, 925, 826	8.00
9.00	Reconciling Items	0	0	(0	0	9.00
10.00	Total (line 8 minus line 9)	17, 795, 369	2, 675, 298	(2, 675, 298	2, 925, 826	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	57, 843	0				1.00
2.00	Land Improvements	508, 587	0				2.00
3.00	Buildings and Fixtures	3, 986, 174	0				3.00
4.00	Building Improvements	2, 247, 042	0				4.00
5.00	Fi xed Equi pment	6, 183, 771	0				5.00
6.00	Movable Equipment	4, 561, 424	0				6.00
7.00	HIT designated Assets	0	0				7.00
8. 00	Subtotal (sum of lines 1-7)	17, 544, 841	0				8.00
9. 00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	17, 544, 841	0				10.00
	1.000 (1.110)	,511,511	Ü	ı			

Heal th	Financial Systems	IU HEALTH PAOLI HOSPITAL			In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151306	Peri od: From 01/01/2014 To 12/31/2014		pared:	
			SL	JMMARY OF CAF	PI TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see instructions)		
		9. 00	10. 00	11.00	instructions) 12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2	<u> </u>			
1.00	CAP REL COSTS-BLDG & FIXT	280, 106	0		0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	786, 000	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 066, 106	0		0 0	0	3.00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Relat						
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					

1.	. 00	CAP REL COSTS-BLDG & FIXT	280, 106	0	0	0	0	1.00
2	. 00	CAP REL COSTS-MVBLE EQUIP	786, 000	0	0	0	0	2.00
3.	. 00	Total (sum of lines 1-2)	1, 066, 106	0	0	0	0	3.00
			SUMMARY 0	F CAPITAL				
		Cost Center Description	0ther	Total (1)				
			Capi tal -Rel at	(sum of cols.				
			ed Costs (see	9 through 14)				
			instructions)					
			14. 00	15. 00				
		PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.	. 00	CAP REL COSTS-BLDG & FLXT	0	280, 106				1.00
2	. 00	CAP REL COSTS-MVBLE EQUIP	0	786, 000				2.00
3.	. 00	Total (sum of lines 1-2)	0	1, 066, 106				3.00

Heal th	n Financial Systems	IU HEALTH PAC	LI 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		pared:
		COME	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	oo uiii
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1. 00	2.00	col . 2) 3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	6, 799, 646	0	6, 799, 64	6 0. 387558	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10, 745, 195	0	10, 745, 19	0. 612442	0	2.00
3.00	Total (sum of lines 1-2)	17, 544, 841	0	17, 544, 84			3.00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
	DART III DECONOLILATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	0		0 388, 076	135, 189	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	0	1		0 388, 076		2.00
3. 00	Total (sum of lines 1-2)	0	0		0 1, 000, 459		3.00
3.00	Total (Saill of Triles 1 2)		SI	JMMARY OF CAPI		173,043	3.00
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
		11. 00	12. 00	13.00	instructions)	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	0	10, 92	9 0	534, 194	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	9, 111			o o		2. 00
3. 00	Total (sum of lines 1-2)	9, 111		•	9 0		
			-	-	*	•	

| In Lieu of Form CMS-2552-10 | Provider CCN: 151306 | Period: | Worksheet A-8 | From 01/01/2014 | To 12/23/2014 | Decided to 12/23/2014 | Provider CCN: 151306 | Period: | Worksheet A-8 | Provider CCN: 151306 | Provider CCN: 1513 Health Financial Systems
ADJUSTMENTS TO EXPENSES

					From 01/01/2014 To 12/31/2014	Date/Time Pre	
				Expense Classification o	n Worksheet A	5/28/2015 11:	53 am
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL			CAP REL COSTS-BLDG & FLXT	1. 00	0	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В	-14, 105	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		-				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	В	-8. 905	ADMINISTRATIVE & GENERAL	5. 00	0	7.00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physi ci an	A-8-2	-1, 327, 285		0.00	0	10.00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	4, 200, 420			0	12. 00
	transactions (chapter 10)	Α σ 1	4, 200, 420				
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-34, 843	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee		0		0. 00	0	
16. 00	and others Sale of medical and surgical	В	-7, 624	CENTRAL SERVICES & SUPPLY	14. 00	0	16.00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0. 00	0	17.00
18. 00	patients Sale of medical records and	В	-9, 896	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)		0			9	
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
05.00	limitation (chapter 14)			UTILLIZATION DEVILEN ONE	114 00		05.00
25. 00	Utilization review - physicians' compensation		U	UTILIZATION REVIEW-SNF	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
	COSTS-BLDG & FLXT						
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27.00
28. 00	Non-physician Anesthetist		-1, 203	NONPHYSICIAN ANESTHETISTS	19. 00	0	28. 00 29. 00
29. 00 30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	U	30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
	[tation (Glapter 14)	l		I	ı		·

					rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/28/2015 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					-		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
	Tana 11 - 1 - 1	1. 00	2. 00	3.00	4. 00	5. 00	
32. 00	1	A	-173, 617	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32. 00
	Depreciation and Interest		00 / 40	ADMINISTRATIVE & SEVERAL			
	MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	00.00
33. 02		A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	BOND RE-FUNDING	В	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	ADVERTISING	Α	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	PATIENT ACCTS MISC CASH	В	-8, 625	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
	REVENUE						
33. 06		Α		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 07	HAF EXPENSES	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	PHARMACY REBATE	В	-9, 783	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 08
33. 09			0		0. 00	0	33. 09
33. 10			0		0. 00	0	33. 10
33. 11			0		0.00	0	33. 11
33. 12			0		0.00	0	33. 12
33. 13			0		0.00	0	33. 13
50.00	TOTAL (sum of lines 1 thru 49)		1, 472, 040				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						1

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs if cost, including applicable overhead, can be determined.

- B. Amount Received if cost cannot be determined.
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to Worksheet A-7.

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

ovider CCN: 151306 | Period: | Worksheet A-8-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared

				10 12/31/2014	5/28/2015 11:			
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	00 4		
			'	Allowable Cost	Included in			
					Wks. A, column			
					5			
	1. 00	2. 00	3. 00	4. 00	5. 00			
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME								
	OFFICE COSTS:							
1. 00		EMPLOYEE BENEFITS DEPARTMENT	IUHBH MGMT SVC FEE	84, 031	0	1.00		
2.00	5. 00	ADMINISTRATIVE & GENERAL	IUHBH MGMT SVC FEE	460, 044	0	2.00		
3.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	IUH MGMT SVC FEE	1, 397, 405	0	3.00		
4.00	5. 00	ADMINISTRATIVE & GENERAL	IUH MGMT SVC FEE	897, 988	128, 646	4.00		
4.01	1.00	CAP REL COSTS-BLDG & FIXT	IUH MGMT SVC FEE	114, 552	0	4.01		
4. 02	91.00	EMERGENCY	PBP ED COVERAGE	1, 746, 046	371, 000	4.02		
4.03	5. 00	ADMINISTRATIVE & GENERAL	IUH MGMT SVC FEE	1, 468, 422	1, 468, 422	4.03		
5.00	TOTALS (sum of lines 1-4).			6, 168, 488	1, 968, 068	5.00		
	Transfer column 6, line 5 to							
	Worksheet A-8, column 2,							
	line 12.							

* 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/				
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 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	В	O. OO I U HEALTH BLOOM O. OO	6.00
7.00	В	0. 00 I U HEALTH 0. 00	7.00
8.00	С	0.00 IUH SIP 0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 Syst	ems		I	U HEALTH	PA0LI	HOSPI TAL			In Lie	u of Form CMS	-2552-10
STATEMI OFFI CE		SERVICES FROM	RELATED	ORGANI ZAT	TONS AND	HOME	Provi der	CCN:	151306	Peri od: From 01/01/2014	Worksheet A-	-8-1
UFFICE										To 12/31/2014	Date/Time Pr 5/28/2015 1	
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUST	MENTS RE	QUI RED AS	A RESULT	OF TR	ANSACTI ONS	WITH	RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:											
1.00	84, 031	0										1.00
2.00	460, 044	0										2.00
3.00	1, 397, 405	0										3.00
4.00	769, 342	0										4.00
4. 01	114, 552	9										4. 01
4. 02	1, 375, 046	1										4. 02
4. 03	1 0	Ō										4. 03

* 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.

5.00

1103 110	. been posted to worksheet A,	cordinas i anazor 2, the amount arrowable should be mareated in cordina 4 or this part	·
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i Ci ilibu	Crimbal Schieft under title XVIII.							
6.00	HOSPI TAL		6.00					
7.00	HOME OFFICE		7.00					
8.00	PHYSICIAN GROUP		8.00					
9.00			9.00					
9. 00 10. 00			10.00					
100.00			100.00					
	-							

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

5.00

4, 200, 420

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

WKSt. A Line # Cost Center/Physician Identifier Total Remuneration Provider Component RCE Amount Physician/Provider Physician/Provider RCE Amount Physician/Provider Physician/Provider RCE Amount Physician/Provider Physician/P							To 12/31/2014	Date/Time Pre 5/28/2015 11:	
1.00		Wkst. A Line #					RCE Amount		
1.00			I denti fi er	Remuneration	Component	Component			
1.00		1 00	3 00	2 00	4 00	5.00	6.00		
2.00 30.00 ADULTS & PEDI ATRICS 50.004 50.004 0 0 0 0 2.00	1 00								1 00
3.00									
4.00									
S. 00							1	ı -	
Cost								0	
7.00				7,200				0	
8.00								0	
9,00								0	
1.00					0			0	
1,880,287 1,327,285 553,002 0 200.00					0			0	
Wkst. A Line # Cost Center/Physician I dentifier Linit Unadjusted RCE Unadjusted RCE Component Share of col.		0.00		1 880 287	1 327 285	553 002		0	
Identifier	200.00	Wkst Aline#	Cost Center/Physician					Physician Cost	200.00
Li mi t Continuing Share of col Insurance									
1.00					,		·		
1.00						J			
2. 00		1.00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
3. 00				0	-	_	1	ı -	
4. 00 60. 00 LABORATORY				0				0	
S				0	1	_	1	0	
6. 00				0	0	0	0	0	
7. 00		1		0	0	0	0	0	
8.00				0	0	0	0	0	
9.00				0	0	0	0	0	
10.00				0	0	0	0	0	
Number Cost Center/Physician Cost Center/Physician Identifier Component Share of col. 14				0	0	0	0	0	
Wkst. A Li ne # Cost Center/Physician I denti fi er Component Share of col. 14 Di sal I owance		0.00		0	0	0	1	0	
Identifier Component Share of col. Li mi t Di sal I owance	200.00	M/L . 1 . A . L	01.01(8)	0	0	0		0	200.00
1.00 2.00 15.00 16.00 17.00 18.00		WKSt. A Line #					Adjustment		
14			rdentiffer		LIIIII	DI Sai i Owance			
1. 00 2. 00 15. 00 16. 00 17. 00 18. 00 1. 00 91. 00 EMERGENCY 0 0 0 1, 268, 115 1. 00 2. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 50, 004 2. 00 3. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 9, 166 3. 00 4. 00 60. 00 LABORATORY 0 0 0 0 4. 00 5. 00 75. 01 CARDI AC REHAB 0 0 0 0 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 6. 00 8. 00 0. 00 0 0 0 0 0 9. 00 9. 00 0. 00 0 0 0 0 9. 00 9. 00 10. 00 0 0 0 0 0 0 9. 00 10. 00									
1. 00 91. 00 EMERGENCY 0 0 1, 268, 115 1. 00 2. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 50, 004 2. 00 3. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 9, 166 3. 00 4. 00 60. 00 LABORATORY 0 0 0 0 0 4. 00 5. 00 75. 01 CARDI AC REHAB 0 0 0 0 0 5. 00 6. 00 0. 00 0 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 9. 00 9. 00 0. 00 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 9. 00 </td <td></td> <td>1.00</td> <td>2.00</td> <td></td> <td>16. 00</td> <td>17. 00</td> <td>18. 00</td> <td></td> <td></td>		1.00	2.00		16. 00	17. 00	18. 00		
3. 00	1. 00	91.00	EMERGENCY	0	0	0	1, 268, 115		1.00
4. 00 60. 00 LABORATORY 0 0 0 0 4. 00 5. 00 75. 01 CARDI AC REHAB 0 0 0 0 0 5. 00 6. 00 0. 00 0 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 6. 00 8. 00 0. 00 0 0 0 0 0 0 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0. 00 0 0 0 0 10. 00	2.00	30.00	ADULTS & PEDIATRICS	0	0	0	50, 004		2.00
5. 00 75. 01 CARDI AC REHAB 0 0 0 0 0 6. 00 6. 00 0. 00 0 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 10. 00	3.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	9, 166		3.00
6.00 0.00 7.00 0.00 8.00 0.00 9.00 0.00 10.00 0.00 0 0 </td <td>4.00</td> <td>60.00</td> <td>LABORATORY</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>4.00</td>	4.00	60.00	LABORATORY	0	0	0	0		4.00
7. 00 0. 00 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 10. 00	5.00	75. 01	CARDI AC REHAB	0	0	0	0		5.00
8. 00 0. 00 9. 00 0. 00 10. 00 0. 00	6.00			0	0	0	0		6.00
9.00 0.00 0 0 0 0 9.00 9.00 10.00 0 0 0 10.00	7.00	0.00		0	0	0	0		7.00
10.00 0.00 0 0 0 10.00	8.00			0	0	0	0		8.00
	9.00	0.00		0	0	0	0		9.00
200.00 0 0 1,327,285 200.00		0.00		0		_	1		
	200.00	[0	0	0	1, 327, 285		200.00

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 11/2014 | Part | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151306

					To	12/31/2014	Date/Time Pre 5/28/2015 11:	
				CAPI TAL REI	ATED COSTS		0, 20, 20, 0	
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		cost center bescription	for Cost	DLDG & FIXI	WVBLE EQUIP	BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7)	1. 00	2. 00	4. 00	4A	
	GENER	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT	534, 194	534, 194				1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	688, 913 3, 807, 359	4, 487	688, 913 6, 302	3, 818, 148		2. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL	4, 546, 298			335, 093	5, 038, 930	5. 00
7.00		OPERATION OF PLANT	797, 378	42, 070	59, 086	126, 824	1, 025, 358	7.00
7. 01	1	UTILITIES	332, 078	0	-	0	332, 078	7. 01
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	69, 246 221, 337	2, 920 7, 505		0 84, 471	76, 267 323, 853	8. 00 9. 00
10.00		DI ETARY	239, 420		21, 505	73, 528	349, 764	10.00
11.00	1	CAFETERI A	20, 077	9, 783		16, 768	60, 367	11.00
13. 00 13. 01		NURSI NG ADMI NI STRATI ON HOUSE SUPERVI SORS	466, 964 327, 517	5, 071 0	7, 123	221, 604 162, 071	700, 762 489, 588	13. 00 13. 01
14. 00	1	CENTRAL SERVICES & SUPPLY	129, 014	19, 954	-	49, 480	226, 474	14. 00
15.00	01500	PHARMACY	239, 655	11, 379	15, 981	98, 727	365, 742	15. 00
16.00		MEDICAL RECORDS & LIBRARY	39, 789	12, 167	17, 089	3, 785	72, 830	16.00
17. 00 18. 00	1	SOCIAL SERVICE OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	17. 00 18. 00
19. 00		NONPHYSI CI AN ANESTHETI STS	346, 335	0	0	163, 004	509, 339	19.00
20.00		NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00		I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY)	0	0	-	0	0	22. 00 23. 00
20.00		IENT ROUTINE SERVICE COST CENTERS		<u> </u>	<u> </u>	<u> </u>	0	20.00
30.00		ADULTS & PEDIATRICS	977, 648	72, 743		441, 699	1, 594, 255	30.00
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0	0	0	31. 00 32. 00
33. 00	1	BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
34. 00	1	SURGICAL INTENSIVE CARE UNIT	0	0	Ö	Ö	0	34. 00
40.00	1	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41. 00 42. 00	1	SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
43. 00		NURSERY	63, 983	2, 433	3, 418	32, 588	102, 422	43. 00
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00 46. 00		NURSING FACILITY OTHER LONG TERM CARE	0	0		0	0	45. 00 46. 00
40.00		LARY SERVICE COST CENTERS	0	0	0	U	U	40.00
50.00	05000	OPERATING ROOM	529, 794	58, 666	82, 396	200, 592	871, 448	50.00
51.00	1	RECOVERY ROOM	127 170	0	0	(1 110	200 075	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	137, 178	4, 857 0	6, 822 0	61, 118 0	209, 975 0	52. 00 53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	989, 646	56, 787	79, 757	346, 293	1, 472, 483	
55.00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	0	0	0	0	0	56. 00 57. 00
58.00	05800		0	0		0	0	58.00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	0	0	O	0	59.00
60.00		LABORATORY	1, 264, 209	17, 939	25, 196	326, 635	1, 633, 979	
60. 01 61. 00		BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	U	U	0	60. 01 61. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	140, 980 285, 157			22, 412 137, 294	172, 754 429, 098	
66. 00		PHYSICAL THERAPY	550, 628			265, 427	874, 404	
67. 00	06700	OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68.00		SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	0	0	0	0	69. 00 70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	252, 494	0	o o	Ö	252, 494	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12, 432	0	0	О	12, 432	72.00
		DRUGS CHARGED TO PATIENTS	1, 053, 315	0	0	0	1, 053, 315 0	
		RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0	0	ol Ol	0	
	07501	CARDI AC REHAB	65, 819	_	-	26, 558	113, 699	
00.00		TIENT SERVICE COST CENTERS				-		00.00
	1	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	88. 00 89. 00
		CLINIC	0	0		o		90.00
					"			

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151306 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 11:53 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS DEPARTMENT** Allocation (from Wkst A col. 7) 4. 00 0 1.00 2.00 4A 91. 00 09100 EMERGENCY 2, 305, 798 1, 664, 148 39, 422 55. 368 546, 860 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 95.00 95.00 C 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 o 0 97.00 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 09900 CMHC 0 0 99.00 99.00 0 99. 10 09910 CORF 0 0 0 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 101 00 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 107.00 10700 LIVER ACQUISITION 0 107.00 Ω 108.00 10800 LUNG ACQUISITION 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 C 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 20, 793, 005 488, 806 686, 521 3, 742, 831 20, 669, 908 118. 00 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 01 19001 VISITING SPECIALTY CLINIC 105 19, 711 0 0 19, 816 190. 01 190. 02 19002 OUTREACH 138, 578 56, 951 206, 129 190. 02 10,600 0 61, 864 190. 03 190. 03 19003 FOUNDATI ON 39, 403 1, 703 2, 392 18, 366 14, 507 190. 04 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 14.507 0 190.05 19005 PAOLI FAMILY PRACTICE 4,713 0 4, 713 190. 05 190. 06 19006 OTHER PROPERTY 6, 984 0 0 20, 358 190. 06 13, 374 191. 00 19100 RESEARCH 0 0 191.00 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 C 0 193. 00 19300 NONPALD WORKERS 0 C 0 0 0 193.00

20, 997, 295

534, 194

688, 913

3, 818, 148

0 200.00

0 201.00

20, 997, 295 202. 00

200.00

201.00 202.00 Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Period: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/28/2015 11:53 am

	Cost Center Description	ADMI NI STRATI V	OPERATION OF	UTILITIES	LAUNDRY &	5/28/2015 11: HOUSEKEEPI NG	
	·	E & GENERAL 5.00	PLANT 7. 00	7. 01	LINEN SERVICE 8.00	9. 00	
GENE	ERAL SERVICE COST CENTERS	3.00	7.00	7.01	8.00	7.00	
	00 CAP REL COSTS-BLDG & FIXT						1.00
	OO CAP REL COSTS-MVBLE EQUIP						2.00
	00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL	5, 038, 930					4. 00 5. 00
	OO OPERATION OF PLANT	323, 762	1, 349, 120				7.00
	01 UTI LI TI ES	104, 855	0	436, 933			7. 01
	DO LAUNDRY & LINEN SERVICE	24, 082	11, 063	3, 023	114, 435		8. 00
	00 HOUSEKEEPI NG	102, 258	28, 432	7, 768	0	462, 311	9.00
	00 DI ETARY 00 CAFETERI A	110, 440	58, 008	15, 849 10, 126	0	20, 383	
•	DO NURSING ADMINISTRATION	19, 061 221, 269	37, 062 19, 213	5, 249	0	13, 023 6, 751	
	01 HOUSE SUPERVI SORS	154, 590	0	0, 247	0	0, 731	13.00
14. 00 0140	OO CENTRAL SERVICES & SUPPLY	71, 510	75, 599	20, 655	0	0	14.00
•	OO PHARMACY	115, 485	43, 110	11, 778	0	0	15. 00
	00 MEDICAL RECORDS & LIBRARY	22, 996	46, 097	12, 594	0	16, 198	
	00 SOCIAL SERVICE 50 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	17. 00 18. 00
	00 NONPHYSICIAN ANESTHETISTS	160, 826	0	0	0	0	19.00
	00 NURSI NG SCHOOL	0	0	0	0	Ö	20.00
21. 00 0210	00 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
	00 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
	OO PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	ATIENT ROUTINE SERVICE COST CENTERS OO ADULTS & PEDIATRICS	503, 394	275, 583	75, 294	38, 468	96, 837	30.00
	DO INTENSIVE CARE UNIT	0 303, 374	273, 303	73, 274	30, 400	0,037	31.00
	OO CORONARY CARE UNIT	0	0	0	0	Ö	32.00
	00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
	00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
	00 SUBPROVI DER - I PF	0	0	0	0	0	40.00
	00 SUBPROVI DER - I RF 00 SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
•	OO NURSERY	32, 340	9, 219	2, 519	374	3, 240	
•	00 SKILLED NURSING FACILITY	0	0	0	0	0,210	1
	00 NURSING FACILITY	0	0	0	0	0	45.00
	OO OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ILLARY SERVICE COST CENTERS	275 1/4	222 240	(0.705	11 005	70,000	F0 00
	00 OPERATING ROOM 00 RECOVERY ROOM	275, 164	222, 260	60, 725 0	11, 025 0	78, 099 0	50. 00 51. 00
	OO DELIVERY ROOM & LABOR ROOM	66, 301	18, 402	5, 028	· ·	l .	ı
	00 ANESTHESI OLOGY	0	0	0	0	0	53.00
	00 RADI OLOGY-DI AGNOSTI C	464, 944	215, 142	58, 780	16, 569	75, 598	54.00
	00 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
	00 RADI OI SOTOPE	0	0	0	0	0	56.00 57.00
	00 CT_SCAN 00 MRI	0	0	0	0	0	58.00
	OO CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
	00 LABORATORY	515, 937	67, 965	18, 569	0	23, 882	
	01 BLOOD LABORATORY	0	0	0	0	0	
	00 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_	_	_	_	61.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
	00 BLOOD STORING, PROCESSING & TRANS. 00 INTRAVENOUS THERAPY	54, 548	14, 751	4, 030	0	0 5, 183	63. 00 64. 00
	00 RESPI RATORY THERAPY	135, 490	10, 473	2, 861	0	3, 680	
	00 PHYSI CAL THERAPY	276, 097	7, 339	25, 118	9, 584	32, 305	
	OO OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
	00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
•	00 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENT	79, 726	0	0	0		70. 00 71. 00
	00 IMPL. DEV. CHARGED TO PATIENTS	3, 925	o	0	0	Ö	72.00
	OO DRUGS CHARGED TO PATIENTS	332, 589	0	0	0	0	73.00
	00 RENAL DIALYSIS	0	0	0	0	0	74.00
	00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
	DATLENT SERVICE COST CENTERS	35, 901	33, 595	9, 179	0	11, 805	75. 01
	PATIENT SERVICE COST CENTERS OO RURAL HEALTH CLINIC		n	0	n	0	88.00
	00 FEDERALLY QUALIFIED HEALTH CENTER		o	0	0	0	89.00
	00 CLI NI C	0	o	0	0	0	90.00
	DO EMERGENCY	728, 066	149, 353	40, 806	36, 733	52, 481	
	OO OBSERVATION BEDS (NON-DISTINCT PART						92.00
	ER REIMBURSABLE COST CENTERS OO HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
	00 AMBULANCE SERVICES	0	0	0		1	
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	<u> </u>	<u> </u>	<u> </u>	<u> </u>	·	

				o 12/31/2014	Date/lime Pre 5/28/2015 11:	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	55 diii
out contor bood per on	E & GENERAL	PLANT	011211120	LINEN SERVICE	11000211221 1110	
	5. 00	7. 00	7. 01	8. 00	9. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	ol c	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	d c	0	0	98.00
99. 00 09900 CMHC	0	0	d c	0	0	99.00
99. 10 09910 CORF	0	0	l c	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	l c	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	d c	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	C	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	C	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	C	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	d c	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	d c	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	d c	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	d c	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	d c	0	0	115.00
116. 00 11600 HOSPI CE	0	0	d c	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4, 935, 556	1, 342, 666	389, 951	113, 456	445, 931	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	1	0	190. 00
190.01 19001 VISITING SPECIALTY CLINIC	6, 257	0	20, 403	979	0	190. 01
190. 02 19002 OUTREACH	65, 086		10, 972	0	14, 112	
190. 03 19003 FOUNDATI ON	19, 534	6, 454	1, 763	0	2, 268	190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	4, 581	0	ol c	0	0	190. 04
190.05 19005 PAOLI FAMILY PRACTICE	1, 488	0	ol c	0	0	190. 05
190. 06 19006 OTHER PROPERTY	6, 428	0	13, 844	0	0	190.06
191. 00 19100 RESEARCH	0	0	ol c	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	ol c	0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0	c c	0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0	0	201.00
202.00 TOTAL (sum lines 118-201)	5, 038, 930	1, 349, 120	436, 933	114, 435	462, 311	202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/28/2015	11:53 am

Cost Contan Decemintion	DIETARY	CAFETERIA	MIDELNC	HOUSE	5/28/2015 11:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	SUPERVI SORS	CENTRAL SERVICES &	
	10.00	11. 00	N 13. 00	13. 01	SUPPLY 14.00	
GENERAL SERVICE COST CENTERS			1			,
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7. 00
7. 01 00701 UTI LI TI ES						7. 01
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	554, 444					10.00
11. 00 01100 CAFETERI A	0	139, 639				11.00
13.00 O1300 NURSING ADMINISTRATION	0	11, 289				13.00
13. 01 01301 HOUSE SUPERVI SORS	0	7, 226		651, 404	20/ 474	13. 01
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	2, 233		0	396, 471	14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	0	4, 567 215		0	0	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	0	213		0	0	17. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)		0		0	0	18. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	o	7, 049	Ö	Ö	Ö	19. 00
20. 00 02000 NURSI NG SCHOOL	o	0	o	Ö	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	O	0	O	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	554, 444	19, 549		221, 153	0	30.00
31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	0		U	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		0	0	34.00
40. 00 04000 SUBPROVI DER - PF	0	0		0	Ö	40. 00
41. 00 04100 SUBPROVI DER - RF	o	0	o o	ő	0	41. 00
42. 00 04200 SUBPROVI DER	o	0	Ö	0	0	42.00
43. 00 04300 NURSERY	O	1, 451	24, 312	16, 420	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
46. 00 04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS		0.014	147 (40	00.710	0	F0 00
50. 00 05000 0PERATING ROOM	0	8, 814	147, 640	99, 710	0	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	2, 722	45, 597	30, 795	0	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0	2, 122	45, 597	30, 793 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		15, 613		0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o o	0,010	o o	Ö	0	55. 00
56. 00 05600 RADI 0I SOTOPE	o	0	0	Ö	0	56. 00
57.00 05700 CT SCAN	О	0	0	0	0	57.00
58. 00 05800 MRI	0	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY	0	14, 760	0	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY		986	16, 520	11, 157	0	63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY		5, 462		11, 137	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	10, 584		0	Ö	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0	o o	ő	0	67.00
68.00 06800 SPEECH PATHOLOGY	o	0	Ö	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	0	O	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	378, 700	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	17, 771	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75. 01 07501 CARDI AC REHAB	U U	76	0	Uj	0	75. 01
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	ol	0		٥	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0		n	0	89. 00
90. 00 09000 CLI NI C		0		n	0	90.00
91. 00 09100 EMERGENCY	l ol	24, 058	403, 004	272, 169	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	<u> </u>					92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00

			10	12/31/2014	Date/lime Prep 5/28/2015 11:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	HOUSE	CENTRAL	
			ADMI NI STRATI O	SUPERVI SORS	SERVICES &	
			N		SUPPLY	
	10.00	11. 00	13.00	13. 01	14.00	
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 1	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0	0 1	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 1	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 1	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 1	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 1	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 1	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 1	111.00
113. 00 11300 I NTEREST EXPENSE					1	113.00
114.00 11400 UTILIZATION REVIEW-SNF					1	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	O	0	0	0	0 1	115.00
116. 00 11600 HOSPI CE	o	0	0	0	0 1	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	554, 444	136, 654	964, 533	651, 404	396, 471 1	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01 19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 01
190. 02 19002 OUTREACH	0	2, 154		0		190. 02
190. 03 19003 FOUNDATI ON	0	831	0	0		190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
190.05 PAOLI FAMILY PRACTICE	0	0	0	0		190. 05
190. 06 19006 OTHER PROPERTY	0	0	0	0	0 1	190.06
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 1	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	O	0 2	201.00
202.00 TOTAL (sum lines 118-201)	554, 444	139, 639	964, 533	651, 404	396, 471	202.00
				· ·		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151306

					3 12/31/2014	5/28/2015 11:	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	SERVI CE (SPECI FY)	NONPHYSI CI AN	
	·		RECORDS &	SERVI CE		ANESTHETI STS	
		15. 00	16. 00	17. 00	18. 00	19. 00	
	GENERAL SERVICE COST CENTERS	10.00	10.00		10.00	171.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7.00
7. 01	00701 UTI LI TI ES						7. 01
8. 00	00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
13. 01	01301 HOUSE SUPERVI SORS						13. 01
14.00	01400 CENTRAL SERVICES & SUPPLY	F40 (02)					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	540, 682 0	170, 930				15. 00 16. 00
			170, 730	0			17. 00
		0	0	0	0		18.00
		0	0	0	0	677, 214	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		٥,			J	20.00
30.00		0	5, 430	0	0	0	
		0	0	0	0	0	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	1 1	O	0	0	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	734	0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY		o	0	0	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM	0	13, 633	0	0	677, 214 0	50. 00 51. 00
52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	2, 346	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	45, 933	0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	0	0	0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	Ö	0	0	Ö	59.00
60.00	06000 LABORATORY	0	24, 591	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0	0	0	61.00
62. 00 63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	40, 355	8, 722	0	0	Ö	64.00
65.00	06500 RESPI RATORY THERAPY	0	2, 462	0	0	0	65.00
	06600 PHYSI CAL THERAPY	0	7, 493	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 355	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	156	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	500, 327	21, 481	0	0	0	73.00
		0	0	0	0	0	74. 00 75. 00
75. 00	07501 CARDI AC REHAB	0	340	0	0	0	75. 01
** = *	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0	0 35, 254	0	0	0	90. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	١	30, 204	U	U	0	91.00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	<u> </u>	I			1	

				To 12/31/2014	Date/Time Pre 5/28/2015 11:	
				OTHER GENERAL SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	(SPECIFY)	NONPHYSI CI AN	
oust defiter bescription	THANNAGE	RECORDS &	SERVI CE	(SI LOTTI)	ANESTHETI STS	
		LI BRARY				
	15. 00	16. 00	17. 00	18. 00	19. 00	
OTHER REIMBURSABLE COST CENTERS			1			
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		0 (- 1	
95. 00 09500 AMBULANCE SERVICES	0	0		0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	
98. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			0 0	1
99. 00 09900 CMHC	0	0				
99. 10 09910 CORF		0				
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101.00 10100 HOME HEALTH AGENCY	o	0		0		101.00
SPECIAL PURPOSE COST CENTERS	'			•	•	
105. 00 10500 KIDNEY ACQUISITION	0	0		0 (0	105.00
106.00 10600 HEART ACQUISITION	0	0		0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0		107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 (109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111.00 11100 ISLET ACQUISITION 113.00 11300 INTEREST EXPENSE	O	0		0	٥	111.00
114. 00 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0				115.00
116. 00 11600 HOSPI CE		0				116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	540, 682	170, 930		0	I	
NONREI MBURSABLE COST CENTERS	2.27.222		I.			1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 (0	190. 00
190.01 19001 VISITING SPECIALTY CLINIC	0	0		0 (190. 01
190. 02 19002 OUTREACH	0	0		0	I	190. 02
190. 03 19003 FOUNDATI ON	0	0		0		190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0		0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	0	0		0		190.05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH	0	0				190. 06 191. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				191.00
193. 00 19300 NONPALD WORKERS		0				193.00
200.00 Cross Foot Adjustments	١	0				200.00
201.00 Negative Cost Centers	l	0		0		201.00
202.00 TOTAL (sum lines 118-201)	540, 682	170, 930		0	677, 214	
	. '		•	•	•	•

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 11/2014 | Part | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151306

					To	12/31/2014	Date/Time Pre 5/28/2015 11:	
				INTERNS &	RESI DENTS			
		Cost Center Description	NURSI NG	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	Subtotal	
			SCH00L	RY & FRINGES	R PRGM COSTS	PRGM		
			20. 00	APPRV 21. 00	APPRV 22. 00	23. 00	24. 00	
	GENER	AL SERVICE COST CENTERS	20.00		22.00	20.00	21100	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00	1	ADMINISTRATIVE & GENERAL						5.00
7. 00	1	OPERATION OF PLANT						7. 00
7. 01	1	UTILITIES						7. 01
8.00	1	LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00	1	CAFETERI A						11.00
13.00		NURSING ADMINISTRATION						13.00
13. 01	1	HOUSE SUPERVI SORS						13. 01
14. 00 15. 00	1	CENTRAL SERVI CES & SUPPLY PHARMACY						14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY						16.00
17. 00	1	SOCIAL SERVICE						17. 00
18. 00		OTHER GENERAL SERVICE (SPECIFY)						18. 00
19.00	1	NONPHYSI CI AN ANESTHETI STS	0					19.00
20. 00 21. 00		NURSING SCHOOL I&R SERVICES-SALARY & FRINGES APPRV	0	0				20. 00 21. 00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRV	0	Ö	0			22.00
23. 00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23. 00
20.00		I ENT ROUTINE SERVICE COST CENTERS		1		0	0.744.077	00.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	0		0	3, 711, 867 0	30. 00 31. 00
32. 00		CORONARY CARE UNIT	0	Ö		0	0	32.00
33.00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	1	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00	1	SUBPROVI DER - I PF SUBPROVI DER - I RF	0	0	0	0	0	40. 00 41. 00
42. 00	1	SUBPROVI DER	0	Ö	Ö	0	0	42.00
43.00		NURSERY	0	0	0	0	193, 031	43.00
44. 00		SKILLED NURSING FACILITY	0	0		0	0	44.00
45. 00 46. 00	1	NURSING FACILITY OTHER LONG TERM CARE	0	0		0	0	45. 00 46. 00
40.00		LARY SERVICE COST CENTERS	0		<u> </u>	<u> </u>	0	40.00
50.00	1	OPERATING ROOM	0	1		0	2, 465, 732	
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 388, 335	51. 00 52. 00
53. 00	1	ANESTHESI OLOGY	0	0	0	0	0.00	53.00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	Ō	O	0	2, 365, 062	
55.00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	0	0	0	0	56. 00 57. 00
	05800		0		0	0	0	58.00
59. 00	1	CARDI AC CATHETERI ZATI ON	0	Ō	O	0	0	59.00
60.00	1	LABORATORY	0	0	0	0	2, 299, 683	60.00
60. 01 61. 00		BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	0	Ö	0	0	0	63.00
64. 00		INTRAVENOUS THERAPY	0	0	0	0	329, 006	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0	0	0	589, 526	
67.00	1	OCCUPATIONAL THERAPY	0		0	0	1, 242, 924 0	67.00
68. 00		SPEECH PATHOLOGY	0	Ö	0	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 713, 275	
		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	34, 284	
73.00	07300	DRUGS CHARGED TO PATIENTS	Ö	0	0	0	1, 907, 712	
	1	RENAL DIALYSIS	0	0	0	0	0	
75. 00 75. 01		ASC (NON-DISTINCT PART)	0	0		0	0 204, 595	75. 00 75. 01
73.01		CARDIAC REHAB TIENT SERVICE COST CENTERS	0		ı	U	204, 595	73.01
	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
		FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 91. 00		CLINIC EMERGENCY	0	0		0	0 4, 047, 722	90. 00 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				J	1, 517, 722	92.00
		'			'	·		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2014 Part I Provi der CCN: 151306

			T	0 12/31/2014	Date/Time Prepared: 5/28/2015 11:53 am
		INTERNS &	RESI DENTS		
Cost Center Description	NURSI NG	SEDVICES SALA	SERVI CES-OTHE	PARAMED ED	Subtotal
cost center bescription	SCH00L	RY & FRINGES	R PRGM COSTS	PRGM	Subtotal
	3011002	APPRV	APPRV	1 Itom	
	20. 00	21. 00	22. 00	23. 00	24. 00
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DIALYSIS	0	0			0 94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00 0 97.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 97. 00 0 98. 00
99. 00 09900 CMHC	0	0		0	0 99.00
99. 10 09910 CORF	0	0	0	0	0 99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	Ö	0 101.00
SPECIAL PURPOSE COST CENTERS				<u> </u>	5,1011.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0 105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0 106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUI SI TI ON	0	0	0	0	0 108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0 111.00
113. 00 11300 I NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		_	_	_	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115.00
116. 00 11600 HOSPI CE	0	0	0	0	0 116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	0	0	0	20, 492, 754 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	0	0	0	0 190, 00
190. 01 19001 VISITING SPECIALTY CLINIC	0	0	0	0	47, 455 190. 01
190. 02 19002 OUTREACH	0	0	l ő	0	298, 453 190. 02
190. 03 19003 FOUNDATI ON	0	Ö	0	0	92, 714 190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	19, 088 190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0	0	0	0	6, 201 190. 05
190. 06 19006 OTHER PROPERTY	0	0	0	0	40, 630 190. 06
191. 00 19100 RESEARCH	0	0	0	0	0 191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
200.00 Cross Foot Adjustments	0	0	0	0	0 200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	1 0	0	0	0	20, 997, 295 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 151306

				10 12/31/2014 Date/lime F 5/28/2015 1	
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	3, 23, 23, 3	
CENT	EDAL CEDALCE COCT CENTEDS	25. 00	26. 00		
1. 00 0010 2. 00 0020 4. 00 0040	ERAL SERVICE COST CENTERS OO CAP REL COSTS-BUDG & FIXT OO CAP REL COSTS-MVBLE EQUIP OO EMPLOYEE BENEFITS DEPARTMENT OO ADMINISTRATIVE & GENERAL				1. 00 2. 00 4. 00 5. 00
7. 00 0070 7. 01 0070 8. 00 0080	OO OPERATION OF PLANT OI UTILITIES OO LAUNDRY & LINEN SERVICE OO HOUSEKEEPING				7. 00 7. 01 8. 00 9. 00
11. 00 0110 13. 00 0130	00 DIETARY 00 CAFETERIA 00 NURSING ADMINISTRATION 01 HOUSE SUPERVISORS				10. 00 11. 00 13. 00 13. 01
15. 00 015 16. 00 016	00 CENTRAL SERVICES & SUPPLY 00 PHARMACY 00 MEDICAL RECORDS & LIBRARY 00 SOCIAL SERVICE				14. 00 15. 00 16. 00 17. 00
19. 00 0190 20. 00 0200 21. 00 0210	50 OTHER GENERAL SERVICE (SPECIFY) 00 NONPHYSICIAN ANESTHETISTS 00 NURSING SCHOOL 00 I&R SERVICES-SALARY & FRINGES APPRV				18. 00 19. 00 20. 00 21. 00
23. 00 023 I NP 30. 00 030	00 1&R SERVICES-OTHER PRGM COSTS APPRV 00 PARAMED ED PRGM-(SPECIFY) ATIENT ROUTINE SERVICE COST CENTERS 00 ADULTS & PEDIATRICS	0	3, 711, 867		22. 00 23. 00 30. 00
32. 00 0320 33. 00 0330 34. 00 0340	00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT	0 0 0 0	0 0 0 0		31.00 32.00 33.00 34.00
41. 00 0410 42. 00 0420 43. 00 0430	00 SUBPROVI DER - I PF 00 SUBPROVI DER - I RF 00 SUBPROVI DER 00 NURSERY	0 0 0	0 0 0 193, 031		40. 00 41. 00 42. 00 43. 00
45. 00 045 46. 00 046 ANC	00 SKILLED NURSING FACILITY 00 NURSING FACILITY 00 OTHER LONG TERM CARE ILLARY SERVICE COST CENTERS	0 0 0	0 0 0		44. 00 45. 00 46. 00
51. 00 0510 52. 00 0520 53. 00 0530	OO OPERATING ROOM OO RECOVERY ROOM OO DELIVERY ROOM & LABOR ROOM OO ANESTHESI OLOGY	0 0 0	2, 465, 732 0 388, 335 0		50. 00 51. 00 52. 00 53. 00
55. 00 0550 56. 00 0560 57. 00 0570	00 RADI OLOGY-DI AGNOSTI C 00 RADI OLOGY-THERAPEUTI C 00 RADI OI SOTOPE 00 CT SCAN	0 0 0	2, 365, 062 0 0 0		54. 00 55. 00 56. 00 57. 00
59. 00 0590 60. 00 0600 60. 01 0600	00 MRI 00 CARDI AC CATHETERI ZATI ON 00 LABORATORY 01 DEBOOD LABORATORY	0 0 0 0	0 0 2, 299, 683 0		58. 00 59. 00 60. 00 60. 01
62. 00 0620 63. 00 0630 64. 00 0640	00 PBP CLINICAL LAB SERVICES-PRGM ONLY 00 WHOLE BLOOD & PACKED RED BLOOD CELL 00 BLOOD STORING, PROCESSING & TRANS. 00 INTRAVENOUS THERAPY	0 0	0 0 0 329, 006		61. 00 62. 00 63. 00 64. 00
66. 00 0666 67. 00 0676 68. 00 0686	00 RESPI RATORY THERAPY 00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY 00 SPEECH PATHOLOGY	0 0 0 0	589, 526 1, 242, 924 0		65. 00 66. 00 67. 00 68. 00
70. 00 070 71. 00 071 72. 00 072	00 ELECTROCARDIOLOGY 00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENT 00 IMPL. DEV. CHARGED TO PATIENTS	0 0 0 0	0 0 713, 275 34, 284		69. 00 70. 00 71. 00 72. 00
74. 00 074 75. 00 075 75. 01 075	DOU DRUGS CHARGED TO PATIENTS DOU RENAL DIALYSIS DOU ASC (NON-DISTINCT PART) DOU CARDIAC REHAB	0 0 0 0	1, 907, 712 0 0 204, 595		73. 00 74. 00 75. 00 75. 01
88. 00 0880 89. 00 0890 90. 00 0900	PATIENT SERVICE COST CENTERS OO RURAL HEALTH CLINIC OO FEDERALLY QUALIFIED HEALTH CENTER OO CLINIC	0 0 0	0 0 0		88. 00 89. 00 90. 00
	00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART	0 0	4, 047, 722		91.00

Provider CCN: 151306 | Period: | Worksheet B | From 01/01/2014 | Part | | To | 13/21/2014 | Part/Time Pr

			To 12/31/2014 Part 1	
Cost Center Description	Intern &	Total	5/28/2015 1	1:53 am
cost center bescription	Residents	TOTAL		
	Cost & Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
OTHER REIMBURSABLE COST CENTERS		'		
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		105.00
106. 00 10600 HEART ACQUISITION	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION		O O		110.00
113.00 11300 INTEREST EXPENSE	ا ا	U		111. 00 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0		115.00
116. 00 11600 HOSPI CE		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)		20, 492, 754		118.00
NONREI MBURSABLE COST CENTERS	0	20, 472, 734		110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	o	47, 455		190. 01
190. 02 19002 OUTREACH	o	298, 453		190. 02
190. 03 19003 FOUNDATI ON	O	92, 714		190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	o	19, 088		190. 04
190.05 19005 PAOLI FAMILY PRACTICE	o	6, 201		190. 05
190.06 19006 OTHER PROPERTY	O	40, 630		190.06
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	o		192.00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
200.00 Cross Foot Adjustments	0	O		200.00
201.00 Negative Cost Centers	0	0		201.00
202.00 TOTAL (sum lines 118-201)	0	20, 997, 295		202. 00

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

				То	12/31/2014	Date/Time Pre 5/28/2015 11:	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	oost conten bescription	Assigned New	DEDG G TTXT	MVBLL LQOIT	oubtotai	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 487	6, 302	10, 789	10, 789	2.00 4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	0	65, 519		157, 539	947	5.00
7. 00	00700 OPERATION OF PLANT	0	42, 070		101, 156	358	7. 00
7. 01	00701 UTI LI TI ES	0	0		0	0	7. 01
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	2, 920 7, 505		7, 021 18, 045	0 239	8. 00 9. 00
10.00	01000 DI ETARY	0	15, 311		36, 816	208	1
11. 00	01100 CAFETERI A	0	9, 783		23, 522	47	11.00
13.00	01300 NURSING ADMINISTRATION	0	5, 071	1	12, 194	626	1
13. 01 14. 00	01301 HOUSE SUPERVI SORS	0	0 19, 954	0 28, 026	47.090	458	1
15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	19, 954		47, 980 27, 360	140 279	•
	01600 MEDICAL RECORDS & LIBRARY	0	12, 167		29, 256	11	16.00
	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0) 0	0	0	461 0	19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	Ö	ő	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		O	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1 0	72, 743	102, 165	174, 908	1, 248	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVIDER - IRF	0	0		Ö	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	o	0	42.00
43.00	04300 NURSERY	0	2, 433	3, 418	5, 851	92	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0 0	0	0	0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS		·	-	-1		
50.00	05000 OPERATING ROOM	0	58, 666	82, 396	141, 062	567	50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0 4, 857	0 4 922	11 470	0 173	51.00 52.00
52.00	05300 ANESTHESI OLOGY	0	4,857 0	6, 822	11, 679 0	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	56, 787	79, 757	136, 544	979	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
	05600 RADI OI SOTOPE	0	0	0	0	0	1
57. 00 58. 00	05700 CT SCAN	0	0		0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	Ö	Ö	0	59.00
	06000 LABORATORY	0	17, 939	25, 196	43, 135	923	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	Ö	ő	0	63.00
	06400 I NTRAVENOUS THERAPY	0	3, 894		9, 362	63	•
65.00	06500 RESPI RATORY THERAPY	0	2, 764		6, 647	388	•
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	24, 267	34, 082	58, 349	750 0	•
	06800 SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	Ö	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		ol Ol	0	72.00 73.00
	07400 RENAL DI ALYSI S	0	Ö	o o	ő	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
75. 01	O7501 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	0	8, 868	12, 454	21, 322	75	75. 01
88. 00	08800 RURAL HEALTH CLINIC	0	0	n	n	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	o o	ő	0	89. 00
	09000 CLINIC	0	0	0	0	0	
91.00	09100 EMERGENCY	0	39, 422	55, 368	94, 790	1, 544	91.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Cost Center Description				To	12/31/2014	Date/Time Pre 5/28/2015 11:	
Assigned New Capital Related Costs Capital Related			CAPI TAL REI	ATED COSTS		372072013 11.	JJ alli
Assigned New Capital Related Costs Capital Related							
P2. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 0 0 0 0 0	Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
Related Costs							
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0						DEPARTMENT	
92. 00 09200 095ERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0			1 00	2.00	2.4	4.00	
OTHER REI MBURSABLE COST CENTERS	02 00 00200 OBSEDVATION PEDS (NON DISTINCT DADT	U	1.00	2.00		4.00	02.00
94. 00 09400 HOME PROCRAM DI ALYSIS 0 0 0 0 0 0 94. 00 95. 00 09500 09500 09600 09800 09900 09					<u> </u>		72.00
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 101. 00 10000 Lar Servi Ces-Not Approx Prom 0 0 0 0 0 101. 00 10100 Hore Health Agency 0 0 0 0 0 0 101. 00 10100 Hore Health Agency 0 0 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 106. 00 10600 Heart AcQUI SI TI ON 0 0 0 0 0 0 107. 00 10700 Li Vera AcQUI SI TI ON 0 0 0 0 0 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 101. 00 10100 INTERESTI EXPENSE 111. 00 111. 00 11100 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115. 00 11600 HOSPI CE 0 0 0 0 0 0 116. 00 10800 CORT			0	n	O	0	94 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0		0	0	I ~	-1		
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 99. 00 998. 00 998. 00 999. 00 99900 CHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 999. 00 99900 CORF 0 0 0 0 0 0 0 99. 10 00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 1010. 00 1010. 00 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 1010. 00 1010		0	0	0	0		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 100. 00 10000 LAR SERVICES-NOT APPRVD PRGM 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS		0	0	0	o	-	
99. 00 09900 CMHC 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 100. 00 100000 &&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS		0	0	o	o	0	1
100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 101. 00 SPECI AL PURPOSE COST CENTERS		0	0	o	o	0	
101. 00	99. 10 09910 CORF	0	0	0	О	0	99. 10
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 105. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 108. 00 108. 00 108. 00 108. 00 109. 00	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	o	0	100.00
105. 00	101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 106. 00 107. 00 107. 00 10700 Liver Acquisition 0 0 0 0 0 0 0 0 107. 00 108. 00 108. 00 10800 Lung Acquisition 0 0 0 0 0 0 0 0 0 108. 00 109. 00 10900 PANCEAS ACQUISITION 0 0 0 0 0 0 0 0 109. 00 109. 00 110.	SPECIAL PURPOSE COST CENTERS						
107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 0 109. 00 109. 00 11000 INTEREST INAL ACQUI SI TI ON 0 0 0 0 0 0 111. 00 111. 00 11100 ISLET ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 113. 00 11300 INTEREST EXPENSE 0 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 115. 00 116. 00 116. 00 SUBTOTALS (SUM OF LINES 1-117) 0 488,806 686,521 1,175,327 10,576 118. 00 190. 00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19,711 0 19,711 0 190. 01 190. 02 19002 0UTREACH 0 10,600 0 10,600 161 190. 02		0	0	0	0		
108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 0 108. 00 109. 00 110. 00 1111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 11		0	0	0	0		
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 109. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 00		0	0	0	0		
110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110. 00 111		0	0	0	0		
111. 00 11100 1 SLET ACQUI SI TI ON 0 0 0 0 0 111. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 116. 00 11	· · · · · · · · · · · · · · · · · · ·	0	0	0	0		
113. 00		0	0	0	0		
114. 00		0	0	0	0	0	
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·						1
116. 00	I I						
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 488, 806 686, 521 1, 175, 327 10, 576 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 190. 01 19001 VI SI TI NG SPECIALTY CLINIC 0 19, 711 0 19, 711 0 190. 01 190. 02 19002 OUTREACH 0 10, 600 0 10, 600 161 190. 02		0	0	0	0		
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 190. 01 19001 VI SI TI NG SPECIALTY CLINI C 0 19, 711 0 19, 711 0 190. 01 190. 02 19002 OUTREACH 0 10, 600 0 10, 600 161 190. 02 190. 02 19002 OUTREACH 0 10, 600 0 10, 600 161 190. 02 19002		0	400,007	(0/ 501	1 175 227		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 190. 00 190. 01 19001 VI SI TI NG SPECIALTY CLINI C 0 19, 711 0 19, 711 0 190. 01 190. 02 19002 0UTREACH 0 10, 600 0 10, 600 161 190. 02		l U	488, 806	686, 521	1, 1/5, 32/	10, 576	1118.00
190. 01 19001 VI SI TI NG SPECIALTY CLINIC 0 19, 711 0 190. 01 190. 02 19002 0UTREACH 0 10, 600 0 10, 600 161 190. 02			0		ام	0	100 00
190. 02 19002 OUTREACH 0 10, 600 0 10, 600 161 190. 02		0	_	_	- 1		
		0					
		0					
190. 0419004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0190. 04		0					
190. 05 19005 PAOLI FAMILY PRACTICE 4, 579 0 0 4, 579 0190. 05		4, 579	0	0	4, 579		
190. 06 19006 OTHER PROPERTY 2, 003 13, 374 0 15, 377 0 190. 06			13. 374	o			1
191.00 RESEARCH 0 0 0 0 0 191.00		0	0	0			1
192.00 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00		0	0	0	0	0	192.00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00	I I	O	0	0	o		
200.00 Cross Foot Adjustments 0 200.00	200.00 Cross Foot Adjustments				О		200.00
201.00 Negative Cost Centers 0 0 0 201.00	201.00 Negative Cost Centers		0	0	o	0	201.00
000 00 TOTAL (11 440 004)	202.00 TOTAL (sum lines 118-201)	6, 582	534, 194	688, 913	1, 229, 689	10, 789	202. 00

Provi der CCN: 151306

				<u>'</u>	0 12/31/2014	5/28/2015 11:	
	Cost Center Description	ADMINISTRATIV E & GENERAL	OPERATION OF	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 00	PLANT 7. 00	7. 01	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	158, 486					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	10, 183	111, 697				7.00
7. 01	00701 UTI LI TI ES	3, 298	0	3, 298			7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	757	916	23			8. 00
9. 00	00900 HOUSEKEEPI NG	3, 216	2, 354	59		23, 913	9.00
10. 00 11. 00	01000 DI ETARY	3, 474 600	4, 803	120		1, 054	10.00
13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	6, 959	3, 068 1, 591	76 40	0	674 349	11. 00 13. 00
13. 01	01301 HOUSE SUPERVI SORS	4, 862	0	0	0	0	13. 01
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 249	6, 259	156	0	0	14.00
15.00	01500 PHARMACY	3, 632	3, 569		0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	723	3, 816	95	0	838	16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	5, 058	0		0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	Ö	Ö	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	15, 833	22, 818	568	2, 930	5, 009	30.00
31. 00	03100 I NTENSI VE CARE UNI T	15, 633	22,010	0	2, 730	3,009	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	ا	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	0	0	0	0	41.00
42.00	04300 NURSERY	1, 017	763	19	28	168	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	1,017	0	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	0.454	40.404	1.50		1 0 10	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	8, 654	18, 401	458 0		4, 040 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 085	1, 524	38	-	334	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 623	17, 812	444	1, 262	3, 910	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57. 00 58. 00	05700 CT SCAN	0	0	0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60.00	06000 LABORATORY	16, 227	5, 627	·	_	1, 235	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1 714	1 221	0	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 716 4, 261	1, 221 867	30 22	0	268 190	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	8, 684	608			1, 671	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	2 500	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	2, 508 123	0	1 0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 460	0	0	0	0	73.00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	07501 CARDI AC REHAB	1, 129	2, 781	69	0	611	75. 01
00.00	OUTPATIENT SERVICE COST CENTERS	1 0			1 0		00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00	09000 CLINIC	n	n		n	0	90.00
91. 00	09100 EMERGENCY	22, 904	12, 365	308	2, 798	2, 715	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0		0	94.00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00

Provi der CCN: 151306

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

			10	5 12/31/2014	Date/IIme Pre 5/28/2015 11:	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	00 0
	E & GENERAL	PLANT		LINEN SERVICE		
	5. 00	7. 00	7. 01	8. 00	9. 00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS	_			_1		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00 11100 SLET ACQUISITION 113.00 11300 NTEREST EXPENSE	0	U	0	U	0	111. 00 113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115.00
116. 00 11600 HOSPI CE	0		0	U O		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	155, 235	111, 163	2, 944	8, 642	23, 066	
NONREI MBURSABLE COST CENTERS	155, 255	111, 103	2, 744	0, 042	23,000	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	T 0	l ol	0	0	0	190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	197		154	75		190.01
190. 02 19002 OUTREACH	2, 047		83	0		190. 02
190. 03 19003 FOUNDATI ON	614	l	13	ol		190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	144	l I	0	o	0	190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	47	o	0	o	0	190. 05
190. 06 19006 OTHER PROPERTY	202	0	104	o	0	190. 06
191. 00 19100 RESEARCH	0	o	0	o	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	o	0	o	0	192.00
193.00 19300 NONPALD WORKERS	0	o	0	o	0	193. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	158, 486	111, 697	3, 298	8, 717	23, 913	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 151306

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

5/28/2015 11:53 am Cost Center Description DI ETARY CAFETERI A NURSI NG HOUSE CENTRAL ADMI NI STRATI O SUPERVI SORS SERVICES & **SUPPLY** Ν 13.01 10 00 11 00 13 00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 UTI LI TI ES 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 46, 475 10 00 01100 CAFETERI A 27, 987 11.00 11.00 01300 NURSING ADMINISTRATION 24, 021 13.00 0 2.262 13.00 13.01 01301 HOUSE SUPERVI SORS 0 1, 448 6,768 13.01 14.00 01400 CENTRAL SERVICES & SUPPLY 0 447 0 57, 231 14.00 01500 PHARMACY 0 15 00 915 0 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 43 0 0 0 16.00 17 00 01700 SOCIAL SERVICE 0 0 0 17.00 0 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 18.00 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19 00 1, 413 0 19 00 02000 NURSING SCHOOL 0 0 20.00 20.00 0 0 o 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 C 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 3, 918 8, 155 2, 297 0 30.00 46.475 03100 INTENSIVE CARE UNIT 31 00 C 0 31.00 32.00 03200 CORONARY CARE UNIT 0 C 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 0 0 34.00 04000 SUBPROVI DER - I PF 0 40.00 C 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 C 0 0 0 41.00 04200 SUBPROVI DER 42.00 0 0 C 0 0 0 42.00 43 00 04300 NURSERY 291 605 171 0 43 00 04400 SKILLED NURSING FACILITY 44.00 C 0 0 0 44.00 04500 NURSING FACILITY 0 0 0 0 45.00 45.00 C 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 1,766 3,677 1,036 0 50.00 05100 RECOVERY ROOM 0 0 51.00 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 320 Ω 52 00 546 1, 136 05300 ANESTHESI OLOGY 53.00 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 54.00 54.00 3.129 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55.00 |05600| RADI 01 SOTOPE 0 0 56 00 56.00 C 0 57.00 05700 CT SCAN C 0 0 0 57.00 0 58.00 05800 MRI 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 59.00 59.00 0 0 06000 LABORATORY 2, 958 O 60 00 0 60 00 60.01 06001 BLOOD LABORATORY 0 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 0 0 62.00 C 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 0 0 0 63.00 06400 INTRAVENOUS THERAPY 0 198 64.00 64.00 116 0 65.00 06500 RESPIRATORY THERAPY 1, 095 0 0 0 65.00 0 0 06600 PHYSI CAL THERAPY 0 66.00 2, 121 0 0 66,00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 67.00 06800 SPEECH PATHOLOGY 0000000 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C 0 54,666 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 2,565 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 07400 RENAL DIALYSIS 0 0 74 00 C 0 74 00 0 0 75.00 07500 ASC (NON-DISTINCT PART) C 0 0 75.00 07501 CARDI AC REHAB 75.01 0 15 0 0 0 75.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 Ω 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 C 0 0 0 90.00 09000 CLI NI C 0 90.00 0 0 09100 EMERGENCY 0 91.00 91.00 4,823 10,037 2,828 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00

Provi der CCN: 151306

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

			10	12/31/2014	Date/lime Pre 5/28/2015 11:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	HOUSE	CENTRAL	00 4111
			ADMI NI STRATI O	SUPERVI SORS	SERVICES &	
			N		SUPPLY	
	10.00	11. 00	13.00	13. 01	14. 00	
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	0	0	0	0	98.00
99. 00 09900 CMHC	o	0	O	o	0	99.00
99. 10 09910 CORF	o	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	o	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	o	o	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107. 00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109. 00 10900 PANCREAS ACQUISITION	o	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	o	0	O	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	o	0	O	0	0	111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0	O	0	0	115.00
116. 00 11600 HOSPI CE	o	0	O	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	46, 475	27, 388	24, 021	6, 768	57, 231	118.00
NONREI MBURSABLE COST CENTERS	,		,		•	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190.01 19001 VISITING SPECIALTY CLINIC	0	0	0	0	0	190. 01
190. 02 19002 OUTREACH	0	432	0	0	0	190. 02
190. 03 19003 FOUNDATI ON	0	167	0	0	0	190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190. 04
190.05 PAOLI FAMILY PRACTICE	0	0	0	0	0	190. 05
190. 06 19006 OTHER PROPERTY	o	0	0	0	0	190.06
191. 00 19100 RESEARCH	o	0	0	0	0	191.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	o	0	0	0	0	192.00
193.00 19300 NONPALD WORKERS	o	0	0	O	0	193.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	0	o	0	201.00
202.00 TOTAL (sum lines 118-201)	46, 475	27, 987	24, 021	6, 768	57, 231	202.00
•	. ,		. '			

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | 14 Fig. 2015 | Part 14 F Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151306

					lo 12/31/2014	Date/lime Pre 5/28/2015 11:	
					OTHER GENERAL SERVI CE		
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	(SPECIFY)	NONPHYSI CI AN	
			RECORDS &	SERVI CE		ANESTHETI STS	
		15. 00	16. 00	17. 00	18. 00	19.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7.00
7. 01	00701 UTI LI TI ES						7. 01
8.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00
9. 00 10. 00	01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
13. 01	01301 HOUSE SUPERVI SORS						13. 01
14.00	01400 CENTRAL SERVICES & SUPPLY	25 044					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	35, 844	34, 782				15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		0		0		17.00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	Ö	0		0		18.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	•	0	6, 932	1
20.00	02000 NURSI NG SCHOOL	0	0	•	0	1	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	1	21. 00 22. 00
	02300 PARAMED ED PRGM-(SPECIFY)		0			•	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-			-		
30. 00		0	1, 104	i e	0	1	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0	1	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	l .	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0			1	34.00
40. 00	04000 SUBPROVI DER - I PF	Ö	0	•	0		40.00
41. 00	04100 SUBPROVI DER - I RF	0	0		0)	41.00
42.00	04200 SUBPROVI DER	0	0		0	1	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	149 0		0 0		43. 00 44. 00
45. 00	04500 NURSING FACILITY		0	•			45.00
46.00	04600 OTHER LONG TERM CARE	0	0		0	•	46.00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	2, 772 0		0 0	1	50.00 51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		477			1	52.00
53.00	05300 ANESTHESI OLOGY	o	0		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 364		0)	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	1	55.00
	05600	0	0		0	1	56. 00 57. 00
	05800 MRI		0	•			58.00
59. 00		Ö	0	•	0		59.00
60.00		0	5, 001		0		60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	1	60.01
62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0		0		61.00 62.00
63. 00	1		0	l			63.00
64.00		2, 675	1, 773		0)	64.00
65.00		0	501		0)	65. 00
66.00		0	1, 524	1	0	1	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0				67. 00 68. 00
69. 00			0				69.00
	07000 ELECTROENCEPHALOGRAPHY	o	0		0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	479		0)	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	32		0]	72.00
74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	33, 169	4, 368 0	1			73.00 74.00
	07500 ASC (NON-DISTINCT PART)		0		0 0	[75.00
75. 01	07501 CARDI AC REHAB	o	69		0 0	1	75. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0	1	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		0				89. 00 90. 00
	09100 EMERGENCY		7, 169		o o		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00

Provider CCN: 151306 | Period: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				То	12/31/2014	Date/Time Pre 5/28/2015 11:	
				0	THER GENERAL	372072013 11.	JJ dill
					SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL		(SPECI FY)	NONPHYSI CI AN	
		RECORDS &	SERVI CE			ANESTHETI STS	
	15. 00	16. 00	17. 00		18. 00	19. 00	
OTHER REIMBURSABLE COST CENTERS	15.00	16.00	17.00		18.00	19.00	
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		0	0		94.00
95. 00 09500 AMBULANCE SERVICES	ol	0		Ö	0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0		0	0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	0		0	0		98.00
99. 00 09900 CMHC	o	0		0	0		99.00
99. 10 09910 CORF	o	0		0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0		0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	0		101.00
SPECIAL PURPOSE COST CENTERS							
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0	0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0	0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0	0		111. 00
113. 00 11300 I NTEREST EXPENSE							113.00
114.00 11400 UTILIZATION REVIEW-SNF							114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0		115. 00
116. 00 11600 HOSPI CE	0	0		0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	35, 844	34, 782		0	0	0	118. 00
NONREI MBURSABLE COST CENTERS			1				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0		190.00
190. 01 19001 VISITING SPECIALTY CLINIC	0	0		0	0		190. 01 190. 02
190. 02 19002 OUTREACH 190. 03 19003 FOUNDATI ON	0	0		0	0		190. 02
190. 03 19003 FOUNDATION 190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0		0	0		190. 03
190.05 19005 PAOLI FAMILY PRACTICE	0	0		0	0		190.04
190. 06 19006 OTHER PROPERTY	0	0		0	0		190.05
191. 00 19100 RESEARCH		0		0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0		0	0		192.00
193. 00 19300 NONPALD WORKERS		0		Õ	0		193.00
200.00 Cross Foot Adjustments		O		Ĭ	J	6, 932	200.00
201.00 Negative Cost Centers	o	0		0	0		201.00
202.00 TOTAL (sum lines 118-201)	35, 844	34, 782		0	0		202.00
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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B Part II Date/Time Prepared: 5/28/2015 11:53 am Provi der CCN: 151306 Peri od: From 01/01/2014 To 12/31/2014 INTERNS & RESIDENTS PARAMED ED Cost Center Description NURSI NG SERVI CES-SALA SERVI CES-OTHE Subtotal RY & FRINGES APPRV R PRGM COSTS SCH00L PRGM APPRV 20. 00 23. 00 21. 00 22.00 24.00

		20.00	21.00	22.00			
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	1			1			
4. 00	OO4OO EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7.00
7. 01	00701 UTI LI TI ES			1			7. 01
8.00	00800 LAUNDRY & LINEN SERVICE			1			8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A			1	ı		11.00
						•	
13.00	01300 NURSI NG ADMI NI STRATI ON					'	13.00
13. 01	01301 HOUSE SUPERVI SORS					-	13.01
14.00	01400 CENTRAL SERVICES & SUPPLY			1		l l	14.00
				1		•	
15. 00	01500 PHARMACY					•	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17.00	01700 SOCIAL SERVICE					-	17.00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)			1		l l	18.00
						•	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS			1		•	19. 00
20.00	02000 NURSI NG SCHOOL	0				2	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		l c	ol I			21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			0		· · · · · · · · · · · · · · · · · · ·	22.00
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23. 00	02300 PARAMED ED PRGM-(SPECIFY)				0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS					285, 263	30.00
31.00	03100 INTENSIVE CARE UNIT						31.00
	03200 CORONARY CARE UNIT					•	
32.00	1 1					•	32.00
33.00	03300 BURN INTENSIVE CARE UNIT					0 3	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT					ol :	34.00
40.00	04000 SUBPROVI DER - I PF			1		•	40.00
	1 1			1			
41.00	04100 SUBPROVI DER - I RF			1		•	41.00
42.00	04200 SUBPROVI DER					0 4	42.00
43.00	04300 NURSERY					9, 154	43.00
44. 00	04400 SKILLED NURSING FACILITY			1			44.00
						•	
45. 00	04500 NURSING FACILITY					0 4	45.00
46.00	04600 OTHER LONG TERM CARE					0 4	46.00
	ANCILLARY SERVICE COST CENTERS						
E0 00						102 272 1	50 00
50.00	05000 OPERATI NG ROOM						50.00
51.00	05100 RECOVERY ROOM					0 2	50. 00 51. 00
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51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN					0 18, 366 18, 366 188, 067	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00
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				-	Го 12/31/2014	Date/Time Pre 5/28/2015 11:	
			INTERNS &	RESI DENTS		072072010 11.	00 4111
Cost Center Description		NURSI NG	SERVI CES-SALA			Subtotal	
		SCH00L	RY & FRINGES APPRV	R PRGM COSTS APPRV	PRGM		
		20. 00	21. 00	22. 00	23. 00	24.00	
OTHER REIMBURSABLE COST CENTE	RS						
94.00 09400 HOME PROGRAM DIALYSIS						0	94.00
95. 00 09500 AMBULANCE SERVICES						0	
96.00 09600 DURABLE MEDICAL EQUIP-RE						0	
97. 00 09700 DURABLE MEDICAL EQUIP-SO						0	
98.00 09850 OTHER REIMBURSABLE COST	CENTERS					0	
99. 00 09900 CMHC						0	
99. 10 09910 CORF	DDOM					0	
100. 00 10000 I &R SERVI CES-NOT APPRVD	PRGM						100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS						0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON						0	105. 00
106. 00 10600 HEART ACQUISITION							106.00
107. 00 10700 LI VER ACQUI SI TI ON							107. 00
108. 00 10800 LUNG ACQUISITION							108.00
109.00 10900 PANCREAS ACQUISITION						0	109.00
110.00 11000 INTESTINAL ACQUISITION							110.00
111.00 11100 I SLET ACQUISITION						0	111.00
113.00 11300 INTEREST EXPENSE							113.00
114.00 11400 UTILIZATION REVIEW-SNF							114.00
115.00 11500 AMBULATORY SURGICAL CENT	ΓER (D. P.)						115. 00
116. 00 11600 HOSPI CE							116. 00
118.00 SUBTOTALS (SUM OF LINES	1-117)	0	0	(0	1, 162, 522	118. 00
NONREI MBURSABLE COST CENTERS	D A CANTEEN		1	ı		0	100.00
190. 00 19000 GLFT, FLOWER, COFFEE SHO							190.00
190. 01 19001 VISITING SPECIALTY CLINI 190. 02 19002 OUTREACH	C						190. 01 190. 02
190. 03 19003 FOUNDATION							190. 02
190. 04 19004 SPRING VALLEY FAMILY PRA	ACTICE						190.03
190. 05 19005 PAOLI FAMILY PRACTICE	TOTTOL						190.05
190. 06 19006 OTHER PROPERTY							190.06
191. 00 19100 RESEARCH							191.00
192. 00 19200 PHYSICIANS' PRIVATE OFFI	CES					0	192.00
193. 00 19300 NONPALD WORKERS						0	193.00
200.00 Cross Foot Adjustments		0	0		0	6, 932	200.00
201.00 Negative Cost Centers		0	0	(0		201.00
202.00 TOTAL (sum lines 118-201	1)	0	0	(0	1, 229, 689	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | 14 Fig. 2015 | Part 14 F Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151306

Desid Continue Description						lo	12/31/2014	Date/lime F 5/28/2015 1	
Cost & Post Streptoms Adjustments Ad		Cost Center Description	Intern &	Total				,	
CENNENDL SERVICE COST CENTERS 76,000 76,00									
MINISTER SERVICE CONTENTING 1,000 26,000			•						
DEBRIFICE SERVICE CUST CENTERS 1				26.00					
2.00		GENERAL SERVICE COST CENTERS	20.00	20.00					
4.00	1.00	00100 CAP REL COSTS-BLDG & FLXT							1.00
0.0000 ADMINI STRATT VE & CERERAL		i i							•
7.00 DOVOID DIFFACTION OF PLANT 8.00 DOSCOL AUMORY & LIFEN SERVICE 9.00 DOSCOL AUMORY & LIFEN SERVICE SERVICE (SPECIFY) 10.00 DOSCOL AUMORY & LIFEN SERVICE SERVICE (SPECIFY) 10.00 DOSCOL AUMORY & LIFEN SERVICE (SPECIFY) 10.00 DOSCOL AL SERVICE (SPECI		1 1							•
7. 0.1 DO 00701 JUTI LITTIES		1 1							1
8.00 00000 LAURIORY & LI LINEN SERVICE 9.00 10									•
9.00 0000000000000000000000000000000000		i i							•
11.00 01100 CAFETERIA		1 1							1
13.00 01300 NURSING AGMIN IN STRATION 13.00 13.01	10.00	01000 DI ETARY							10.00
13.01 13.01 10.025 EURENT SORS 13.01 14.00		I I							•
14.00 14.00 14.00 14.00 14.00 15.0		1 1							•
15.00 1500		1 1							•
16.00 1600 MEDICAL RECORDS & LIBRARY									•
17.00 1700 SOCIAL SERVICE (SPECIFY) 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19									•
19.00 1900 NORPHYSICI AN AMESTHETISTS 20.00 2000 2000 UNISKIN SCHOOL 20.00 2000 UNISKIN SCHOOL 20.00 2000 UNISKIN SCHOOL 21.00 22.00 2200 2200 LARS SERVICES-SALARY & FRINGES APPRV 22.00 2200 2000 ABANABE DE PROM. (SPECI FLY 22.00 285, 263 30.00 3									17. 00
20.00 2000 NURSI INS SCHOOL 22.00 22									•
21.00		I I							1
22.0 0.200 IAR SERVICES-OTHER PROM COSTS APPRV 23.0		i i							•
23.00									•
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 3		I I							•
31.00	20.00	` '	I I						
32 00 30200 COROMARY CARE UNIT 0 0 0 0 33.00 33.00 33.00 33.00 03300 DURN INTENSIVE CARE UNIT 0 0 0 34.00 40		1 1	0						•
33.00		1 1	0						•
34. 00 30400 SURGICAL INTENSIVE CARE UNIT 0 0 0 40.00		1 1	0	0					•
40.00 04000 SUBPROVI DER - I PF 0 0 0		1 1	0	0					•
42.00 04200 SUBPROVI DER 0 0 0 42.00 04400 04410 0		1 1	0	0					•
43. 00 04300 NURSERY			0						•
44. 00 04400 SKILLED NURSING FACILITY		i i	0						•
45. 00 04500 NURSI NG FACILITY		1 1	0						•
46. 00 04600 OTHER LONG TERN CARE		1 1							•
50.00	46.00	04600 OTHER LONG TERM CARE	0	0					•
51.00 05100 DECOVERY ROOM 0 0 0 0 0 0 0 0 0	50.00			100.070					
52.00 05200 05200 05300 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0						•
53. 00 05300 ABSTHESI OLOGY 0 0 0 55. 00		1 1	0						•
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 56. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 58. 00 58. 00 68. 00 69. 00 <td< td=""><td></td><td>I I</td><td>o</td><td>0</td><td></td><td></td><td></td><td></td><td>•</td></td<>		I I	o	0					•
56.00 05600 RADI OI SOTOPE 0 0 0 0 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 59.00 5	54.00		o	188, 067					54.00
57. 00 05700 CT SCAN 0 0 57. 00 58. 00 05800 MRI 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 0 75, 246 60. 00 60. 01 06000 BLOOD LABORATORY 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 17, 833 64. 00 65. 00 06400 INTRAVENOUS THERAPY 0 17, 833 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 13, 971 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 74, 627 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 69. 00 </td <td></td> <td>I I</td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>		I I	0						1
58.00 05800 MRI 0 0 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.01 60.01 61.00 60.01 61.00 60.01 61.00 60.01 61.00 62.00 60.00 62.00 60.01 61.00 62.00 60.01 62.00 60.01 62.00 60.01 61.00 62.00 60.01 62.00 60.01 62.00 60.00 62.00 60.00 62.00 60.00 62.00 60.00 62.00 60.00 62.00 60.00 62.00 60.00 63.00 66.			0	0					
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 60.00 06000 LABORATORY 0 75, 246 60.01 06001 BLOOD LABORATORY 0 0 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 64.00 06400 INTRAVENOUS THERAPY 0 17, 833 64.00 65.00 06500 RESPI RATORY THERAPY 0 13, 971 65.00 66.00 06600 PHYSI CAL THERAPY 0 74, 627 66.00 67.00 06600 PHYSI CAL THERAPY 0 0 76.20 68.00 06800 SPEECH PATHOLOGY 0 0 67.00 69.00 06900 ELECTROCACEPHALOGRAPHY 0 0 0 70.00 07000 ELECTROCACEPHALOGRAPHY 0 0 70.00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 2,720 <			0	0					
60. 00 06000 LABORATORY 0 75, 246 60. 00 60. 01 660.			0						•
61. 00			o	75, 246					
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 63.00 6300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0			O	0					60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 06400 INTRAVENOUS THERAPY 0 17, 833 64. 00 06500 RESPI RATORY THERAPY 0 13, 971 65. 00 06600 PHYSI CAL THERAPY 0 74, 627 66. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0		1 1	_	_					•
64. 00			0						
65. 00			0						
66. 00 06600 PHYSI CAL THERAPY 0 74, 627 66. 00 67. 00 6700 OCCUPATI ONAL THERAPY 0 0 0 0 67. 00 68. 00 6800 SPECH PATHOLOGY 0 0 0 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 0 0 69. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 57, 653 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 2, 720 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 47, 997 73. 00 07400 RENAL DI ALYSI S 0 47, 997 73. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0						
68. 00		I I	o						•
69. 00			O	0					
70. 00			0	0					•
71. 00			0	0					•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2,720 73. 00 73. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 47,997 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0		1 1							•
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 47, 997 73. 00 74. 00 74. 00 75. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0									
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			0						
75. 01 07501 CARDI AC REHAB 0 26, 071 75. 01 00TPATI ENT SERVI CE COST CENTERS 88. 00 08900 RURAL HEALTH CLINI C 0 0 0 89. 00 90. 00 09900 CLINI C 0 0 0 99. 00 91. 00 09100 EMERGENCY 0 162, 281 91. 00	74.00	07400 RENAL DIALYSIS	0						74.00
SB. 00 OBSOO RURAL HEALTH CLI NI C O O O S8. 00			0	-					
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 162, 281 91. 00	/5. 01		0	26, 071					/5.01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 99. 00 9	88. 00		n	n					88. 00
91. 00 09100 EMERGENCY 0 162, 281 91. 00									•
			0	0					
72. 00 07200 0D3EKVATION DED3 (NON-DISTINGT PAKT U 92.00		I I	0	162, 281					•
	72.00	103200 ODSERVATION DEDS (NON-DISTINCT PART	<u>ı 0</u>		<u> </u>				J 92.00

Provider CCN: 151306 | Period: | Worksheet B | From 01/01/2014 | Part II | Form 12/21/2014 | Part II | Par

			From 01/01/2014 Part II To	Prenared:
			5/28/2015 1	11: 53 am
Cost Center Description	Intern &	Total		
	Resi dents			
	Cost & Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	O		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	O		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	O		98. 00
99. 00 09900 CMHC	0	O		99. 00
99. 10 09910 CORF	0	O		99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS		-1		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	O		107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	O		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	O		110.00
111. 00 11100 SLET ACQUISITION	0	O		111. 00
113. 00 11300 INTEREST EXPENSE				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	1 1 () 5 ()		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 162, 522		118. 00
NONREI MBURSABLE COST CENTERS				100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190. 01 19001 VISITING SPECIALTY CLINIC	0	20, 137		190. 01
190. 02 19002 OUTREACH	0	14, 053		190.02
190. 03 19003 FOUNDATION	0	5, 592		190.03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	144		190. 04 190. 05
190. 05 19005 PAOLI FAMILY PRACTICE	0	4, 626		
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH		15, 683		190. 06 191. 00
		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS		0		192.00
		6, 932		200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		6, 932		200.00
202.00 TOTAL (sum lines 118-201)		1, 229, 689		201.00
202.00 TOTAL (Suil TITIES TTO-201)	١	1, 227, 007		1202.00

	Financial Systems	IU HEALTH PAC		CON 15120/ 5		u of Form CMS-2	
COST	ALLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2014 Fo 12/31/2014		pared:
		CAPI TAL REI	LATED COSTS			5/28/2015 11:	53 am
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE		ADMI NI STRATI V	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT	n	E & GENERAL (ACCUM. COST)	
				(GROSS		(ACCOM. COST)	
				SALARI ES)			
	OFNEDAL CEDIUSE COCT OFNEDO	1. 00	2. 00	4. 00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	54, 880					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	01,000	50, 392				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	461	B .				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 731					
7. 00 7. 01	00700 OPERATION OF PLANT 00701 UTILITIES	4, 322	4, 322	1		1, 025, 358 332, 078	
8. 00	00800 LAUNDRY & LINEN SERVICE	300	300	1	o o	76, 267	1
9.00	00900 HOUSEKEEPI NG	771	771			323, 853	1
10.00	01000 DI ETARY	1, 573				349, 764	1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	1, 005 521	1, 005 521			60, 367 700, 762	1
13. 01	01301 HOUSE SUPERVI SORS	0				489, 588	1
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 050				226, 474	
15.00	01500 PHARMACY	1, 169				365, 742	
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 250		7,646		72, 830 0	
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0			-	o o	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	329, 297	0	509, 339	1
20.00	02000 NURSI NG SCHOOL	0	0		0	0	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0			-	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0				l e	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 473					
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0				0	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	Ö		-	Ö	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0) (-	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0		-	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER				-	0	
43. 00	04300 NURSERY	250	250	1	-	102, 422	
44.00	04400 SKILLED NURSING FACILITY	0	0			0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0			0	
40.00	ANCI LLARY SERVI CE COST CENTERS	0		/	<u> </u>	0	40.00
50.00	05000 OPERATING ROOM	6, 027	6, 027	405, 232	2 0	871, 448	50.00
51.00	05100 RECOVERY ROOM	0	_	(
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	499	499	123, 470			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 834	5, 834	1		1, 472, 483	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0) (0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	
57. 00 58. 00	05700 CT SCAN 05800 MRI	0	0			0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö		o o	ő	1
60.00	06000 LABORATORY	1, 843	1, 843	659, 861	0	1, 633, 979	
60. 01	06001 BLOOD LABORATORY	0	0		0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	61.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö		o o	ő	
64. 00	06400 I NTRAVENOUS THERAPY	400				172, 754	
65.00	06500 RESPIRATORY THERAPY	284	B .			429, 098	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 493	2, 493	536, 210		874, 404 0	
68. 00	06800 SPEECH PATHOLOGY	0	o		-	Ō	
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	0 252, 494	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			12, 432	
	07300 DRUGS CHARGED TO PATIENTS	0	0)	o o	1, 053, 315	
74.00	07400 RENAL DI ALYSI S	0	0		0	0	1
	07500 ASC (NON-DISTINCT PART) 07501 CARDIAC REHAB	0 911	0 911) (53 651	,	0 113, 699	
75.01	OUTPATIENT SERVICE COST CENTERS	911	1 911	53, 651	u ₁ 0	1 113, 099	, 75.01
88. 00	08800 RURAL HEALTH CLINIC	0	0			1	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			l	
90.00	09000 CLI NI C	0	0) (0	0	90.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi de	r CCN: 151306	Peri od:	Worksheet B-1	
				From 01/01/2014		
				To 12/31/2014		
	CADLTAL DEL	ATED COCTO			5/28/2015 11:	53 am
	CAPI TAL REL	TATED COSTS				
C+ C+ D	DIDC & FLVT	MANDLE FOLLID	- FMDLOVEE	D!!!-#!-	ADMINI CTDATIV	
Cost Center Description	BLDG & FIXT	MVBLE EQUIP			ADMI NI STRATI V	
	(SQUARE FEET)	(SQUARE FEET)		n	E & GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
	1.00	0.00	SALARI ES)			
04 00 00400 EUEDOENOV	1. 00	2.00	4.00	5A	5. 00	04.00
91. 00 09100 EMERGENCY	4, 050	4, 05	1, 104, 75	0	2, 305, 798	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					L	92.00
OTHER REIMBURSABLE COST CENTERS	T		_1		_	
94.00 09400 HOME PROGRAM DIALYSIS	0		0	0 0		
95. 00 09500 AMBULANCE SERVICES	0		0	0		
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0		
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98. 00
99. 00 09900 CMHC	0		0	0	0	99.00
99. 10 09910 CORF	0		o	0 0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		o	0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0		ol	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	<u>'</u>		•		•	
105. 00 10500 KI DNEY ACQUI SI TI ON	0		0	0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0		ol	0 0	0	106.00
107. 00 10700 LIVER ACQUISITION	0		0	0 0	0	107.00
108. 00 10800 LUNG ACQUI SI TI ON	0		ol	0 0		108.00
109. 00 10900 PANCREAS ACQUISITION	n o			0 0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0			0 0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0			0		111.00
113. 00 11300 NTEREST EXPENSE	U		٩	9	' 0	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0		115.00
116. 00 11600 HOSPI CE	0		0	0		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	50, 217	50, 21	7, 561, 18	-5, 038, 930	15, 630, 978	1118.00
NONREI MBURSABLE COST CENTERS					1 0	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190.00
190. 01 19001 VISITING SPECIALTY CLINIC	2, 025		0	0 0		190. 01
190. 02 19002 OUTREACH	1, 089		0 115, 05			
190. 03 19003 FOUNDATI ON	175	17	'5 37, 10			190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0		0	0		190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0		0	0	4, 713	190. 05
190. 06 19006 OTHER PROPERTY	1, 374		0	0	20, 358	190.06
191. 00 19100 RESEARCH	0		0	0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		o	0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0		ol	0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	534, 194	688, 91	3 3, 818, 14	8	5, 038, 930	
Part I)	001,171	000, 71	0,010,1		0,000,700	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	9. 733856	13. 67107	0. 49500	06	0. 315755	203 00
204.00 Cost to be allocated (per Wkst. B,	7. 700000	.5.5,707	10, 78		158, 486	1
Part II)			10, 70		130, 400	
205.00 Unit cost multiplier (Wkst. B, Part			0.00139	19	0. 009931	205 00
II)			0.0010]	
1 1117	1	1	T	1	I .	1

Heal th	Financial Systems	IU HEALTH PAC	LI HOSPITAL	L		In Lie	u of Form CMS-	2552-10
	LLOCATION - STATISTICAL BASIS		Provi	der		eri od:	Worksheet B-1	
						rom 01/01/2014 o 12/31/2014	Date/Time Pre	
	Octob Octob December 1	ODEDATION OF			L ALINDRY O	HOUGEVEEDING	5/28/2015 11:	53 am
	Cost Center Description	OPERATION OF PLANT	UTILITIE (SQUARE FE		LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS	
		(SQUARE FEET)	(SQUARE IL	LI)	(POUNDS OF	(SQUARE LELT)	SERVED)	
		(SQOTINE TEET)			LAUNDRY)		OLIVED)	
		7. 00	7. 01		8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	1	1		1			
1.00	00100 CAP REL COSTS-BLDG & FIXT							1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP							2.00 4.00
4. 00 5. 00	OO400							5.00
7. 00	00700 OPERATION OF PLANT	36, 584						7.00
7. 01	00701 UTI LI TI ES	00,001		366				7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	300		300	1) i		8.00
9.00	00900 HOUSEKEEPI NG	771		771	c	35, 677		9. 00
10.00	01000 DI ETARY	1, 573		573	1	.,	5, 320	1
11.00	01100 CAFETERI A	1, 005	1,	005	1	.,	0	11.00
13. 00 13. 01	01300 NURSI NG ADMI NI STRATI ON 01301 HOUSE SUPERVI SORS	521		521 0	C		0	13. 00 13. 01
14. 00	01400 CENTRAL SERVI CES & SUPPLY	2, 050	2	050	1	_	0	14.00
15. 00	01500 PHARMACY	1, 169		169	1		0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 250		250	1	1, 250	0	16.00
17.00	01700 SOCIAL SERVICE	0		0	1	1	0	17.00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0		0	C	0	0	18. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0		0		0	0	19.00
20.00	02000 NURSI NG SCHOOL	0		0			0	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0		0			0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0		0		-	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		l .			,		20.00
30.00	03000 ADULTS & PEDIATRICS	7, 473	7,	473	4, 323	7, 473	5, 320	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	C	0	0	31.00
32.00	03200 CORONARY CARE UNIT	0		0	C	0	0	32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0		0		0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0			0	34.00
40. 00 41. 00	04000 SUBPROVI DER	0		0		_	0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0		0			0	42.00
43. 00	04300 NURSERY	250		250	1		0	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	1		0	44.00
45.00	04500 NURSING FACILITY	0		0	c c	o	0	45.00
46.00	04600 OTHER LONG TERM CARE	0		0	(0	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	/ 027		007	1 220		0	
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	6, 027	0,	027			0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	499		499	1		0	52.00
53. 00	05300 ANESTHESI OLOGY	0		0) 'ć	ol '´ol	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 834	5,	834	1, 862	5, 834	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	C	0	0	55.00
	05600 RADI OI SOTOPE	0		0		0	0	56.00
57.00	1	0		0		0	0	57.00
58.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0		0			0	58.00
60.00	06000 LABORATORY	1, 843	1	843		1, 843	0	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0,049	''	043		0	0	60.01
61.00	1			_			_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	C	o	0	62.00
63.00		0		0	C	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	400		400		400	0	64.00
	06500 RESPI RATORY THERAPY	284		284	1	284	0	65.00
66.00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	199		493	1, 077	2, 493	0	66.00
68.00		0		0			0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0		0			0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0		0		o	0	1
71.00		0		0	d	o	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	ı c	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0		0		0	0	73.00
	07400 RENAL DIALYSIS	0		0			0	74.00
75. 00 75. 01	O7500 ASC (NON-DISTINCT PART) O7501 CARDIAC REHAB	911		911		911	0	
75.01	OUTPATIENT SERVICE COST CENTERS	911		711	1	7 7 1 1	0	75.01
88. 00	08800 RURAL HEALTH CLINIC	0		0		0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	d	_	0	ı
90.00	09000 CLI NI C	0		0	(o o	0	90.00
	09100 EMERGENCY	4, 050	4,	050	4, 128	4, 050	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	I		I	1		92.00

Cost Center Description	Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description	COST ALLOCATION - STATISTICAL BASIS		Provi der			Worksheet B-1	
Cost Center Description							
Cost Center Description				T	o 12/31/2014	Date/Time Pre	pared:
PLANT CSOUARE FEET LINEWISSABLE COST CENTERS 7.00 7.01 8.00 9.00 10.00					1	r'	<u>53 am</u>
OTHER RELIMBURSABLE COST CENTERS	Cost Center Description						
OTHER RELIMBURSABLE COST CENTERS		PLANT	(SQUARE FEET)	LINEN SERVICE	(SQUARE FEET)	(MEALS	
OTHER RELIMBURSABLE COST CENTERS		(SQUARE FEET)		(POUNDS OF		SERVED)	
OTHER RELIMBURSABLE COST CENTERS 0				LAUNDRY)			
OTHER RELIMBURSABLE COST CENTERS 0		7. 00	7. 01	8, 00	9. 00	10.00	
94.00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 95.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 95.00 96.00 09500 OMBULANCE SERVICES 0 0 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUIJ P.ENITED 0 0 0 0 0 0 0 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 99.00 99.00 09900 OMBO OMBO	OTHER RELMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 95.00 97.00 00700 DURABLE MEDICAL EQUIP P-RENTED 0 0 0 0 0 0 0 0 0		0	0	0	0	0	94 00
96. 00 09600 DURABLE MEDI CAL EQUIP_RENTED 0 0 0 0 0 0 0 97. 00 97. 00 09700 DURABLE MEDI CAL EQUIP_SOLD 0 0 0 0 0 0 0 0 0		0		1			
97. 00 09700 DURABLE MEDI CAL EQUIP-SOLD 0 0 0 0 0 0 97. 00 98. 00 09900 OHFRE REIMBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 99. 00 09900 CAMPC 0 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORP 0 0 0 0 0 0 0 0 0		0		1		1	
98. 00 09950 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 99. 00 0990 CORP 0 0 0 0 0 0 0 0 0		0	0				
99.00 09900 CMHC 0 0 0 0 0 0 0 0 0		0	0	0	0		1
99, 10 09910 CORF 0 0 0 0 0 0 0 0 0		0	0	0	0	1	
100.00 100.00 100.00 100.00 0 0 0 0 0 0 0 0		0	ľ	1	-		
101.00 10100 HOME HEALTH ACENCY SPECIAL PURPOSE COST CENTERS	99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECI AL PURPOSE COST CENTERS	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
105.00 105.00 INNEY ACQUISITION	101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
105.00 105.00 INNEY ACQUISITION	SPECIAL PURPOSE COST CENTERS			•		<u>'</u>	1
106.00 106.00 106.00 106.00 107.00 107.00 108.00 107.00 107.00 107.00 107.00 108.00 1		0	0	0	0	0	105 00
107.00 10700 10700 10700 10700 10700 10700 10700 108		0	1	-			
108.00 10800 LUNG ACQUISITION		0					
109.00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109.00		0	0				
110.00 11000 INTESTINAL ACQUISITION		0	0	0	0		
111.00 11100 1 1 1 1 1 1 1		0	0	0	0	l	1
113. 00 11300 INTEREST EXPENSE		0	0	1 0	0	•	1
114.00		0	0	0	0	0	111. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	113.00 11300 I NTEREST EXPENSE						113.00
116.00 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) 36, 409 38, 703 12,750 34, 413 5,320 118. 00 118. 00 190. 00	114.00 11400 UTILIZATION REVIEW-SNF						114.00
116.00 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) 36, 409 38, 703 12,750 34, 413 5,320 118. 00 118. 00 190. 00	115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
18.00 SUBTOTALS (SUM OF LINES 1-117) 36,409 38,703 12,750 34,413 5,320 118.00		0	0	0	0	0	116, 00
NONREIMBURSABLE COST CENTERS 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 190.00 190		36 409	38 703	12 750	34 413		
190. 00		00, 107	00,700	12,700	01, 110	0,020	1110.00
190.01 19001 VISITING SPECIALTY CLINIC 0 2,025 110 0 190.01 190.02 19002 0UTREACH 0 1,089 0 190.02 190.03 19003 FOUNDATION 175 175 0 175 0 190.03 190.03 FOUNDATION 175 175 0 0 175 0 190.03 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0 0 190.05 190.05 190.05 190.05 190.06 190.06 190.06 190.06 0 190.06 0 0 0 0 0 190.06 190.0			0	1	0	0	100 00
190. 02 19002 OUTREACH 0 1,089 0 1,089 0 190. 02 190. 03 19003 FOUNDATION 175 175 0 175 0 190. 03 19004 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0 0 0 190. 04 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0 0 0 190. 05 190. 06 190.06 190.06 190.06 190.06 191.00 191.00 191.00 191.00 191.00 191.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 NONPAID WORKERS 0 0 0 0 0 0 192.00 193.00 193.00 193.00 Nonpaid by Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 Unit cost multiplier (Wkst. B, Part II) 3.053165 0.076050 0.677838 0.670264 8.735902 205.00			1	1	_	l	1
190. 03 19003 FOUNDATION		0		1			
190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0 0 190.04 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 0 0 190.05 19006 PAOLI FAMILY PRACTICE 0 0 0 0 0 0 190.05 190.06 19006 OTHER PROPERTY 0 1,374 0 0 0 0 1910.06 19100 RESEARCH 0 0 0 0 0 0 191.00 19100 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 191.00 192.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 200.00 Cross Foot Adjustments Negative Cost Centers 201.00 Negative Cost Centers 201.00 Unit cost multiplier (Wkst. B, Part I) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 37.00 37.00 0.00 0.00 0.00 0.00 0.00 0.		0	1				
190.05 19005 19005 19005 19006 19006 19006 19006 19006 19006 19006 19006 19006 19006 19006 19006 19006 19006 190000 190000 190000 190000 19000 19000 19000 19000 19000 19000 19000 19000		175	l	1			
190.06 19006 OTHER PROPERTY 0 1,374 0 0 0 190.06 191.00 191.00 191.00 191.00 191.00 191.00 192.00 192.00 192.00 192.00 192.00 193.00 193.00 193.00 NONPAID WORKERS 0 0 0 0 0 0 193.00 200.00 Cross Foot Adjustments Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 Unit cost multiplier (Wkst. B, Part II) 37.00 205.00 Unit cost multiplier (Wkst. B, Part II) 37.00 37.00 07.00	190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190. 04
191.00 19100 RESEARCH 0 0 0 0 0 0 191.00 192.00 192.00 192.00 193.00 193.00 193.00 193.00 NONPAID WORKERS 0 0 0 0 0 0 193.00 200.00 Cross Foot Adjustments 202.00 Regative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 Part II) Unit cost multiplier (Wkst. B, Part II) 36.877323 10.075474 8.705474	190.05 19005 PAOLI FAMILY PRACTICE	0	0	0	0	0	190. 05
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 37.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 38.003165 0.076050 0.677838 0.670264 8.735902 205.00	190. 06 19006 OTHER PROPERTY	0	1, 374	0	0	0	190.06
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 3.053165 0.076050 0.677838 0.670264 8.735902 205.00	191. 00 19100 RESEARCH	0	0	0	0	0	191.00
193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 37.00 205.00 Unit cost multiplier (Wkst. B, Part II) 38.87323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Part II) 37.00 205.00 Unit cost multiplier (Wkst. B, Part III) 38.873590 205.00 20		0	0	0	0	0	192 00
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 3.053165 0.076050 0.677838 0.670264 8.735902 205.00 205.		0	١	1	n		
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 Unit cost multiplier (Wkst. B, Part IIII) 207.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		0	٥	Ĭ		Ĭ	1
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 Unit cost multiplier (Wkst. B, Part II) 207.00 Unit cost multiplier (Wkst. B, Part III) 208.00 Unit cost multiplier (Wkst. B, Part III) 208.00 Unit cost multiplier (Wkst. B, Part III) 209.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII							
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 Unit cost multiplier (Wkst. B, Part III) 207.00 Unit cost multiplier (Wkst. B, Part III) 208.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	1 1 3	4 040 400	407 000	444 405	4/0 044	FF 4 444	1
203.00 Unit cost multiplier (Wkst. B, Part I) 36.877323 10.075474 8.898523 12.958236 104.218797 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part 3.053165 0.076050 0.677838 0.670264 8.735902 205.00		1, 349, 120	436, 933	114, 435	462, 311	554, 444	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 3, 298 8, 717 23, 913 46, 475 204.00 Unit cost multiplier (Wkst. B, Part 3.053165 0.076050 0.677838 0.670264 8.735902 205.00							
Part II) 205.00 Unit cost multiplier (Wkst. B, Part 3.053165 0.076050 0.677838 0.670264 8.735902 205.00			l e	1		l	1
205.00 Unit cost multiplier (Wkst. B, Part 3.053165 0.076050 0.677838 0.670264 8.735902 205.00	204.00 Cost to be allocated (per Wkst. B,	111, 697	3, 298	8, 717	23, 913	46, 475	204.00
	Part II)						1
	205.00 Unit cost multiplier (Wkst. B, Part	3. 053165	0. 076050	0. 677838	0. 670264	8. 735902	205.00
							1
		•	•	•	•	•	•

	Financial Systems	TU HEALTH PAC		0011 454007 D		u of Form CMS-2	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: com 01/01/2014 o 12/31/2014	Worksheet B-1 Date/Time Pre 5/28/2015 11:	pared:
	Cost Center Description	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI O N	HOUSE SUPERVI SORS (DI RECT	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	33 aiii
			(DI RECT	NRSI NG HRS)	(COSTED		
		11. 00	NRSI NG HRS) 13. 00	13. 01	REQUIS.) 14.00	15. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	13.01	14.00	13.00	
1. 00 2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 UTILITIES 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						1.00 2.00 4.00 5.00 7.00 7.01 8.00 9.00
10. 00 11. 00 13. 00 13. 01 14. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01301 HOUSE SUPERVI SORS 01400 CENTRAL SERVI CES & SUPPLY	6, 304, 583 509, 664 326, 262 100, 803	2, 599, 733 0 0	2, 599, 733 0	277, 353	1 140 045	10.00 11.00 13.00 13.01 14.00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LIBRARY 01700 SOCI AL SERVI CE 01850 OTHER GENERAL SERVI CE (SPECIFY) 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	206, 214 9, 719 0 0 318, 239	0 0 0	0 0 0 0 0	0 0 0 0	1, 148, 845 0 0 0 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
21. 00 22. 00 23. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	000000000000000000000000000000000000000	0	0 0	0 0	0 0 0	
30. 00 31. 00 32. 00 33. 00 34. 00	O3000 ADULTS & PEDIATRICS O3100 INTENSIVE CARE UNIT O3200 CORONARY CARE UNIT O3300 BURN INTENSIVE CARE UNIT O3400 SURGICAL INTENSIVE CARE UNIT	882, 614 0 0		882, 614 0 0 0	0 0 0 0	0 0 0 0	30.00 31.00 32.00 33.00 34.00
40. 00 41. 00 42. 00 43. 00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER 04300 NURSERY	0 0 0 0 65, 530	0 0 0 0 65,530	0 0 0 0 65, 530	0 0	0 0	40. 00 41. 00 42. 00
44. 00 45. 00 46. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0		0 0 0	0 0 0	0 0 0	
50.00	05000 OPERATING ROOM	397, 938	397, 938	397, 938	0	0	
	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM O5300 ANEXTHESI OLOGY DEACHOSTICS	122, 900 0	0	0 122, 900 0	0	0 0	52. 00 53. 00
54. 00 55. 00 56. 00 57. 00		704, 928	0 0	0 0 0	0 0 0	0 0 0	55.00
58. 00 59. 00 60. 00	1 1	0 0 666, 390	0 0	0	0	0 0	
62.00	O6001 BLOOD LABORATORY O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY O6200 WHOLE BLOOD & PACKED RED BLOOD CELL O6200 BLOOD STOPLING PROCESSING & TRANS	0	0	0	0	0	
63. 00 64. 00 65. 00 66. 00	06500 RESPI RATORY THERAPY	44, 526 246, 621 477, 838	0	44, 526 0 0	0	85, 747 0 0	64. 00 65. 00
69.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 0	0 0 0	0 0 0	0 0 0	0 0 0	67. 00 68. 00 69. 00
71. 00 72. 00 73. 00 74. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	000000000000000000000000000000000000000	0 0 0	0 0 0	0 264, 921 12, 432 0 0 0	0 0 0 1, 063, 098 0	71.00 72.00 73.00 74.00 75.00
75. 01	O7501 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	3, 411	0	0	0	0	75. 01
88. 00 89. 00 90. 00 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0 0 1, 086, 225	0	0 0 0 0 1, 086, 225	0 0 0 0	0 0 0 0	89. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00

Health Financial Systems	IU HEALTH PAG	OLI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre	
Cost Conton Doscription	CAFETERI A	NURSING	HOUSE	CENTRAL	5/28/2015 11: PHARMACY	53 am
Cost Center Description	(MAN HOURS)	ADMI NI STRATI O	SUPERVI SORS	SERVICES &	(COSTED	
	(WAN HOURS)	N	(DI RECT	SUPPLY	REQUIS.)	
		(DI RECT	NRSI NG HRS)	(COSTED	REQUIS.)	
		NRSI NG HRS)	NKSING HKS)	REQUIS.)		
	11. 00	13. 00	13. 01	14. 00	15. 00	
OTHER REIMBURSABLE COST CENTERS	11.00	13.00	13.01	14.00	15.00	
94. 00 09400 HOME PROGRAM DI ALYSI S		0		0	0	94.00
95. 00 09500 AMBULANCE SERVICES				0 0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			1	0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD				0	0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS				0	0	
99. 00 09900 CMHC				0	0	
99. 10 09910 CORF				0	0	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM				0 0		100.00
101.00 10100 HOME HEALTH AGENCY		1		0 0		101.00
SPECIAL PURPOSE COST CENTERS		ıl U		0	U	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	T C	0	1	ol o	0	105.00
				0 0		105.00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION				0 0		108.00
				0		107.00
108. 00 10800 LUNG ACQUISITION				0		
109. 00 10900 PANCREAS ACQUISITION				0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				0		110.00
111. 00 11100 SLET ACQUISITION		0		0	0	111.00
113. 00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0		0		115.00
116. 00 11600 HOSPI CE	(1 (0 0 0 0 0	0	0 500 70	0		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	6, 169, 822	2, 599, 733	2, 599, 73	3 277, 353	1, 148, 845	1118.00
NONREI MBURSABLE COST CENTERS	1					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	1		0		190.00
190. 01 19001 VISITING SPECIALTY CLINIC	07.000	1		0		190. 01
190. 02 19002 OUTREACH	97, 233	1		0		190.02
190. 03 19003 FOUNDATION	37, 528	l .		0		190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	C	0		0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	C	0		0		190.05
190. 06 19006 OTHER PROPERTY	0	0		0		190.06
191. 00 19100 RESEARCH	C	0		0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0		0		192.00
193. 00 19300 NONPALD WORKERS	C	0		0	0	193. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	139, 639	964, 533	651, 40	4 396, 471	540, 682	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)					0. 470631	
204.00 Cost to be allocated (per Wkst. B,	27, 987	24, 021	6, 76	8 57, 231	35, 844	204. 00
Part II)	0.004:		0.005:-	0 00/5:=	0 0010	005 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 004439	0. 009240	0. 00260	0. 206347	0. 031200	205.00
11)	1	I	I			I

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151306 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 11:53 am OTHER GENERAL SERVI CE MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG Cost Center Description (SPECIFY) RECORDS & **SERVICE** (TIME SPENT) **ANESTHETLSTS** SCHOOL (ASSI GNED (TIME SPENT) LI BRARY (ASSI GNED (GROSS REVE TIME) TIME) NUE) 16. 00 17. 00 18.00 19.00 20.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 UTI LI TI ES 7.01 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 13.01 01301 HOUSE SUPERVI SORS 13.01 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 54, 996, 792 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18.00 01900 NONPHYSICIAN ANESTHETIŜTS 0 O 100 19 00 Ω 19 00 0 20.00 02000 NURSING SCHOOL 0 C 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 747, 227 30.00 03000 ADULTS & PEDIATRICS 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 32.00 0 03200 CORONARY CARE UNIT 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34 00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 0 0 40.00 0 0 41 00 0 C 0 41.00 04200 SUBPROVI DER 0 42.00 42.00 0 0 04300 NURSERY 0 43.00 236, 033 0 0 43.00 0 04400 SKILLED NURSING FACILITY 44.00 0 44.00 0 0 45.00 04500 NURSING FACILITY 0 C 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 4, 386, 286 0 100 0 0 51.00 05100 RECOVERY ROOM 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 754, 847 0 0 0 0 52.00 0 0 05300 ANESTHESI OLOGY 0 53.00 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 14, 779, 166 0 54.00 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 0 0 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 05700 CT SCAN 0 57 00 0 C 0 57 00 58.00 05800 MRI 0 C 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0 0 0 0 0 59.00 06000 LABORATORY 7, 912, 308 0 60.00 0 60.00 0 60.01 06001 BLOOD LABORATORY 0 0 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 63 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63 00 0 06400 INTRAVENOUS THERAPY 0 64.00 2, 806, 164 C 0 64.00 06500 RESPIRATORY THERAPY 792,006 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 2, 410, 764 0 0 0 0 0 66.00 06700 OCCUPATIONAL THERAPY Ω 0 67 00 67 00 Ω 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 757, 767 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 50, 332 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 6, 911, 570 0 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 0 75 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75.00 07501 CARDI AC REHAB 109, 242 0 0 0 0 75.01 75.01 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 C 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 90. 00 09000 CLINIC 0 0 0 ol 90.00 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151306 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 11:53 am OTHER GENERAL SERVI CE NONPHYSI CI AN NURSI NG Cost Center Description MEDI CAL SOCI AL (SPECI FY) RECORDS & **SERVICE** (TIME SPENT) **ANESTHETISTS** SCHOOL (TIME SPENT) (ASSI GNED (ASSI GNED LI BRARY (GROSS REVE TIME) TIME) NUE) 19.00 20.00 16. 00 17. 00 18.00 91. 00 09100 EMERGENCY 11, 343, 080 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 95.00 95.00 0 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 o 0 97.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 09900 CMHC 0 99.00 99.00 C 0 99. 10 09910 CORF 0 0 0 O 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 01101 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 0 107.00 107. 00 10700 LIVER ACQUISITION Ω 108.00 10800 LUNG ACQUISITION C 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 o 0 109.00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 o 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 C 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 115.00 116. 00 11600 HOSPI CE C 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 54, 996, 792 0 100 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 01 19001 VISITING SPECIALTY CLINIC 0 0 0 0 0 190. 01 190. 02 19002 OUTREACH 0 0 0 0 190.02 0 190. 03 19003 FOUNDATI ON 0 0 0 0 0 190.03 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 190 04 Ω 0 190.05 19005 PAOLI FAMILY PRACTICE 0 190.05 190.06 19006 OTHER PROPERTY 0 0 0 0 190.06 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 192.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 C 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 200.00 201. 00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 170, 930 0 677, 214 0 202.00 Part I) 0.000000 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.003108 0.000000 0.000000 6, 772. 140000 0 204.00 204.00 Cost to be allocated (per Wkst. B, 34.782 6.932 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000632 0.000000 0.000000 69. 320000 0.000000 205.00

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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/28/2015 11:53 am Provi der CCN: 151306

THE FIRST CONTINUES PROPERTY FOR PARTY FOR PAR						5/28/2015 1	1: 53 am
PROJECT APPROX CASTOCATE			INTERNS &	RESI DENTS			
PROJECT APPROX CASTOCATE		Octob Octob December 11	CEDVILOEC CALA	TOEDWINES OFFIE			
## APPROV (ASSIGNED TIME) ## APPROV (ASSIGNE		Cost Center Description					
TIMES					,		
CEREMAL SERVICE COST CERTERS					I I I WE		
CARRIENT SERVICE COST CENTERS 1.00					23. 00		
2.00 00000 CAP REL DOSTS-AVEILE EQUIP 2.00 00000 AUMIN IN STRATI VE & CENERAL 5.00 1.00		GENERAL SERVICE COST CENTERS	•				
4.00	1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
5.00 00000 ADMIN INTERTIVE & GENERAL							2.00
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.000000 0.000000 0.00000000		1					4. 00
7. 0.1 0.0701 UTILITIES		1					•
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10.00 10.000 DETARY		1					•
11.00 11.0		1					•
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13.01 13.01 13.01 13.01 13.01 14.00 14.0							•
14.00 14.00 PARBACY							•
16.00 1600 MEDI CAL, RECORDS & LIBRARY 16.00 17.00 170.00 1							14. 00
17.00 1700	15.00	01500 PHARMACY					15.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 19.00 19.0							•
19.00 01900 NONPHYSICIAN AMESTHETISTS 20.00							
20.00 2000 NURSING SCHOOL 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00		, ,					•
21.00 02100 IAR SERVICES-SALARY & FRINGES APRIV 0 22.00 222.00 222.00 02200 PARAMED ED PRCM-(SPECIFY) 0 22.00 22.00 220.00 220.00 23.00 INFASTE LET ROUTINE SERVICE COST CENTERS 0 0 0 0 30.00 30.							•
22.00 02200 PARAMED ED PROM_ (SPECTEY)							•
23.00			0				•
INPATI ENT ROUTI NE SERVICE COST CENTERS 0				0		0	•
30. 00 303000 ADULTS & PEDI ATRICS 0 0 0 31.0 03.0 03200 INTENSIVE CARE UNIT 0 0 0 32.0 03200 ORROMARY CARE UNIT 0 0 0 0 32.0 03300 COROMARY CARE UNIT 0 0 0 0 33.0 034.0 03400 SURRI INTENSIVE CARE UNIT 0 0 0 0 34.0 03400 SURRI CALL INTENSIVE CARE UNIT 0 0 0 0 44.0 00 0400 SUBPROVIDER - IPF 0 0 0 0 0 44.0 04.0 0400 SUBPROVIDER - IPF 0 0 0 0 0 0 41.0 04.1 00 04.	23.00			l	l	<u> </u>	25.00
31.00 03100 INTERSI VE CARE UNIT	30.00		0	0		0	30.00
33.00 03300 0340		1	0	O		0	•
34. 00 03400 SURRICAL INTENSIVE CARE UNIT 0 0 0 34. 00 0 0 0 0 0 0 0 0 0	32.00	03200 CORONARY CARE UNIT	0	0		0	32.00
40. 00 04000 SUBPROVI DER - 1 PF			0	0		0	•
11 00 04100 SUBPROVI DER			0	0	1		•
42 00 04200 SUBPROVIDER		1	0	0	1		•
43. 00 04300 NURSERY		1	0	0	1	-	1
44. 00 04400 SAILLED NURSING FACILITY			0				•
45.00 04500 NURSI NG FACILITY		1					•
46. 00 04600 OTHER LONG TERM CARE		1					•
ANCILLARY SERVICE COST CENTERS		1	0		1		•
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0			•	•	•		
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0	50.00	O5000 OPERATING ROOM	0	0		0	50.00
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00			0	0		0	51.00
54.00 05400 RADI OLOGY-THERAPEUTI C			0	0		-	•
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56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0 55. 00 58. 00 05800 MRI 0 0 0 0 0 55. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 60. 00 60. 01 06000 LABORATORY 0 0 0 0 0 60. 00 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 64. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 65. 00 66. 00 06600 PHSI CAL THERAPY 0 0 0 0 65. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 68. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 75. 01 07501 CARDI AC REHAB 0 0 0 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0				
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75. 01 07501 CARDI AC REHAB 0 0 0 0 00TPATIENT SERVI CE COST CENTERS 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 89. 00 08900 RURAL HEALTH CENTER 0 0 0 89. 00 08900 RURAL HEALTH CENTER 0 0 0 89. 00 08900 RURAL HEALTH CENTER 0 0 0 89. 00 08900 RURAL HEALTH CENTER 0 0 0 89. 00 08900 RURAL HEALTH CENTER 0 0 0 89. 00 08900 RURAL HEALTH CENTER 0 0 0 89. 00 08900 RURAL HEALTH CENTER 0 0 0 89. 00 08900			0	0	1	=	•
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89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00	88. NN		0	0		O	88.00
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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151306

Cost Center Description SERVICES-SALA SERVICES-OTHE PARAMED ED RY & FRINGES R PRGM COSTS PRGM	33 dill
Cost Center Description SERVICES-SALA SERVICES-OTHE PARAMED ED	
APPRV APPRV (ASSI GNED	
(ASSI GNED (ASSI GNED TIME)	
TIME) TIME)	
21. 00 22. 00 23. 00	
91. 00 09100 EMERGENCY 0 0 0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REI MBURSABLE COST CENTERS	
94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0	94.00
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 96. 00 09600 DURABLE MEDI CAL FOULP-RENTED 0 0 0 0 0 0 0 0 0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0 0 0	96. 00 97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0	98.00
99. 00 09900 CMHC	99.00
99. 10 09910 CORF	99. 10
100.00 10000 L&R SERVI CES-NOT APPRVD PRGM 0 0 0	100.00
101.00 10100 HOME HEALTH AGENCY 0 0 0	101.00
SPECIAL PURPOSE COST CENTERS	1
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0	105.00
106. 00 10600 HEART ACQUISITION 0 0	106.00
107. 00 10700 LI VER ACQUISITION 0 0	107.00
108.00 10800 LUNG ACQUISITION 0 0	108.00
109.00 PANCREAS ACQUISITION 0 0 0	109.00
110.00 11000 INTESTINAL ACQUISITION 0 0 0	110.00
111.00 11100 ISLET ACQUISITION 0 0	111. 00
113.00 11300 INTEREST EXPENSE	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	114. 00
115.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0	115.00
116. 00 11600 HOSPI CE 0 0 0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 0	118. 00
NONREI MBURSABLE COST CENTERS	100 00
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 01 1900 VESTI NG SPECIALTY CLINIC 0 0 0 0 0 0 0 0 0	190.00
190. 01 19001 VI SITING SPECIALTY CLINIC 0 0 0 190. 02 19002 OUTREACH 0 0 0	190. 01 190. 02
190. 03 19003 FOUNDATION 0 0 0	190. 02
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0	190.03
190. 05 19005 PAOLI FAMILY PRACTICE	190.04
190. 06 19006 OTHER PROPERTY 0 0 0	190.03
191.00 19100 RESEARCH 0 0 0	191.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0	192.00
193. 00 19300 NONPAI D WORKERS 0 0 0	193.00
200.00 Cross Foot Adjustments	200.00
201.00 Negative Cost Centers	201.00
202.00 Cost to be allocated (per Wkst. B, 0 0 0	202.00
Part I)	
203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, 0 0 0	204.00
Part II)	
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000	205.00
	I

Heal th Financial		IU HEALTH PAG		00N 4F400/		u of Form CMS-	2552-10
COMPUTATION OF RA	TIO OF COSTS TO CHARGES		Provi der	CCN: 151306	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 11:	pared:
			Ti tl	e XVIII	Hospi tal	Cost	33 aiii
Cost	Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	ROUTINE SERVICE COST CENTERS S & PEDIATRICS	3, 711, 867	I	3, 711, 86	57 0	0	30.00
	ISIVE CARE UNIT	3, 711, 667	l .	3, 711, 00	0 0	0	
1 1	IARY CARE UNIT	C			0 0	0	
	INTENSIVE CARE UNIT CAL INTENSIVE CARE UNIT				0 0	0	33.00
	OVI DER - I PF	C			0 0	0	40.00
	OVI DER - I RF	C			0 0	0	
42. 00 04200 SUBPR 43. 00 04300 NURSE		193, 031		193, 03	31 0	0	
44. 00 04400 SKI LL	ED NURSING FACILITY	C			0 0	0	1
	NG FACILITY	C			0 0	0	
	LONG TERM CARE SERVICE COST CENTERS	C			0 0	0	46. 00
50. 00 05000 OPERA	TING ROOM	2, 465, 732	l .	2, 465, 73		0	
51. 00 05100 RECOV		200 225		200 27	0 35	0	
52. 00 05200 DELI V 53. 00 05300 ANEST	YERY ROOM & LABOR ROOM	388, 335		388, 33	0 0	0	
54. 00 05400 RADIO	LOGY-DI AGNOSTI C	2, 365, 062		2, 365, 06	52 0	0	54.00
	LOGY-THERAPEUTI C	C			0 0	0	
56. 00 05600 RADI 0 57. 00 05700 CT S0					0 0	0	56.00 57.00
58. 00 05800 MRI		C			0 0	0	58.00
	AC CATHETERI ZATI ON	2 200 493		2 200 49	0 0	0	59.00
60. 00 06000 LABOR 60. 01 06001 BLOOD	ATURY LABORATORY	2, 299, 683		2, 299, 68	0 0	0	
	CLINICAL LAB SERVICES-PRGM ONLY	C			0 0	0	1
	BLOOD & PACKED RED BLOOD CELL	C			0 0	0	
	STORING, PROCESSING & TRANS. VENOUS THERAPY	329, 006		329, 00	0 0	0	63.00
65. 00 06500 RESPI	RATORY THERAPY	589, 526				0	65.00
	CAL THERAPY	1, 242, 924	C	1, 242, 92	24 0	0	66.00
1 1	PATIONAL THERAPY CH PATHOLOGY				0 0	0	
69. 00 06900 ELECT	ROCARDI OLOGY	C			0 0	0	
1 1	ROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT	713, 275		713, 27	0 0	0	70.00
1 1	DEV. CHARGED TO PATIENTS	34, 284	l .	34, 28		0	
73. 00 07300 DRUGS	CHARGED TO PATIENTS	1, 907, 712		1, 907, 7		0	73.00
74. 00 07400 RENAL	. DIALYSIS NON-DISTINCT PART)	C			0 0	0	
75. 01 07501 CARDI		204, 595		204, 59			75. 00
	SERVICE COST CENTERS		ī]
88. 00 08800 RURAL	. HEALIH CLINIC MALLY QUALIFIED HEALTH CENTER	C	•		0 0	0	
90. 00 09000 CLI NI		C			0 0	0	90.00
91. 00 09100 EMERG		4, 047, 722		4, 047, 72		0	
	EVATION BEDS (NON-DISTINCT PART BURSABLE COST CENTERS	1, 885, 937		1, 885, 93	37	0	92.00
94. 00 09400 HOME	PROGRAM DIALYSIS	C			0 0	0	
95. 00 09500 AMBUL		C			0 0	0	
	SLE MEDICAL EQUIP-RENTED SLE MEDICAL EQUIP-SOLD				0 0	0	
98. 00 09850 OTHER	REIMBURSABLE COST CENTERS	C			0 0	0	
99. 00 09900 CMHC 99. 10 09910 CORF		0			0	0	
	SERVICES-NOT APPRVD PRGM				0	0	
101. 00 10100 HOME		C			0	0	101.00
105. 00 10500 KI DNE	RPOSE COST CENTERS Y ACOULSITION				O	0] 105. 00
106. 00 10600 HEART			ł		ŏ		106. 00
107. 00 10700 LI VER		C			0		107.00
108. 00 10800 LUNG 109. 00 10900 PANCR					U O	0	108.00 109.00
	TINAL ACQUISITION				ŏ		1109.00
111. 00 11100 I SLET	ACQUI SI TI ON	C			0		111.00
113. 00 11300 I NTER	ZEST EXPENSE ZATION REVIEW-SNF						113. 00 114. 00
	ATORY SURGICAL CENTER (D. P.)	C			0		115.00
116.00 11600 HOSPI			l .		0		116.00

Health Finar	ncial Systems	IU HEALTH PAC	LI H	OSPI TAL		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES				Provi der		Peri od: Worksheet C		
						To 12/31/2014	Date/Time Pre	pared: 53 am
				Ti tl	e XVIII	Peri od: From 01/01/2014 To 12/31/2014 Worksheet C Part I Date/Time Prepar 5/28/2015 11:53 Cost Costs RCE Di sal I owance 4.00 5.00 0 200		
						Costs		
	Cost Center Description	Total Cost	Cost Therapy Limit		Total Costs	RCE	Total Costs	
	·	(from Wkst.		Adj .		Di sal I owance		
		B, Part I,						
		col. 26)						
		1. 00		2. 00	3. 00	4. 00	5. 00	
200.00	Subtotal (see instructions)	22, 378, 691		0	22, 378, 69	1 0	0	200.00
201.00	Less Observation Beds	1, 885, 937			1, 885, 93	7	0	201.00
202. 00	Total (see instructions)	20, 492, 754		0	20, 492, 75	4 0	0	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 151306

					5/28/2015 11:	53 am_
			e XVIII	Hospi tal	Cost	
Cost Center Description	Inpati ent	Charges Outpatient	Total (col. 6	Cost or Other	TEFRA	
cost center bescription	Tilpati eiit	outpatrent	+ col . 7)	Ratio	Inpati ent	
			' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	nati o	Ratio	
	6. 00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	873, 766		873, 766			30.00
31. 00 03100 INTENSIVE CARE UNIT	0		9			31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0)			32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T						34.00
40. 00 04000 SUBPROVI DER - PF						40.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
42. 00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	236, 032		236, 032	2		43.00
44. 00 04400 SKILLED NURSING FACILITY	0					44.00
45. 00 04500 NURSING FACILITY	0					45.00
46. 00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0)		46. 00
50. 00 O5000 OPERATING ROOM	558, 692	3, 827, 594	4, 386, 286	0. 562146	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0,027,074	4, 300, 200	0.000000	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	573, 809	181, 038	754, 84		0. 000000	
53. 00 05300 ANESTHESI OLOGY	O	0		0. 000000	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	75, 100	14, 704, 066	14, 779, 166		0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0.000000	0.000000	
56. 00 05600 RADI 01 SOTOPE	0	0		0.000000	0.000000	56.00
57. 00 05700 CT SCAN 58. 00 05800 MRI		0		0. 000000 0. 000000	0. 000000 0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0.000000	0. 000000	
60. 00 06000 LABORATORY	515, 301	7, 397, 007	7, 912, 308		0. 000000	
60. 01 06001 BL00D LABORATORY	0	0	, , , ,	0. 000000	0.000000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0. 000000	0. 000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0. 000000	0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	()	0.000000	0.000000	
64. 00 06400 I NTRAVENOUS THERAPY	470, 329	2, 335, 834			0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	145, 576 18, 877	646, 430 2, 391, 886			0. 000000 0. 000000	1
67. 00 06700 OCCUPATI ONAL THERAPY	18, 877	2, 391, 000	2,410,70		0. 000000	
68. 00 06800 SPEECH PATHOLOGY		0		0. 000000	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	238, 628	519, 139			0. 000000	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	50, 332			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	318, 266	6, 593, 304			0.000000	73.00
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STINCT PART)	0 0	0		0. 000000 0. 000000	0. 000000 0. 000000	74. 00 75. 00
75. 00 07500 ASC (NON-DISTINCT FART) 75. 01 07501 CARDI AC REHAB		109, 242	109, 242		0. 000000	75.00
OUTPATIENT SERVICE COST CENTERS	٥,	107, 212	107,212	1. 072000	0.00000	70.01
88. 00 08800 RURAL HEALTH CLINIC	0	0	(88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	0	0	1	0.000000	0. 000000	
91. 00 09100 EMERGENCY	421, 849	10, 921, 232			0.000000	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	873, 461	873, 46	2. 159154	0. 000000	92.00
94. 00 09400 HOME PROGRAM DIALYSIS	O	0		0.000000	0. 000000	94.00
95. 00 09500 AMBULANCE SERVICES		0		0. 000000	0. 000000	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	Ö	0		0. 000000	0. 000000	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0			0.000000	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0. 000000	98. 00
99. 00 09900 CMHC	0	0				99.00
99. 10 09910 CORF	0	0	(99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	1)		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	O	0				105.00
106. 00 10600 HEART ACQUISITION		0				106.00
107.00 10700 LIVER ACQUISITION	0	0				107.00
108.00 10800 LUNG ACQUISITION	0	0				108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	(109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0				110.00
111.00 11100 SLET ACQUI SI TI ON	0	0	"	7		111.00
113. 00 11300 INTEREST_EXPENSE 114. 00 11400 UTILIZATION_REVIEW-SNF						113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0	,			115.00
116. 00 11600 HOSPI CE		Ö				116.00
200.00 Subtotal (see instructions)	4, 446, 225	50, 550, 565	54, 996, 790			200.00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL				In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der CCN: 151306		Period: Worksheet C			
					From 01/01/2014			
					To 12/31/2014	Date/Time Pre		
						5/28/2015 11:	53 am	
			Titl	e XVIII	Hospi tal Cost			
		Ch	arges					
Cost Center Description	I npati ent	Outp	oati ent	Total (col. (Cost or Other	TEFRA		
				+ col. 7)	Ratio	I npati ent		
						Ratio		
	6. 00		7. 00	8. 00	9. 00	10.00		
201.00 Less Observation Beds							201.00	
202.00 Total (see instructions)	4, 446, 225	50	0, 550, 565	54, 996, 79	ol l		202.00	

| Period: | Worksheet C | Part | | To | 12/31/2014 | To | Hospital | Hospital | Cost | Prom CMS-2552-10 | Worksheet C | Part | Part | Date/Time Prepared: | 5/28/2015 | 11:53 | am | Cost | Promocedary | Cost | Promocedary | Cost | Promocedary | Promocedary | Cost | Promocedary | Cost | Promocedary | Promocedar Title XVIII

MART LETT ROUTINE SERVICE DIST CENTERS 10.00 10.				Title XVIII	Hospi tal	Cost	
National National Nationa		Cost Center Description	PPS Inpatient		<u> </u>		
		•					
INVALIDATION SERVICE COST CERTERS 30.00							
30.00 30.000 AMULTS & PEPLATRICS 30.00		INPATIENT ROUTINE SERVICE COST CENTERS					
31.00	30 00					3(0.00
32.00 30.00 50.0		l					
33.00 (0.3000 DURN INTERSIVE CARE UNIT							
0.9400 SURRICUAL INTENSIVE CARE UNIT		· · · · · · · · · · · · · · · · · · ·				l l	
40.00 0.0005 SUBPROVIDER 1 1 1 1 1 1 1 1 1		· · · · · · · · · · · · · · · · · · ·				l l	
41.00 01-00 SUBPROVIDER - IRF		· · · · · · · · · · · · · · · · · · ·				•	
42.00		· · · · · · · · · · · · · · · · · · ·				•	
44.00 04400 MIRSENT 44.00 A4400 A4						l l	
44.00 04.0	42.00	04200 SUBPROVI DER				42	2.00
45.00 04500 MIRST NOT PERM CARE 44.00	43.00	04300 NURSERY				43	3.00
40.00 AGCOLOTHER LOW TERM CARE	44.00	04400 SKILLED NURSING FACILITY				44	4.00
40.00 AGCOLOTHER LOW TERM CARE	45.00	04500 NURSING FACILITY				45	5.00
ANCILLEARY SERVICE COST CENTERS 5.0.00 DOSCOOD OPERATING KOOWN 5.1.00 DOSCOOD OPERATING KOOWN 5.1.00 DOSCOOD OPERATING KOOWN 5.2.00 DOSCOOD OPERATING KOOWN 6.2.00 DOSCOOD OPERATING KOOW	46.00	04600 OTHER LONG TERM CARE				46	6.00
			1				
15.1 0.0 05100 RECOVERY ROOM & LABOR ROOM 0.0000000 0.53.00 05200 05300 05300 05400 05400 05400 05400 05400 05500	50 00		0.000000			50	0 00
1.0 1.0		· · · · · · · · · · · · · · · · · · ·	1			l	
53.00 03.00 ANESTHESI OLOGY 0.000000 55.00		· · · · · · · · · · · · · · · · · · ·	1				
94.00 09-400 RADI OLGOY- HERAPEUTI C 0.000000 55.00 55.00 05500 RADI OLGOY- HERAPEUTI C 0.0000000 55.00 55.00 05500 RADI OLGOY- HERAPEUTI C 0.0000000 55.00 55.00 5500 C 5500		· · · · · · · · · · · · · · · · · · ·	1			•	
55.00		· · · · · · · · · · · · · · · · · · ·	1			l l	
55.00 05600 RADI IO STORPE 0.000000 55.00		· · · · · · · · · · · · · · · · · · ·				•	
157.00 05700 CT SCAN 0.000000 55.00 05900 0810 05900 0810 05900 0810 05900 0600 05900 0600		· · · · · · · · · · · · · · · · · · ·				l l	
B.B. 00 OBSOOD MRI			0. 000000			56	6.00
59.00 05900 CARDIAC CATHETER TATION 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	57.00	05700 CT SCAN	0. 000000			57	7.00
99.00 08900 CARDIAC CATHETERIATION 0.000000 59.00 0.00000 60.00	58.00	05800 MRI	0. 000000			58	8.00
60.00	59.00	05900 CARDI AC CATHETERI ZATI ON				59	9.00
0.000 0.6000 0.6000 0.4000RATORY 0.000000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		· · · · · · · · · · · · · · · · · · ·					
1.1 0		l					
C. 0. 0. 0. 0. 0. 0. 0.						l l	
63.00 06300 06100 STORING, PROCESSING & TRANS. 0.000000 064.00 064.00 064.00 066.00 06500 0659 RATORY THERAPY 0.000000 065.00 06500 0659 RATORY THERAPY 0.000000 066.00 066.00 06600 09493 064.00 06600 0940		· · · · · · · · · · · · · · · · · · ·	1				
64.00		· · · · · · · · · · · · · · · · · · ·					
65. 00 06500 RESPIRATORY THERAPY 0.000000 06. 00 06. 00 066. 00 066.00 071.00 0710.00						l l	
66.00 07.00 07.0		· · · · · · · · · · · · · · · · · · ·	1				
67.00 0x700 0x700 0x700 0x700 0x10x1 THERAPY 0x1000000 0x800		· · · · · · · · · · · · · · · · · · ·	1			•	
68. 00 0.6800 SPECCH PATHOLOGY 0.000000 6.8 0.00 0.90 0 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.00000000	66. 00	06600 PHYSI CAL THERAPY	0. 000000			66	6. 00
69 0 0 06900 CELETROCARDI OLOGY 0 0 000000 77 0 00 70 00 70 00 77 0 0 77 0 00 77 0 00 77 0 0 77 0 00 77 0 00 77 0 00 77 0 0 77 0 00 77 0 0 77 0	67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67	7.00
70. 00 07000 07000 ELECTROENCEPHALOGRAPHY 0. 0000000 72. 00 77. 00 7	68.00	06800 SPEECH PATHOLOGY	0. 000000			68	8.00
17.1 00	69.00	06900 ELECTROCARDI OLOGY	0. 000000			69	9.00
17.1 00		· •	1			l l	
72. 00 072.00 170.00 1		· •	1			l l	
73. 00 07300 DRIVES CHARGED TO PATIENTS 0.000000 73. 00 74. 00 07400 PATAL DI ALYSIS 0.0000000 74. 400 75. 00 07500 O7501 CARDI AC REHAB 0.0000000 0.000000 75. 01 07501 CARDI AC REHAB 0.0000000 0.000000 75. 01 07501 CARDI AC REHAB 0.0000000 0.000000 88. 00 08800 RURAL HEALTH CLINIC 88. 00 89. 00 09900 CEDERALLY OUALIFIED HEALTH CENTER 89. 00 99. 00 09900 CEDERALLY OUALIFIED HEALTH CENTER 0.000000 99. 00 90. 00 09000 CLINIC 0.000000 99. 00 91. 00 09100 MERCENCY 90. 0000000 91. 00 92. 00 09200 OSSERVATION BEDS (NON-DISTINCT PART 0.000000 91. 00 94. 00 09400 HOME PROGRAM DIALYSIS 0.000000 94. 00 95. 00 09500 DIARBALE MEDI CAL EQUI P-RENTED 0.000000 95. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 99. 00 09900 OMHC 99. 00 99. 00 09900 0MHC 99. 00 99. 00 09900 99. 00 99. 00 09900 99. 00 99. 00 09900 99. 00		· •	1			l l	
74. 00 07400 RENAL DI ALYSIS 0.000000 75. 00 75			1			l l	
75. 00 07500 ASC. (NON-DISTINCT PART) 0. 000000 75. 00 75. 01 07501 CARDIAC REHAB 0. 000000 75. 01 0000000 000000 000000 0000000 75. 01 0000000 00000 00000 00000 000000			1			l l	
75. 01 07501 CARDÍAC REHAB 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 0.00000000		· · · · · · · · · · · · · · · · · · ·	1			•	
DUTPATI ENT SERVICE COST CENTERS 88. 00			1			l l	
88. 00 08800 RURAL HEALTH CLINIC 89. 00 99. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 99. 00 99. 00 99000 CLINIC 0.000000 91. 00 99000 CLINIC 99. 00 99. 00 99000 CLINIC 99. 00 99. 00 99000 99000 CLINIC 99. 00 99. 00 990000 99000 99000 99000 99000 99000 99000 99000 990000 990000 990000 99000 99000 99000 99000 99000 99000 99000 99000 99000 990000	/5.01		0. 000000				5.01
89, 00 09900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 090.00							
90. 00 09000 CLINI C 0. 0000000 99. 00 991. 00 991. 00 991. 00 991. 00 991. 00 991. 00 992. 00 09500 08560 07160 08560 09500 08560 096000 096000 096000 096000 096000 096000 096000 096000 096000 096000 096000 096000 096000 0960000 0960000 0960000 09600000 09600000 096000000 0960000000 09600000000 096000000000 0960000000000						88	8.00
91. 00 09100 MERGENCY 0.000000 92. 00 0.000000 92. 00 0.000000 92. 00 0.000000 92. 00 0.000000 92. 00 0.000000 92. 00 0.000000 92. 00 0.000000 93. 00 0.000000 93. 00 0.000000 94. 00 0.000000 95. 00 0.000000 95. 00 0.000000 95. 00 0.000000 95. 00 0.000000 95. 00 0.000000 97. 00 0.000000 97. 00 0.000000 98. 00 0.000000 0.000000 97. 00 0.000000 99. 00 0.000000 0.000000 0.0000000 0.00000000						89	9.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.0000000 0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSIS 0.000000 95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 99. 00 09900 CMHC 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 09010 CORF 99. 10	90.00	09000 CLI NI C	0. 000000			90	0.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.0000000 0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSIS 0.000000 95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 99. 00 09900 CMHC 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 09010 CORF 99. 10	91.00	09100 EMERGENCY	0. 000000			9-	1.00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI LYSIS 0. 000000 95. 00 09500 AMBULANCE SERVICES 0. 0000000 95. 00 09500 AMBULANCE SERVICES 0. 0000000 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 0000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 0000000 97. 00 098. 00 09850 OTHER REIMBURSABLE COST CENTERS 0. 0000000 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 10 00910 CORF 99. 10 00910 CORF 99. 10 100. 00 10000 BAR SERVICES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 10100 HOME HEALTH AGENCY 101. 00 10500 KI DNEY ACQUI SITI ON 106. 00 10600 HEART ACQUI SITI ON 106. 00 10600 HEART ACQUI SITI ON 107. 00 10700 LI VER ACQUI SITI ON 108. 00 10800 LIVER ACQUI SITI ON 109. 00 10900 PANCREAS ACQUI SITI ON 109. 00 10900 PANCREAS ACQUI SITI ON 109. 00 110. 00 11000 INTESTI NAL ACQUI SITI ON 110. 00 11100 INTESTI NAL ACQUI SITI ON 111. 00 11100 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11400 UTI LIZATI ON REVIEW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 11600 HOSPI CE Subtotal (see instructions) Less Observation Beds 201. 00 2			1			92	2.00
94. 00 09400 HOME PROGRAM DI ALYSIS 0.000000 95. 00 95. 00 96. 00 09600 MBULANCE SERVICES 0.000000 95. 00 97. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 98. 00 09850 OTHER REI IMBURSABLE COST CENTERS 0.000000 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 10 09910 CORF 100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 10100 HOME HEALTH AGENCY 101. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 10500 KI DNEY ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 10800 LUNG ACQUI SI TI ON 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11100 INTESTI NAL ACQUI SI TI ON 111. 00 11100 INTESTI NAL ACQUI SI TI ON 111. 00 11100 INTERST EXPENSE 113. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115. 00 10000 HOSPI CE Subtotal (see instructions) 200. 00 200. 00 Subtotal (see instructions) 201. 00 201. 00 Less Observation Beds						′•	
95. 00 09500 DMRABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 09800 OTHER REI MBURSABLE COST CENTERS 0. 000000 98. 00 09900 CMHC 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM 100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY 101. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10700 LI VER ACQUI SI TI ON 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 1110. 0 INTESTI NAL ACQUI SI TI ON 111. 00 11300 INTERSTI EXPENSE 1114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 100. 00 Subtotal (see instructions) Less Observation Beds 201. 00	94 00		0.00000			0/	4 00
96. 00		l	1				
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 98. 00 99850 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 00 99900 CMHC 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 101. 00 EART ACQUI SI TI ON 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10700 LIVER ACQUI SI TI ON 107. 00 10900 PANCREAS ACQUI SI TI ON 107. 00 10900 NTESTI NAL ACQUI SI TI ON 109. 00 1000 INTESTI NAL ACQUI SI TI ON 109. 00 1000 INTESTI NAL ACQUI SI TI ON 101. 00 111. 00 111. 00 111. 00 111. 00 111. 00 114. 00 114. 00 114. 00 114. 00 114. 00 115. 00 115. 00 MBULATORY SURGI CAL CENTER (D. P.) 115. 00 1000 NOSPI CE 116. 00 1000 1000 NOSPI CE 116. 00 1000 NOSPI CE 116. 00 1000			1			l l	
98. 00							
99. 00 09900 CMHC 99. 10 09910 CORF 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SITI ON 107. 00 10700 LI VER ACQUI SITI ON 108. 00 10800 LUNG ACQUI SITI ON 109. 00 10900 PANCREAS ACQUI SITI ON 109. 00 10900 PANCREAS ACQUI SITI ON 110. 00 11100 I NTESTI NAL ACQUI SITI ON 111. 00 11100 I NTESTI NAL ACQUI SITI ON 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00						l l	
99. 10			0.000000				
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 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 108. 00 10900 PANCEAS ACQUI SI TI ON 109. 00 10900 INTESTI NAL ACQUI SI TI ON 110. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 116. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00						l l	
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 106. 00 10600 HEART ACQUI SI TI ON 106. 00 10700 LI VER ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 111. 00 11100 I SLET ACQUI SI TI ON 111. 00 113. 00 113. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 115. 00 115. 00 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 116. 00 100. 00 Less Observati on Beds 201. 00 201. 00 Less Observati on Beds 201. 00		· · · · · · · · · · · · · · · · · · ·				99	9. 10
SPECIAL PURPOSE COST CENTERS	100.00	10000 I&R SERVICES-NOT APPRVD PRGM				100	0.00
105. 00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 110.00 110.00 111.00 111.00 111.00 111.00 113.00 113.00 114.00 114.00 115.00 115.00 115.00 115.00 115.00 115.00 116.00 116.00 116.00 108PICE 116.00 200.00 Subtotal (see instructions) Less Observation Beds	101.00	10100 HOME HEALTH AGENCY				10	1.00
105. 00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 110.00 110.00 111.00 111.00 111.00 111.00 113.00 113.00 114.00 114.00 115.00 115.00 115.00 115.00 115.00 115.00 116.00 116.00 116.00 108PICE 116.00 200.00 Subtotal (see instructions) Less Observation Beds		SPECIAL PURPOSE COST CENTERS					
106. 00	105.00					105	5.00
107. 00						l l	
108. 00 10800 LUNG ACQUISITION 108. 00 10900 PANCREAS ACQUISITION 109. 00 110. 00 11000 INTESTINAL ACQUISITION 110. 00 111. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 100. 00 201. 00 Less Observation Beds 201. 00							
109. 00 10900 PANCREAS ACQUISITION 109. 00 110. 00 11000 INTESTINAL ACQUISITION 110. 00 111. 00 11							
110. 00 111. 00 111. 00 111. 00 111. 00 111. 00 113. 00 113. 00 113. 00 114. 00 114. 00 115. 0							
111. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 115. 0		· •				l l	
113. 00 114. 00 114. 00 115. 00 115. 00 116. 00 116. 00 116. 00 200. 00 201. 00 Less Observation Beds 113. 00 114. 00 114. 00 115. 00 115. 00 116. 00 200. 00 201. 00 116. 00 201. 00 117. 00 118. 00 119. 00 1 119. 00 119. 00 119. 00 119. 00 1 119. 00 119. 00 1 119		· · · · · · · · · · · · · · · · · · ·				•	
114.00 11400 11400 11400 11500 11500 11500 11600 11600 11600 11600 200.00 201.00 Less Observation Beds		· · · · · · · · · · · · · · · · · · ·				l l	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 115.00 116.00 116.00 1200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201.00		· · · · · · · · · · · · · · · · · · ·					
116. 00 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	114.00	11400 UTILIZATION REVIEW-SNF					
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)				115	5.00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	116.00	11600 H0SPI CE				1116	6.00
201.00 Less Observation Beds 201.00							
202.00		· · · · · · · · · · · · · · · · · · ·					
		, (400.0.0)	<u>1 </u>			202	

COMPU ¹	TATION OF RATIO OF COSTS TO CHARGES		Provi d	ler (CCN: 151306	Period: From 01/01/2014 To 12/31/2014		nared:
			-	Ti +I	e XIX	Hospi tal	5/28/2015 11: PPS	
				11 (1	C XIX	Costs	113	
	Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Lim Adj.	ni t	Total Costs	RCE Di sal I owance	Total Costs	
		col . 26)	0.00		2.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2. 00		3. 00	4. 00	5. 00	
30. 00		3, 711, 867		Т	3, 711, 80	57 0	3, 711, 867	30.00
31. 00	03100 INTENSIVE CARE UNIT	0			-, ,	0 0		1
32.00	03200 CORONARY CARE UNIT	0				0 0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0				0 0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0				0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0					0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0					0	42.00
43. 00	04300 NURSERY	193, 031			193, 03	31 0	193, 031	1
44.00	04400 SKILLED NURSING FACILITY	0				0 0	0	44.00
45. 00	04500 NURSI NG FACI LI TY	0				0 0	l .	
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0				0 0	0	46.00
50. 00	05000 OPERATING ROOM	2, 465, 732		Т	2, 465, 73	32 0	2, 465, 732	50.00
51. 00	05100 RECOVERY ROOM	0		ı	2/ 100/ / 1	0 0		1
52.00	05200 DELIVERY ROOM & LABOR ROOM	388, 335			388, 33	35 0	388, 335	52.00
53.00	05300 ANESTHESI OLOGY	0				0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 365, 062			2, 365, 0	52 0	, ,	1
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0		1			0	
57. 00	05700 CT SCAN	0					0	57.00
58. 00	05800 MRI	0				0 0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				0 0		59. 00
60.00	06000 LABORATORY	2, 299, 683			2, 299, 68	33 0	2, 299, 683	1
60. 01	06001 BLOOD LABORATORY	0				0	0	60.01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		1			0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0					l ő	1
64.00	06400 INTRAVENOUS THERAPY	329, 006			329, 00	06 0	329, 006	1
65. 00	06500 RESPI RATORY THERAPY	589, 526		0	589, 52			1
66.00	06600 PHYSI CAL THERAPY	1, 242, 924		0	1, 242, 92	24 0		
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0		0		0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		۷			0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		ı		0 0	Ö	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	713, 275			713, 2	75 0	713, 275	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	34, 284			34, 28			1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 907, 712		- 1	1, 907, 7	12 0	1, 907, 712 0	I
	07500 ASC (NON-DISTINCT PART)	0		ı			0	1
	07501 CARDI AC REHAB	204, 595			204, 59	95 0		
	OUTPATIENT SERVICE COST CENTERS							
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0 0	0	
90.00		0		1			1	
91. 00		4, 047, 722			4, 047, 72		· -	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 885, 937			1, 885, 93		1, 885, 937	
04.00	OTHER REIMBURSABLE COST CENTERS		I					04.00
94. 00 95. 00		0				0 0	1	
	09600 DURABLE MEDICAL EQUIP-RENTED	0						1
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0				0 0	Ö	
	09850 OTHER REIMBURSABLE COST CENTERS	0				0 0	0	98. 00
	09900 CMHC	0				0	0	
	09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM	0				0	0	99. 10 100. 00
	10100 HOME HEALTH AGENCY	0				0		101.00
	SPECIAL PURPOSE COST CENTERS						_]
	10500 KIDNEY ACQUISITION	0	•			0		105.00
	10600 HEART ACQUISITION	0	ł			0		106. 00 107. 00
	D10700 LIVER ACQUISITION D10800 LUNG ACQUISITION	0		1		0		107.00
	10900 PANCREAS ACQUISITION	0		l		o	l	109.00
110.00	11000 INTESTINAL ACQUISITION	0				0		110.00
	11100 ISLET ACQUISITION	0				0	0	111.00
	11300 INTEREST EXPENSE							113.00
	D11400 UTILIZATION REVIEW-SNF D11500 AMBULATORY SURGICAL CENTER (D.P.)	0				0	_	114. 00 115. 00
	0 11600 HOSPICE	0				0		116.00
	•		•			•		

Health Fina	IU HEALTH PAC	LI H	OSPI TAL		In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES				Provi der		Peri od: From 01/01/2014	Worksheet C Part I	
						To 12/31/2014	Date/Time Pre 5/28/2015 11:	pared: 53 am_
				Ti t	le XIX	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost	Ther	herapy Limit Total Costs		RCE	Total Costs	
		(from Wkst.		Adj .		Di sal I owance		
		B, Part I,						
		col. 26)						
		1.00		2.00	3. 00	4. 00	5. 00	
200.00	Subtotal (see instructions)	22, 378, 691		0	22, 378, 69	1 0	22, 378, 691	200.00
201.00	Less Observation Beds	1, 885, 937			1, 885, 93	7	1, 885, 937	201.00
202. 00	Total (see instructions)	20, 492, 754		0	20, 492, 75	4 0	20, 492, 754	202. 00

Health Financial Systems	IU HEALTH PAOLI H	HOSPITAL In Lieu of Form CMS-				u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN:		From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 11:53 am
		Ti t	tle XI	X	Hospi tal	PPS

							5/28/2015 11:	53 am_
				Charges	le XIX	Hospi tal	PPS	
		Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		oost senter beserveren	patront	output. o	+ col . 7)	Ratio	Inpati ent	
					·		Rati o	
	Lucat	LENT DOUTING OFFINAS OFFI	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	873, 766		873, 766			30.00
31. 00	1	INTENSIVE CARE UNIT	0/3, /60		0/3, /60			31.00
32. 00		CORONARY CARE UNIT	ا		ĺ			32.00
33. 00		BURN INTENSIVE CARE UNIT	Ö		0			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	o		0			34.00
40.00		SUBPROVI DER - I PF	0		0			40.00
41.00		SUBPROVI DER - I RF	0		0			41.00
42.00		SUBPROVI DER	0		0			42.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	236, 032		236, 032			43. 00 44. 00
45. 00		NURSING FACILITY	0					45.00
46. 00	1	OTHER LONG TERM CARE	o		Ö			46.00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	558, 692	3, 827, 594		0. 562146	0. 000000	50.00
51.00		RECOVERY ROOM	[0	101 020	· -	0.000000	0.000000	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	573, 809	181, 038 0		0. 514455 0. 000000	0. 000000 0. 000000	
54.00		RADI OLOGY-DI AGNOSTI C	75, 100	14, 704, 066	· -	0. 160027	0. 000000	
55. 00		RADI OLOGY-THERAPEUTI C	0	0	0	0. 000000	0. 000000	
56.00	05600	RADI OI SOTOPE	o	0	0	0. 000000	0. 000000	56.00
57.00		CT SCAN	0	0	0	0. 000000	0. 000000	1
58.00	05800		0	0	0	0. 000000	0.000000	1
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	U E1E 201	7 207 007	7 010 200	0.000000	0.000000	1
60.00	1	BLOOD LABORATORY	515, 301	7, 397, 007	7, 912, 308	0. 290646 0. 000000	0. 000000 0. 000000	
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0. 000000	0. 000000	
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	Ö	0	0	0. 000000	0. 000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	o	0	0	0. 000000	0. 000000	63.00
64. 00		INTRAVENOUS THERAPY	470, 329	2, 335, 834		0. 117244	0. 000000	
65.00		RESPI RATORY THERAPY	145, 576	646, 430		0. 744345	0.000000	1
66. 00 67. 00		PHYSI CAL THERAPY	18, 877	2, 391, 886		0. 515573	0.000000	
68.00		OCCUPATI ONAL THERAPY SPEECH PATHOLOGY		0	0	0. 000000 0. 000000	0. 000000 0. 000000	
69.00		ELECTROCARDI OLOGY	0	0		0. 000000	0. 000000	
70. 00		ELECTROENCEPHALOGRAPHY	Ö	0	0	0. 000000	0. 000000	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	238, 628	519, 139	757, 767	0. 941285	0. 000000	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	50, 332		0. 681157	0. 000000	
73.00		DRUGS CHARGED TO PATIENTS	318, 266	6, 593, 304		0. 276017	0.000000	
74.00	1	RENAL DIALYSIS	0	0	0	0. 000000	0. 000000 0. 000000	1
75. 00 75. 01		ASC (NON-DISTINCT PART) CARDIAC REHAB		109, 242	109, 242	0. 000000 1. 872860	0.000000	1
70.01		TIENT SERVICE COST CENTERS	<u> </u>	107, 212	107,212	1. 072000	0.000000	70.01
88. 00	08800	RURAL HEALTH CLINIC	0	0	0	0. 000000	0. 000000	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0			0. 000000	
90.00		CLI NI C	0	10 021 222			0.000000	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	421, 849 0	10, 921, 232 873, 461		0. 356845 2. 159154	0. 000000 0. 000000	1
72.00		REIMBURSABLE COST CENTERS	<u> </u>	073, 401	073, 401	2. 137134	0.00000	72.00
94.00		HOME PROGRAM DIALYSIS	0	0	0	0. 000000	0. 000000	94.00
95.00	1	AMBULANCE SERVICES	0	0		0. 000000	0. 000000	
96.00		DURABLE MEDICAL EQUIP-RENTED	0	0		0. 000000	0.000000	
97. 00 98. 00		DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSABLE COST CENTERS	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	97. 00 98. 00
99.00	09900			0		0.000000	0.000000	99.00
	09910		ا	0	ĺ			99. 10
	1	I&R SERVICES-NOT APPRVD PRGM	Ö	0	Ō			100.00
101.00		HOME HEALTH AGENCY	0	0	0			101. 00
105.00		AL PURPOSE COST CENTERS						105 00
		KIDNEY ACQUISITION HEART ACQUISITION	0	0				105. 00 106. 00
		LIVER ACQUISITION		0	٥			107.00
	1	LUNG ACQUISITION	o	0	0			108.00
109.00	10900	PANCREAS ACQUISITION	o	0	0			109. 00
	1	INTESTINAL ACQUISITION	0	0	0			110. 00
		I SLET ACQUI SI TI ON	0	0	0			111.00
	1	INTEREST EXPENSE UTILIZATION REVIEW-SNF						113. 00 114. 00
		AMBULATORY SURGICAL CENTER (D.P.)	ا	0	_			115.00
		HOSPI CE		0				116.00
200.00		Subtotal (see instructions)	4, 446, 225	50, 550, 565	54, 996, 790	<u> </u>	<u> </u>	200.00
		<u> </u>						

Health Financial Systems	IU HEALTH PAOLI HOSPITAL				In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der		Peri od:	Period: Worksheet C		
					From 01/01/2014			
					To 12/31/2014	Date/Time Pre		
						5/28/2015 11:	53 am	
			Ti t	Title XLX Hospital		PPS		
		Ch	arges					
Cost Center Description	I npati ent	0utp	oati ent	Total (col. (Cost or Other	TEFRA		
				+ col. 7)	Ratio	I npati ent		
						Ratio		
	6. 00	7	7. 00	8. 00	9. 00	10.00		
201.00 Less Observation Beds							201.00	
202.00 Total (see instructions)	4, 446, 225	50	0, 550, 565	54, 996, 79	0		202.00	

			Ti +I o VI V	Hospi tal	5/28/2015 11:53 am
	Cost Center Description	PPS Inpatient	Title XIX	Hospi tal	PPS
	oost denter beserretten	Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				30.00
32. 00	03200 CORONARY CARE UNIT				32.00
33. 00	03300 BURN INTENSIVE CARE UNIT				33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000 SUBPROVI DER - I PF				40.00
41.00	04100 SUBPROVI DER – I RF				41.00
42.00	04200 SUBPROVI DER				42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY				43.00
45. 00	04500 NURSING FACILITY				45. 00
46. 00	04600 OTHER LONG TERM CARE				46.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 562146			50.00
51. 00 52. 00	05100 RECOVERY ROOM	0.000000			51. 00 52. 00
53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0. 514455 0. 000000			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 160027			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00	05600 RADI OI SOTOPE	0. 000000			56.00
57.00	05700 CT SCAN	0. 000000			57.00
58.00	05800 MRI	0.000000			58.00
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY	0. 000000 0. 290646			59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	0. 290040			60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 117244			64.00
65.00	06500 RESPIRATORY THERAPY	0. 744345			65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0. 515573 0. 000000			66.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68.00
	06900 ELECTROCARDI OLOGY	0. 000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 941285			71. 00
72. 00 73. 00	+ I	0. 681157			72.00
74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0. 276017 0. 000000			73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
75. 01	07501 CARDI AC REHAB	1. 872860			75. 0
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90. 00 91. 00	O9000 CLI NI C O9100 EMERGENCY	0. 000000 0. 356845			90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2. 159154			92. 00
	OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			94.00
	09500 AMBULANCE SERVICES	0. 000000			95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97. 00 98. 00	O9700 DURABLE MEDI CAL EQUI P-SOLD O9850 OTHER REIMBURSABLE COST CENTERS	0. 000000 0. 000000			97. 00 98. 00
	09900 CMHC	0. 000000			99.00
	09910 CORF				99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00	10100 HOME HEALTH AGENCY				101.00
105 01	SPECIAL PURPOSE COST CENTERS				105.00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION				105. 00 106. 00
	10000 HEART ACQUISTION				107.00
	10800 LUNG ACQUISITION				108.00
	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
	11100 I SLET ACQUI SI TI ON				111.00
	11300 INTEREST EXPENSE				113.00
	11400 UTI LI ZATI ON REVI EW-SNF				114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE				115. 00 116. 00
200.00					200.00
					1200.00
201.00					201.00

Health Financial Systems

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

				10	12/31/2014	5/28/2015 11:	
			Tit	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	·	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 465, 732	183, 273	2, 282, 459	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	388, 335	18, 366	369, 969	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 365, 062	188, 067	2, 176, 995	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	2, 299, 683	75, 246	2, 224, 437	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	329, 006	17, 833	311, 173	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	589, 526	13, 971	575, 555	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 242, 924	74, 627	1, 168, 297	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	713, 275	57, 653	1	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	34, 284	2, 720	1	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 907, 712	47, 997		0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 75. 01	07500 ASC (NON-DISTINCT PART) 07501 CARDIAC REHAB	204 505	24 071	170 524	0	0	75. 00 75. 01
75.01	OUTPATIENT SERVICE COST CENTERS	204, 595	26, 071	178, 524	υ	0	75.01
88. 00	08800 RURAL HEALTH CLINIC	0	0	O	ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	0		ol	0	89. 00
90.00	09000 CLI NI C	0	0	Ö	ol	0	90.00
91.00	09100 EMERGENCY	4, 047, 722	162, 281	3, 885, 441	o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 885, 937	145, 525		o	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00	09900 CMHC	0	0	0	0	0	99.00
	09910 CORF	0	0	0	0	0	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON	0	0	0	o		105. 00
	10500 REDIVEY ACQUISITION	0	0		0		106.00
	10000 HEART ACQUISITION	0	0	1	0		107.00
	10800 LUNG ACQUISITION	0	0		0		108.00
	10900 PANCREAS ACQUISITION	0	0		ol Ol		109.00
	11000 INTESTINAL ACQUISITION	o o	0		ol		110.00
	11100 I SLET ACQUISITION	, o	n	ا	n n		111.00
	11300 INTEREST EXPENSE				Ĭ	Ü	113.00
	11400 UTILIZATION REVIEW-SNF				ļ		114.00
	11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0	o	ol	0	115.00
	11600 H0SPI CE	0	0	o	o	0	116. 00
200.00	Subtotal (sum of lines 50 thru 199)	18, 473, 793	1, 013, 630	17, 460, 163	o		200. 00
201.00	1 1	1, 885, 937	145, 525		0		201. 00
202.00	Total (line 200 minus line 201)	16, 587, 856	868, 105	15, 719, 751	O	0	202. 00

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Peri od: Worksheet C From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared: 5/28/2015 11:53 am

		T: 1	L VIV	11 2. 1 1	5/28/2015 11:	53 am
			le XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to			
	Operati ng	Part I,	Charge Ratio			
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 465, 732	4, 386, 286	0. 562146			50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	388, 335	754, 847				52.00
53. 00 05300 ANESTHESI OLOGY	000,000	701,017	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 365, 062	14, 779, 166				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 303, 002	14, 779, 100				55.00
	0		0.000000			•
56. 00 05600 RADI 01 SOTOPE	0	0	0. 000000			56.00
57. 00 05700 CT SCAN	0	0	0. 000000			57.00
58. 00 05800 MRI	0	0	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 000000			59.00
60. 00 06000 LABORATORY	2, 299, 683	7, 912, 308	0. 290646			60.00
60. 01 06001 BL00D LABORATORY	0	0	0.000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	329, 006	2, 806, 163				64.00
65. 00 06500 RESPIRATORY THERAPY	589, 526					65.00
66. 00 06600 PHYSI CAL THERAPY	1, 242, 924					66.00
	1, 242, 724	2,410,703				67.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0. 000000			
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	713, 275					71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	34, 284	50, 332	0. 681157			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 907, 712	6, 911, 570	0. 276017			73. 00
74.00 07400 RENAL DI ALYSI S	0	0	0.000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000			75.00
75. 01 07501 CARDI AC REHAB	204, 595	109, 242	1. 872860			75. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000			89. 00
90. 00 09000 CLI NI C	0	0	0. 000000			90.00
91. 00 09100 EMERGENCY	4, 047, 722	11, 343, 081	0. 356845			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 885, 937		2. 159154			92.00
OTHER REIMBURSABLE COST CENTERS	1,000,707	070, 101	2. 107101			72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0. 000000			94.00
95. 00 09500 AMBULANCE SERVICES	0		0. 000000			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			0. 000000			96.00
						1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 000000			97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
99. 00 09900 CMHC	0	0	0. 000000			99.00
99. 10 09910 CORF	0	0	0. 000000			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	_	0. 000000			100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0.000000			101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	0.000000			105.00
106.00 10600 HEART ACQUISITION	0	0	0. 000000			106.00
107. 00 10700 LIVER ACQUISITION	0	l .				107.00
108.00 10800 LUNG ACQUISITION	0	0				108.00
109. 00 10900 PANCREAS ACQUISITION	0		0. 000000			109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		١	0. 000000			110.00
111. 00 11100 SLET ACQUISITION			0. 000000			111.00
113. 00 11300 NTEREST EXPENSE			0.000000			113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_	_	0.000000			114.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0					115.00
116. 00 11600 HOSPI CE	0	_	0. 000000			116.00
200.00 Subtotal (sum of lines 50 thru 199)	18, 473, 793					200. 00
201.00 Less Observation Beds	1, 885, 937					201.00
202.00 Total (line 200 minus line 201)	16, 587, 856	53, 886, 992				202. 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der	CCN: 151306	Peri od:	Worksheet D	
				From 01/01/2014	Part II	
				To 12/31/2014	Date/Time Pre	pared:
					5/28/2015 11:	53 am_
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	183, 273	4, 386, 286	0. 04178	18, 543	775	50.00
51.00 05100 RECOVERY ROOM	0	0	0. 00000	00	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 366	754, 847	0. 02433	3, 711	90	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	188, 067	14, 779, 166	0. 01272	25 43, 370	552	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 00000		0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000		0	56.00
57. 00 05700 CT SCAN	0	0	0. 00000		0	57.00
58. 00 05800 MRI	0	0	0. 00000		o o	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59.00
60. 00 06000 LABORATORY	75, 246	7, 912, 308			1, 166	1
60. 01 06001 BLOOD LABORATORY	73, 240	7, 712, 300	0. 00000		1, 100	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.00000	0	0	61.00
		0	0.0000	20		1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	17, 833	2, 806, 163		· ·	177	
65. 00 06500 RESPI RATORY THERAPY	13, 971	792, 006			1, 065	1
66. 00 06600 PHYSI CAL THERAPY	74, 627	2, 410, 763			352	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000		0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0. 00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	57, 653	757, 767	0. 07608	33 106, 293	8, 087	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 720	50, 332	0. 05404	11 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	47, 997	6, 911, 570	0. 00694	14 121, 592	844	73.00
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	00	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	00	0	75. 00
75. 01 07501 CARDI AC REHAB	26, 071	109, 242	0. 23865	54 0	0	75. 01
OUTPATIENT SERVICE COST CENTERS				•	•	1
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000		0	89.00
90. 00 09000 CLI NI C	0	0	0. 00000		o o	90.00
91. 00 09100 EMERGENCY	162, 281	11, 343, 081	1		643	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	145, 525	873, 461	0. 16660		l	1
OTHER REIMBURSABLE COST CENTERS	143, 323	073, 401	0. 10000	0	0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00 0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0.00000	0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		^	0. 00000	0	0	
		0				
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.00000		0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	1 010 (00	D 00/ 000	0.00000		0	98.00
200.00 Total (lines 50-199)	1, 013, 630	53, 886, 992	I	560, 738	13, /51	200. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2014 | Part IV |
| To 12/31/2014 | Date/Time Prepared: | 5/28/2015 | 11:53 am THROUGH COSTS

						5/28/2015 11:	53 am
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Allied Healt	h All Other	Total Cost	
		Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	677, 214	0		0 0	677, 214	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	o	0		0 0	0	56.00
57.00	05700 CT SCAN	o	0		0 0	0	57.00
58.00	05800 MRI	o	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0		0 0	0	59.00
60.00	06000 LABORATORY	ol	0		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	o	0		o c	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0		0 0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	ol	0		0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY		0		0 0	Ö	64.00
65. 00	06500 RESPI RATORY THERAPY		0		0 0	Ö	65.00
66. 00	06600 PHYSI CAL THERAPY		0		0 0	Ö	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0		0 0	Ö	67.00
68. 00	06800 SPEECH PATHOLOGY		0			Ö	68.00
69. 00	06900 ELECTROCARDI OLOGY		0			Ö	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0			Ö	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0			Ö	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0			Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0			Ö	73.00
74.00	07400 RENAL DI ALYSI S		0			Ö	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0		0 0	_	75.00
75. 00	07501 CARDI AC REHAB	0	0		0 0		75. 00
75.01	OUTPATIENT SERVICE COST CENTERS	<u> </u>			0 0	, 0	73.01
88. 00	08800 RURAL HEALTH CLINIC		0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0 0		89. 00
90. 00	09000 CLINIC		0		0 0	_	90.00
91. 00	09100 EMERGENCY		0		0 0	1	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0	1	0 0	1	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	l ol			0 0	0	92.00
94. 00	09400 HOME PROGRAM DIALYSIS		0		0 0	0	94. 00
95.00	09500 AMBULANCE SERVICES		U			1	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0 0	0	95. 00 96. 00
			0				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0			0	97.00
98. 00 200. 00	O9850 OTHER REIMBURSABLE COST CENTERS Total (lines 50-199)	477 214	0		0 0		98.00
200.00	n Total (Titles 50-199)	677, 214	U	1	o _l	0//, 214	200.00

| Peri od: | Worksheet D | From 01/01/2014 | Part IV | To 12/31/2014 | Date/Time Prepared: | 11/2014 | Part IV | Par THROUGH COSTS

				0 12/31/2014	5/28/2015 11:		
			Ti tl	e XVIII	Hospi tal	Cost	<u> </u>
	Cost Center Description	Total		Ratio of Cost	Outpati ent	I npati ent	
	•	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	Ü	
		4)		·	col. 7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	0	4, 386, 286			18, 543	50.00
51.00	05100 RECOVERY ROOM	0	0	0. 000000		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	754, 847	0. 000000		3, 711	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0. 000000	0. 000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 779, 166			43, 370	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000		0	55.00
56.00	05600 RADI OI SOTOPE	0	0			0	56.00
57.00	05700 CT SCAN	0	0	0. 000000		0	57.00
58.00	05800 MRI	0	0			0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60.00	06000 LABORATORY	0	7, 912, 308			122, 650	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0. 000000	0. 000000	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000	0. 000000	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	2, 806, 163	0.000000	0. 000000	27, 903	64.00
65.00	06500 RESPI RATORY THERAPY	0	792, 006	0.000000	0.000000	60, 363	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 410, 763	0.000000	0. 000000	11, 387	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0. 000000		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	757, 767			106, 293	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	50, 332			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 911, 570			121, 592	73.00
74.00	07400 RENAL DI ALYSI S	0	0	0. 000000		0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0			0	75.00
75. 01	07501 CARDI AC REHAB	0	109, 242	0. 000000	0. 000000	0	75. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	1			0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89. 00
90.00	09000 CLI NI C	0	0			0	90.00
91.00	09100 EMERGENCY	0	, ,	0. 000000		44, 926	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	873, 461	0. 000000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0. 000000	0. 000000	0	94.00
95.00	09500 AMBULANCE SERVI CES						95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0			0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0	98.00
200.00	Total (lines 50-199)	0	53, 886, 992	l		560, 738	200. 00

Peri od: Worksheet D From 01/01/2014 Part IV To 12/31/2014 Date/Time Prepared: 5/28/2015 11:53 am THROUGH COSTS

						5/28/2015 11:	53 am_
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	۱		
		Costs (col. 8	ŭ	Costs (col.	9		
		x col. 10)		x col. 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS	1			I		
	05000 OPERATING ROOM	2, 863	0)	0		50.00
	05100 RECOVERY ROOM	2,000	0	1	o		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		0		52.00
	05300 ANESTHESI OLOGY		0		0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
		0	0	(0		55.00
	05500 RADI OLOGY-THERAPEUTI C	0	U	<u>'</u>	0		
56. 00	05600 RADI OI SOTOPE	0	Ü)	0		56.00
	05700 CT SCAN	0	0)	0		57.00
	05800 MRI	0	0)	0		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0)	0		59. 00
60.00	06000 LABORATORY	0	0)	0		60.00
60. 01	06001 BLOOD LABORATORY	0	0		0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0		0		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	ol	0	ol .	0		63.00
	06400 I NTRAVENOUS THERAPY	0	0		0		64.00
	06500 RESPIRATORY THERAPY		0		0		65.00
	06600 PHYSI CAL THERAPY		0		0		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
	06800 SPEECH PATHOLOGY	0	0				68.00
		0	0	(0		1
	06900 ELECTROCARDI OLOGY	0	U	<u>'</u>	0		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	Ü	<u>'</u>	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0)	0		73. 00
	07400 RENAL DIALYSIS	0	0)	0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0)	0		75. 00
75. 01	07501 CARDI AC REHAB	0	0)	0		75. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0		88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0		0		89.00
	09000 CLI NI C	o	0		0		90.00
	09100 EMERGENCY	0	0		o		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>		1	<u> </u>		1 /2.00
	09400 HOME PROGRAM DIALYSIS	0	0	1	0		94.00
	09500 AMBULANCE SERVICES	١	U	Ί	٦		95.00
			^	J			
	09600 DURABLE MEDICAL EQUIP-RENTED		0	<u>'</u>	0		96.00
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	<u>'</u>	0		97.00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0)	0		98. 00
200. 00	Total (lines 50-199)	2, 863	0	P	0		200.00

	Halici ai Systellis	TU HEALTH PAC				u or Form CW3	2552-10
APPORTI ON	WENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	epared:
			T	\0.01.1.1		5/28/2015 11:	53 am
			l liti	e XVIII	Hospi tal	Cost	
	Cook Cooker December 1	0+ +-	PPS	Charges	C+	Costs	
	Cost Center Description	Cost to	Rei mbursed	Cost Reimbursed	Cost Reimbursed	PPS Services (see inst.)	
		Charge Ratio From	Services (see		Servi ces Not	(See Thst.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
ANG	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM	0. 562146	0	1, 190, 19	3 0	0	50.00
51. 00 05°	100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM	0. 514455	0	7, 84	9 0	0	52.00
	300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0. 160027	0	4, 685, 39	0	0	54.00
55. 00 05!	500 RADI OLOGY-THERAPEUTI C	0. 000000	0)	0	0	55.00
56. 00 056	600 RADI OI SOTOPE	0. 000000	0)	0	0	56.00
57. 00 05	700 CT SCAN	0. 000000	0		0	0	57.00
58. 00 058	800 MRI	0. 000000	0		0	0	58.00
59.00 059	900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59.00
60.00 060	000 LABORATORY	0. 290646		2, 864, 51	5 0	0	60.00
60. 01 060	001 BLOOD LABORATORY	0. 000000	0)	0	0	60. 01
61.00 06	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000)		0		61.00
62.00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0)	0	0	62.00
	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0)	0	0	63.00
64. 00 064	400 INTRAVENOUS THERAPY	0. 117244	- 0	.,		0	64.00
65. 00 06!	500 RESPI RATORY THERAPY	0. 744345	0	230, 55	1 0	0	65.00
	600 PHYSI CAL THERAPY	0. 515573	•	600, 76		0	66.00
	700 OCCUPATI ONAL THERAPY	0. 000000	•)	0	0	67.00
	800 SPEECH PATHOLOGY	0. 000000)	0	0	68. 00
	900 ELECTROCARDI OLOGY	0. 000000	•)	0	0	69. 00
	000 ELECTROENCEPHALOGRAPHY	0. 000000	•)	0	0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 941285	1	220,00		0	
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 681157	1	1, 00.		0	72. 00
	300 DRUGS CHARGED TO PATIENTS	0. 276017		1 0,00.,,		0	73.00
	400 RENAL DI ALYSI S	0. 000000	1	1	0	0	1
	500 ASC (NON-DISTINCT PART)	0. 000000			0	0	1
	501 CARDI AC REHAB	1. 872860	0	77, 55	9 0	0	75. 01
	TPATIENT SERVICE COST CENTERS	0.000000	ı		1		00 00
	800 RURAL HEALTH CLINIC	0. 000000				0	
1	900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	•			0	
	000 CLI NI C 100 EMERGENCY	0. 000000		2 122 40	0 0	0	1
		0. 356845	•			0	1
	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS	2. 159154		470, 24	υ ₁		92.00
	400 HOME PROGRAM DI ALYSIS	0. 000000	1	1)		94.00
1	500 AMBULANCE SERVICES	0. 000000	•		ว		95.00
	600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			o n	0	1
	700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			0 0	0	1
	850 OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0	0	1
200.00	Subtotal (see instructions)			18, 209, 05	2 4, 723	-	200.00
201 00	Less PRP Clinic Lah Services-Program			1	n ., , , _ 0	ľ	201 00

18, 209, 052

4, 723

201.00

0 202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 +/- line 201) APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151306 Peri od: Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/28/2015 11:53 am Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 669, 065 50.00 05100 RECOVERY ROOM 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 4,038 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 749, 789 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 0 0 60.00 06000 LABORATORY 832, 560 0 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 0 61 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 130, 426 64.00 06500 RESPIRATORY THERAPY 65 00 171, 609 0 65 00 06600 PHYSI CAL THERAPY 66.00 309, 740 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 69 00 06900 FLECTROCARDLOLOGY 0 0 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 213, 067 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 971 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 995, 026 1.304 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 07501 CARDI AC REHAB 145, 257 75.01 75.01 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 09000 CLI NI C 90.00 90.00 0 0 91.00 09100 EMERGENCY 1, 114, 641 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1,015,331 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94 00 95.00 09500 AMBULANCE SERVICES 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 0

6, 360, 520

6, 360, 520

1, 304

1, 304

98.00

200.00

201.00

202.00

98.00

200.00

201.00

202.00

09850 OTHER REIMBURSABLE COST CENTERS

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Health FinancialSystemsIU HEALTH PAOLIHOSPITALAPPORTIONMENT OFMEDICAL, OTHER HEALTH SERVICES AND VACCINE COSTProvide

			102000		5/28/2015 11:	53 am
		Ti tl	e XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Servi ces	
'	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not	,	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	,		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 562146	C		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	l c		ol ol	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 514455	l d	1	o o	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	i c			Ö	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 160027	Ĭ	1		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	Č	1		0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000		1		0	56.00
57. 00 05700 CT SCAN	0. 000000		1		0	57.00
		·	1	-		
58. 00 05800 MRI	0. 000000	C	1	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	C	1	0	0	59.00
60. 00 06000 LABORATORY	0. 290646	C	1	0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	C	1	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	[C	1	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	C)	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 117244	C)	0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 744345	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 515573	C		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	l c		ol ol	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	l c		ol ol	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	l c		ol ol	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	l c		ol ol	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 941285			o	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 681157	ĺ			Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 276017	٦			0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	,			0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000		1		0	75.00
			1	-	0	75.00
75. 01 O7501 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	1. 872860		ή	0 0	U	75.01
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
					_	
	0. 000000				0	89.00
90. 00 09000 CLI NI C	0. 000000	C	1	0	0	90.00
91. 00 09100 EMERGENCY	0. 356845	C	1	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2. 159154	C)	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		ı	1			
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000		1	0		94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	C)	0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	[C)	0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	C)	o o	0	98.00
200.00 Subtotal (see instructions)		[c		o o	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)		C		o o	0	202.00
	1	•	1			•

Health Financial Systems I U HEALTH PACTOR APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST IU HEALTH PAOLI HOSPITAL

		'		5/28/2015 11:53 am
		Title XV	III Swing Beds - SNF	Cost
	Costs		· · · ·	
Cost Center Description	Cost	Cost		
,	Reimbursed Re	imbursed		
		vices Not		
		bject To		
		& Coins.		
		ee inst.)		
ANOULL ADV. CEDVI OF COCT OFNITEDS	6. 00	7. 00		
ANCILLARY SERVICE COST CENTERS	_			
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	o		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	l ol	ol		55.00
56. 00 05600 RADI 01 SOTOPE		0		56.00
57. 00 05700 CT SCAN	0	0		57.00
58. 00 05800 MRI		o		58.00
		0		
59. 00 05900 CARDI AC CATHETERI ZATI ON	-1	-1		59.00
60. 00 06000 LABORATORY	0	0		60.00
60. 01 06001 BLOOD LABORATORY	0	0		60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	О	0		64.00
65. 00 06500 RESPIRATORY THERAPY		ol		65.00
66. 00 06600 PHYSI CAL THERAPY	l ol	ol		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	ام	o		67.00
68. 00 06800 SPEECH PATHOLOGY	0	o		68.00
69. 00 06900 ELECTROCARDI OLOGY		0		69.00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY		0		70.00
	0	0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74. 00 07400 RENAL DI ALYSI S	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
75. 01 07501 CARDI AC REHAB	0	0		75. 01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0		89.00
90. 00 09000 CLI NI C	l	o		90.00
91. 00 09100 EMERGENCY	0	O		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	o		92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		94.00
		٩		
95. 00 09500 AMBULANCE SERVI CES				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Subtotal (see instructions)	0	0		200. 00
201.00 Less PBP Clinic Lab. Services-Program	0			201.00
Only Charges				
202.00 Net Charges (line 200 +/- line 201)	0	0		202. 00

Harlah Simonial Contant	LIL UEAL TU DAO	I I HOCDI TAI		1-11-		2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	TU HEALTH PAO COSTS			Period: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet D Part I Date/Time Pre 5/28/2015 11:	epared:
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
, , , , , , , , , , , , , , , , , , ,	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	.,	Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2.00	0.00	1. 00	0.00	_
30. 00 ADULTS & PEDIATRICS	285, 263	0	285, 26	3 1, 725	165, 37	30.00
31. 00 INTENSIVE CARE UNIT	0	_	1	0 1,720	0.00	
32. 00 CORONARY CARE UNIT	0			0 0	0.00	
33. 00 BURN INTENSIVE CARE UNIT	0			0	0.00	1
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0			0	0.00	
40. 00 SUBPROVI DER - I PF	0	0		0	0.00	
	0	0		0 0		1
	0	0	1	-	0.00	
42. 00 SUBPROVI DER	0	0	1	0	0.00	1
43. 00 NURSERY	9, 154		9, 15		38. 30	1
44.00 SKILLED NURSING FACILITY	0			0	0.00	
45. 00 NURSING FACILITY	0			0	0. 00	
200.00 Total (lines 30-199)	294, 417		294, 41	7 1, 964		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			,			4
30.00 ADULTS & PEDIATRICS	190	31, 420	1			30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
32.00 CORONARY CARE UNIT	0	0	1			32.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 SUBPROVI DER - I PF	0	0				40.00
41. 00 SUBPROVI DER - I RF	0	0)			41.00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	182	6, 971				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
45.00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30-199)	372	38, 391				200.00
	1		•			•

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 151306	Peri od:	Worksheet D	
				From 01/01/2014	Part II	
				To 12/31/2014	Date/Time Pre 5/28/2015 11:	pared:
						53 am_
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)	Í				
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	183, 273	4, 386, 286	0. 04178	314, 832	13, 155	50.00
51. 00 05100 RECOVERY ROOM	0	0			0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	18, 366	754, 847	l .			
53. 00 05300 ANESTHESI OLOGY	10, 300	754, 647	0. 00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	188, 067	14, 779, 166			380	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	100,007	14,779,100	0.00000		0	55.00
	0	0			1	
56. 00 05600 RADI 01 SOTOPE	0	0			0	56.00
57. 00 05700 CT SCAN	0	0	0. 00000		0	57.00
58. 00 05800 MRI	0	0	0. 00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000		0	59.00
60. 00 06000 LABORATORY	75, 246	7, 912, 308			1, 357	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	17, 833	2, 806, 163			480	64.00
65. 00 06500 RESPIRATORY THERAPY	13, 971	792, 006			462	65.00
66. 00 06600 PHYSI CAL THERAPY	74, 627	2, 410, 763			27	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0			Ö	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	57, 653	_	•		2, 800	
· ·	1	· ·				
	2, 720	50, 332	•		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	47, 997	6, 911, 570			922	
74. 00 07400 RENAL DI ALYSI S	0	0			0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0			0	75. 00
75. 01 07501 CARDI AC REHAB	26, 071	109, 242	0. 23865	0	0	75. 01
OUTPATIENT SERVICE COST CENTERS			1		T .	
88.00 08800 RURAL HEALTH CLINIC	0	0			0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89. 00
90. 00 09000 CLI NI C	0	0			0	90.00
91. 00 09100 EMERGENCY	162, 281	11, 343, 081	0. 01430	7 44, 460	636	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	145, 526	873, 461	0. 16660	0 8	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	00 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	n	0			0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			0	98.00
200. 00 Total (lines 50-199)	1, 013, 631	· ·		1, 112, 766	1	
255.55	1,010,001	00,000,772	1	1, 112, 700	2,,,,,,,	

Health Financial Systems	IU HEALTH PAG	OLI H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA			Provi der	CCN: 151306	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part III	pared:
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Alli	ed Heal th	All Other	Swi ng-Bed	Total Costs	
	School		Cost	Medi cal	Adjustment	(sum of cols.	
				Educati on	Amount (see	1 through 3,	
				Cost	instructions)	minus col. 4)	
	1. 00		2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	C	1	0		0	_	
31.00 03100 INTENSIVE CARE UNIT	C		0		0	0	31.00
32. 00 03200 CORONARY CARE UNIT	C		0		0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	C		0		0	0	33.00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	C		0		0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	C		0		0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	C		0		0		41.00
42. 00 04200 SUBPROVI DER	C		0		0	0	
43. 00 04300 NURSERY	C		0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	C		0		0	0	44.00
45.00 04500 NURSING FACILITY	C		0		0	0	
200.00 Total (lines 30-199)	C		0		0	0	200.00
Cost Center Description	Total Patient		er Diem	I npati ent	I npati ent		
	Days		col. 5 ÷	Program Days	Program		
		_ C	col. 6)		Pass-Through		
					Cost (col. 7		
			7.00	0.00	x col. 8)		
LADATIENT DOUTLAG CEDALOG COCT CENTEDO	6. 00		7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	1 705	-	0.00	10	20		20.00
30. 00 03000 ADULTS & PEDIATRICS	1, 725		0. 00 0. 00	19			30. 00 31. 00
31. 00 03100 INTENSIVE CARE UNIT					-		
32. 00 03200 CORONARY CARE UNIT			0.00		0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0.00		0		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T			0.00		0		34.00
40. 00 04000 SUBPROVI DER - I PF			0.00		0		40.00
41. 00 04100 SUBPROVI DER - I RF			0.00		0		41.00
42. 00 04200 SUBPROVI DER			0.00	4.6	0 0		42.00
43. 00 04300 NURSERY	239	(0.00	18		1	43.00
44. 00 04400 SKILLED NURSING FACILITY			0.00		0		44.00
45. 00 04500 NURSING FACILITY	1 2/4		0. 00	0-	0 0		45. 00
200.00 Total (lines 30-199)	1, 964	Н	l	37	['] 2 0		200. 00

THROUGH COSTS

					10 12/31/20	5/28/2015 11:	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Allied Healt	h All Other	Total Cost	
		Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						_
50.00	05000 OPERATING ROOM	677, 214	0		0	0 677, 214	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0 0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0 0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0 0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0 0	56. 00
57.00	05700 CT SCAN	0	0		0	0 0	57.00
58. 00	05800 MRI	0	0		0	0 0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	59.00
60.00	06000 LABORATORY	0	0		0	0 0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0 0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0 0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0 0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0 0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0 0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0 0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0 0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0 0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0 0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0 0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0 0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0	0 0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0 0	75.00
75. 01	07501 CARDI AC REHAB	0	0		0	0 0	75. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0 0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0 0	89.00
90.00	09000 CLI NI C	0	0		0	0 0	90.00
91.00	09100 EMERGENCY	0	0		0	0 0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0 0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DIALYSIS	0	0		0	0 0	
95.00	09500 AMBULANCE SERVI CES						95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0 0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0 0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0 0	
200.00	Total (lines 50-199)	677, 214	0		0	0 677, 214	200.00

| Peri od: | Worksheet D | From 01/01/2014 | Part IV | To 12/31/2014 | Date/Time Prepared: | 11/2014 | Part IV | Par THROUGH COSTS

					0 12/31/2014	5/28/2015 11:	
			Ti t	le XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total		Ratio of Cost	Outpati ent	Inpati ent	
	oost outtor besett per on	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col . 5 ÷	to Charges	Charges	
		col . 2, 3 and	col. 8)	col. 7)	(col . 6 ÷	onal ges	
		4)	001. 0)	001. 7)	col. 7)		
		6. 00	7. 00	8. 00	9.00	10. 00	
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	101.00	
50.00	05000 OPERATING ROOM	0	4, 386, 286	0. 154393	0.000000	314, 832	50. 00
51. 00	05100 RECOVERY ROOM	i o	1, 000, 200	0. 000000		0 , 332	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	i o	754, 847	•		308, 736	52. 00
53. 00	05300 ANESTHESI OLOGY	0	701,017	0. 000000		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	i o	14, 779, 166			29, 859	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	14, 777, 100	0.000000		27,037	55. 00
56. 00	05600 RADI OI SOTOPE	0	0			0	56.00
57. 00	05700 CT SCAN	0	0			0	57.00
58. 00	05800 MRI	0	0			0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0			0	59.00
60.00	06000 LABORATORY		7, 912, 308			142, 661	60.00
60.00	06001 BL00D LABORATORY	0	1,912,300	0.000000		142, 661	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	l o	0.000000	0.000000	U	61. 00
		0	_	0.00000	0 000000	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		75 500	63.00
64.00	06400 NTRAVENOUS THERAPY	0	2, 806, 163			75, 588	64.00
65.00	06500 RESPI RATORY THERAPY	0	792, 006			26, 185	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 410, 763			862	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0			0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0			0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	757, 767			36, 797	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	50, 332	•		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 911, 570			132, 786	73.00
74.00	07400 RENAL DIALYSIS	0	0			0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0			0	75. 00
75. 01	07501 CARDI AC REHAB	0	109, 242	0. 000000	0. 000000	0	75. 01
	OUTPATIENT SERVICE COST CENTERS	1			0.000000		
88. 00	08800 RURAL HEALTH CLINIC	0	l ~			0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89. 00
90.00	09000 CLINIC	0	0			0	90.00
91. 00	09100 EMERGENCY	0	1 , ,			44, 460	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	873, 461	0. 000000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0. 000000	0. 000000	0	94.00
95.00	09500 AMBULANCE SERVI CES						95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	96.00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0			0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0	98. 00
200.00	Total (lines 50-199)	0	53, 886, 992			1, 112, 766	200. 00

 Heal th Financial
 Systems
 IU HEALTH PAOLI

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 IU HEALTH PAOLI HOSPITAL Provi der CCN: 151306

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2014 | Part IV | To | 12/31/2014 | Date/Time Prepared: | 5/28/2015 | 11:53 am | THROUGH COSTS

			Ti +	le XIX	Hospi tal	PPS	00 4111
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent	1103pi tai	113	
	cost center bescription						
		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	48, 608	C) (50.00
51.00	05100 RECOVERY ROOM	o	C) (51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C) (52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o o	Ċ				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0					55.00
56. 00	05600 RADI OLOGI - MERAI EUTIC				1		56.00
	05700 CT SCAN	0		1	1		
57. 00		0	C				57.00
58. 00	05800 MRI	0	C)			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C))		59. 00
60.00	06000 LABORATORY	0	C)			60.00
60. 01	06001 BLOOD LABORATORY	0	C)			60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C				62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	C) (63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00	06500 RESPI RATORY THERAPY	0	Ċ				65.00
66. 00	06600 PHYSI CAL THERAPY	0	Č				66.00
67. 00	06700 OCCUPATI ONAL THERAPY		Č		1		67.00
68. 00	06800 SPEECH PATHOLOGY						68.00
69. 00	06900 ELECTROCARDI OLOGY	0					69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0					70.00
71. 00	I I	0					71.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C				
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		1		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C)			73. 00
74. 00	07400 RENAL DIALYSIS	0	C) (74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C				75. 00
75. 01	07501 CARDI AC REHAB	0	C	(75. 01
	OUTPATIENT SERVICE COST CENTERS				_		
88. 00	08800 RURAL HEALTH CLINIC	0	C) (88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C) (89. 00
90.00	09000 CLI NI C	0	C) (90.00
91.00	09100 EMERGENCY	0	C) (91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	C) (92.00
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DIALYSIS	0	C) (94.00
95. 00	09500 AMBULANCE SERVICES]			95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C				96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		·				97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS		0	1			98.00
200.00	I I	48, 608	C				200.00
200.00	10141 (11163 30-177)	40,000	C	'I	1		1200.00

APPORTI ONN	MENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
					From 01/01/2014 To 12/31/2014		parad.
					10 12/31/2014	5/28/2015 11:	53 am
			Ti t	le XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	· ·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS						
- 1	OO OPERATING ROOM	0. 562146		503, 35		0	
	OO RECOVERY ROOM	0. 000000			0	0	51.00
	DO DELIVERY ROOM & LABOR ROOM	0. 514455	0	85, 45		0	52.00
	OO ANESTHESI OLOGY	0. 000000	0		0	0	53.00
	OO RADI OLOGY-DI AGNOSTI C	0. 160027	0	2, 470, 74		0	54.00
	OO RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55.00
	OO RADI OI SOTOPE	0. 000000	0		0	0	56.00
57. 00 0570	OO CT SCAN	0. 000000	0		0	0	57.00
	OO MRI	0. 000000	0		0	0	58. 00
	OO CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59.00
60.00 0600	OO LABORATORY	0. 290646	0	1, 260, 24	6 0	0	60.00
	01 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
61.00 0610	OO PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61.00
62. 00 0620	OO WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0	0	62.00
63.00 0630	DO BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64. 00 0640	OO INTRAVENOUS THERAPY	0. 117244	0	299, 97	8 0	0	64.00
65. 00 0650	OO RESPI RATORY THERAPY	0. 744345	0	121, 35	0 0	0	65.00
66. 00 0660	DO PHYSI CAL THERAPY	0. 515573	0	405, 93	2 0	0	66.00
67. 00 0670	OCCUPATIONAL THERAPY	0. 000000	0		0 0	0	67.00
68. 00 0680	OO SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69.00 0690	DO ELECTROCARDI OLOGY	0. 000000	0		0	0	69.00
70.00 0700	DO ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71. 00 0710	OO MEDICAL SUPPLIES CHARGED TO PATIENT	0. 941285	0	83, 70	8 0	0	71.00
72. 00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	0. 681157	0		0 0	0	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0. 276017	0	467, 14	4 0	0	73.00
74. 00 0740	DO RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75. 00 0750	DO ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75.00
75. 01 0750	D1 CARDI AC REHAB	1. 872860	0	69	8 0	0	75. 01
OUTF	PATIENT SERVICE COST CENTERS						
88. 00 0880	OO RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00 0890	OO FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00 0900	DO CLI NI C	0. 000000	0		0 0	0	90.00
91.00 0910	DO EMERGENCY	0. 356845	0	2, 787, 32	7 0	0	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	2. 159154	0	109, 47	0	0	92.00
	ER REIMBURSABLE COST CENTERS						
94. 00 0940	OO HOME PROGRAM DIALYSIS	0. 000000			0		94.00
95. 00 0950	OO AMBULANCE SERVICES	0. 000000	0		0		95.00
	DO DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96. 00
97. 00 0970	DO DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
98. 00 0985	OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98. 00
200. 00	Subtotal (see instructions)		0	8, 595, 40	8 0	0	200. 00
201. 00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)		0	8, 595, 40	8 0	0	202.00

Provider CCN: 151306 Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/28/2015 11:53 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 282, 960 50.00 05100 RECOVERY ROOM 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 43, 961 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 395, 386 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 0 0 60.00 06000 LABORATORY 366, 285 0 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 0 61 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 35, 171 64.00 06500 RESPIRATORY THERAPY 65 00 90 326 0 65 00 06600 PHYSI CAL THERAPY 66.00 209, 288 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 69 00 06900 FLECTROCARDLOLOGY 0 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 78, 793 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 128, 940 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 07501 CARDI AC REHAB 1, 307 75.01 0 75.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 09000 CLI NI C 90.00 90.00 0 0 91.00 09100 EMERGENCY 994, 644 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 236, 363 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94 00 95.00 09500 AMBULANCE SERVICES 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 98.00 200.00 Subtotal (see instructions) 2, 863, 424 0 200.00

2, 863, 424

0

201.00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Only Charges

Health Financial Systems	IU HEALTH PAOLI HOSPI	In Lieu	of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Pro	ovider CCN: 151306	Peri od: From 01/01/2014	Worksheet D-1
			To 12/31/2014	Date/Time Prepared: 5/28/2015 11:53 am
		Title XVIII	Hospi tal	Cost

			10 12/01/2011	5/28/2015 11:	53 am
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
	DART I ALL DROW DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				1
1. 00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		1, 732	1.00
2. 00	Inpatient days (including private room days, excluding swing-be			1, 725	
	Private room days (excluding swing-bed and observation bed days		rivate room days	0	3.00
0.00	do not complete this line.	5) you have only p.	. varo i oom dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed	d days)		845	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	7	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	~ 31 of the cost	0	7.00
0.00	reporting period	l)	M . C . II	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (eveluding	r cuing bod and	381	9.00
9.00	newborn days)	the Program (excruding	g swifig-bed and	301	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	room days)	7	10.00
	through December 31 of the cost reporting period (see instructi		com dayo,	Í	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, ent	ter 0 on this line)	<i>,</i>		
12.00	Swing-bed NF type inpatient days applicable to titles ${\tt V}$ or ${\tt XIX}$	only (including privat	te room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX $$			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar year				
	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)			0	
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 Docombor 21 o	of the cost		17.00
17.00	reporting period	s till odgir becelliber 31 t	i the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost		18.00
	reporting period	arter becomber or er			10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	f the cost	0.00	19.00
	reporting period	G			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of 1	the cost	0. 00	20.00
	reporting period				
	Total general inpatient routine service cost (see instructions)			3, 711, 867	
22. 00	Swing-bed cost applicable to SNF type services through December	131 of the cost report	ting period (line	. 0	22.00
22 00	5 x line 17) Swing had east applicable to SNE type complete for December 3	of the cost respective	a nowled (line (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	si of the cost reportif	ig period (iine d	0	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na neriod (line	0	24.00
24.00	7 x line 19)	or the cost reporti	ng perrou (Trie	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	l of the cost reporting	period (line 8	0	25. 00
	x line 20)		, , , , , , , , , , , , , , , , , , , ,		
	Total swing-bed cost (see instructions)			15, 002	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		3, 696, 865	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	us line 22)(see instru	stions)	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		LI UIIS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	. 31)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line		1
37.00	27 minus line 36)			5, 5, 5, 5, 5, 5	57.55
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS			1
				2, 143. 11	38.00
38. 00	Adjusted general inpatient routine service cost per diem (see i	noti deti onoj			
	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			816, 525	39.00
39. 00 40. 00		38) n (line 14 x line 35)		816, 525 0 816, 525	40.00

	Financial Systems	IU HEALTH PAOL						u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST			Provi der	CCN: 15130		eriod: rom 01/01/2014 o 12/31/2014	Worksheet D-1 Date/Time Pre	
						'	0 12/31/2014	5/28/2015 11:	
	01.01	Total			e XVIII		Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	I np	otal ati ent ays	Average I Diem (col ÷ col. 2	. 1	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00		. 00	3.00		4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0		C		0. 00	0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O		C	I	0. 00	0	0	43.00
44. 00	CORONARY CARE UNIT			0	1	0.00	0	0	1
45.00		0		C		0. 00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0		C	1	0. 00	0	0	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description								47.00
	·							1. 00	
48. 00	Program inpatient ancillary service cost (Wk)			258, 639	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see i	nstructi	ons)			1, 075, 164	49.00
50.00	Pass through costs applicable to Program inp	atient routine	servi	ces (fro	m Wkst. D,	sum	of Parts I and	0	50.00
-1 00						_	6.5		
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y ser	vices (f	rom Wkst. I), sı	ım of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)						0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		el ated	, non-ph	ysician and	esthe	etist, and	0	53.00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges							0	54.00
55. 00	Target amount per discharge							-	55.00
56. 00	Target amount (line 54 x line 55)						>	0	
57. 00 58. 00	Difference between adjusted inpatient operat	ing cost and ta	arget	amount (line 56 mii	nus I	ine 53)	0	1
59.00									59.00
	market basket				•		,		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line						the amount by	0.00	
01.00	which operating costs (line 53) are less that							U	01.00
	amount (line 56), otherwise enter zero (see	instructions)					S		
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (saa instru	ıction	e)				0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstru	ic trom	3)				0] 03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember	31 of th	e cost rep	ortir	ng period (See	15, 002	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	oer 31	of the	cost repor	ti ng	period (See	0	65.00
66. 00	1	ne costs (line	64 pl	us line	65)(title:	XVIII	only). For	15, 002	66.00
	CAH (see instructions)		_ '		6.11				,,,,,,,
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	т ресе	mber 31	or the cos	t rep	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D)ecemb	er 31 of	the cost	repor	ting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI							0	69.00
70. 00	Skilled nursing facility/other nursing facil		•			37)			70.00
71.00	Adjusted general inpatient routine service c	ost per diem (I							71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (lin	e 14 v I	ine 35)				72.00
74. 00	Total Program general inpatient routine serv		•						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e cost	s (from	Worksheet I	B, Pa	art II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)							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 d	er recor	ds)				78. 00 79. 00
80. 00	Total Program routine service costs for comp	arison to the c				mi nu	us line 79)		80.00
	Inpatient routine service cost per diem limi								81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (· .						82.00
84. 00	Program inpatient ancillary services (see in		13)						84.00
85. 00	Utilization review - physician compensation	(see instruction							85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough	85)					86.00
87. 00	Total observation bed days (see instructions							880	87.00
	Adjusted general inpatient routine cost per	•	- line	2)				2, 143. 11	
88. 00	Observation bed cost (line 87 x line 88) (se							1, 885, 937	

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 11:	pared: 53 am
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	285, 263	3, 696, 865	0. 07716	3 1, 885, 937	145, 525	90.00
91.00 Nursing School cost	0	3, 696, 865	0.00000	0 1, 885, 937	0	91.00
92.00 Allied health cost	0	3, 696, 865	0.00000	0 1, 885, 937	0	92.00
93.00 All other Medical Education	0	3, 696, 865	0. 00000	0 1, 885, 937	0	93. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu of Form CMS-2552-1		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151306	From 01/01/2014		
		To 12/31/2014	Date/Time Prepared: 5/28/2015 11:53 am	
	Title XIX	Hospi tal	PPS	

do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 190, 190, 190, 190, 190, 190, 190, 190,	11:53 am	5/28/2015 11:			
DART I - ALL PROVIDER COMPONENTS	;	PPS	Hospi tal	Title XIX	
PART I - ALL PROVIDER COMPONENTS		1.00	-		Cost Center Description
IMPATIENT DAYS 1.00 Impatient days (including private room days and swing-bed days, excluding newborn) 1,73 1,7		1.00			DART I ALL DROWLDED COMPONENTS
Inpattient days (Including private room days and swing-bed adm newborn) 1,73.					
Inpatient days (including private room days, excluding swing-bed and newborn days) 1,72%	732 1.00	1 732		excluding newborn)	
Derivate room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 84.00 Semi-private room days (excluding swing-bed and observation bed days). Semi-private room days (excluding swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line). 7.00 Total saing-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 Total saing-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). 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days). 9.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days). 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 (inclendar year, enter 0 on this line). 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line). 13.00 Swing-bed SNF type inpatient days applicable to title V or XIX only (including private room days). 14.00 Medically necessary private room days applicable to title V or XIX only (including private room days). 15.00 Nursery days (title V or XIX only). 16.00 Nursery days (title V or XIX only). 17.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period. 18.00 Medical or rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period. 18.00 Medical or rate for swing-bed SNF services applicable to services after December 31 of t					
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25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 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 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 34 x line 31) 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)	0 24.00	l	ng perrou (Trie	31 of the cost reporti	
x line 20) 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 charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)	0 25.00	0	period (line 8	of the cost reporting	1
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Private room charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)		1	p = 1 = 1 = 1		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)	0 26.00	0			Total swing-bed cost (see instructions)
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)	367 27.00	3, 711, 867		ine 21 minus line 26)	General inpatient routine service cost net of swing-bed cost (
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)					PRIVATE ROOM DIFFERENTIAL ADJUSTMENT
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)	0 28.00	ł	arges)	and observation bed ch	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)	0 29.00	ł			
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)	0 30.00	l .			, , , , , , , , , , , , , , , , , , , ,
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 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)		i e		line 28)	,
34.00 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)		i e			
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) 0.00		i e	. + :)		
36.00 Private room cost differential adjustment (line 3 x line 35)		l e	LLI ONS)		
	0 36.00	i e		: 31)	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,711,86		•	fferential (line	nd private room cost di	, , , , , , , , , , , , , , , , , , , ,
27 minus line 36)	,0,1,3,1.00	3, /11, 00/	ricicitiai (IIIIe	ia private ruull cust al	· ·
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM I NPATI ENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				TMENTS	
	81 38.00	2, 151. 81			
		408, 844			
	0 40.00	1		•	3 3 1
	344 41.00	408, 844			

Heal th	Financial Systems IU	HEALTH PAOLI HO	SPI TAI	In lie	u of Form CMS-2	2552-10	
	TATION OF INPATIENT OPERATING COST		Provider CCN: 151306	Peri od:	Worksheet D-1	1002 10	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:	
			Title XIX	Hospi tal	5/28/2015 11: PPS	53 am_	
	Cost Center Description	Total T	otal Average Per	Program Days	Program Cost		
	l r		atient Diem (col. 1		(col. 3 x		
			Days ÷ col. 2) 2.00 3.00	4. 00	col . 4) 5.00		
42.00	NURSERY (title V & XIX only)	193, 031	239 807. 6		146, 994	42.00	
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	ol	0 0.0	ol ol	0	43. 00	
43. 00 44. 00	CORONARY CARE UNIT	0	0 0.0		0	44.00	
	BURN INTENSIVE CARE UNIT	О	0.0		0	45. 00	
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0.0	0 0	0	46. 00 47. 00	
47.00	Cost Center Description					47.00	
10.00			200		1. 00	10.00	
48. 00 49. 00					498, 004 1, 053, 842		
17.00	PASS THROUGH COST ADJUSTMENTS	111 ougi 107 (300 1	nstructions)		1, 000, 012	17.00	
50.00	Pass through costs applicable to Program inpatie	nt routine servi	ces (from Wkst. D, sur	n of Parts I and	38, 391	50.00	
51. 00		nt ancillary ser	rvices (from Wkst. D. s	sum of Parts II	76, 339	51. 00	
	and IV)	,	,				
52. 00 53. 00	Total Program excludable cost (sum of lines 50 at Total Program inpatient operating cost excluding		l non nhysisian anastl	notict and	114, 730 939, 112		
55.00	medical education costs (line 49 minus line 52)	capital related	i, non-physician anesti	letist, and	939, 112	33.00	
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge				0 00	54. 00 55. 00	
56. 00	Target amount (line 54 x line 55)				0.00	56.00	
57. 00	Difference between adjusted inpatient operating	cost and target	amount (line 56 minus	line 53)	0	57.00	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost report	ing period endir	ng 1996 jundated and co	mnounded by the	0.00	58. 00 59. 00	
37.00	market basket	0.00	37.00				
60.00	' '				0.00	60.00	
61. 00	If line 53/54 is less than the lower of lines 55 which operating costs (line 53) are less than ex				0	61. 00	
	amount (line 56), otherwise enter zero (see inst			tiio tai got			
62.00	Relief payment (see instructions)	(acc i not musti or	·•)		0	62. 00 63. 00	
03.00	63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00		hrough December	31 of the cost reporti	ng period (See	0	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs a</pre>	fter December 31	of the cost reporting	n period (See	0	65. 00	
00.00	instructions)(title XVIII only)		•	, , ,			
66. 00	Total Medicare swing-bed SNF inpatient routine of CAH (see instructions)	osts (line 64 pl	us line 65)(title XVII	I only). For	0	66. 00	
67. 00	,	sts through Dece	ember 31 of the cost re	eporting period	0	67. 00	
	(line 12 x line 19)	. I Cl B I	24 . 6 . 11				
68.00	Title V or XIX swing-bed NF inpatient routine compliance 13 x line 20)	sts after Decemb	per 31 of the cost repo	orting period	U	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient rout				0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING Skilled nursing facility/other nursing facility/					70. 00	
71.00	Adjusted general inpatient routine service cost		, , ,			71.00	
72.00	Program routine service cost (line 9 x line 71)		, , , , , , , , , , , , , , , , , , , ,			72.00	
73. 00 74. 00	Medically necessary private room cost applicable Total Program general inpatient routine service					73. 00 74. 00	
75. 00	Capital -related cost allocated to inpatient rout			Part II, column		75. 00	
7/ 00	26, line 45)	`				7/ 00	
76. 00 77. 00	Program capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)	,				76. 00 77. 00	
78. 00	Inpatient routine service cost (line 74 minus li	ne 77)				78. 00	
79. 00 80. 00	1 33 3			ous Lino 70)		79.00	
81.00	Total Program routine service costs for comparise Inpatient routine service cost per diem limitation		Timi tation (Time 76 MH	ius IIIIc /7)		80. 00 81. 00	
82.00	Inpatient routine service cost limitation (line	9 x line 81)				82.00	
83. 00 84. 00	Reasonable inpatient routine service costs (see Program inpatient ancillary services (see instru					83. 00 84. 00	
85.00	Utilization review - physician compensation (see					85. 00	
86. 00	Total Program inpatient operating costs (sum of	lines 83 through	1 85)			86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THE Total observation bed days (see instructions)	ROUGH COST			880	87. 00	
88. 00	Adjusted general inpatient routine cost per diem		2)		2, 151. 81	88. 00	
89. 00	Observation bed cost (line 87 x line 88) (see in:	structions)			1, 893, 593	89. 00	

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 11:	pared: 53 am
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	285, 263	3, 711, 867	0. 07685	2 1, 893, 593	145, 526	90.00
91.00 Nursing School cost	0	3, 711, 867	0. 00000	0 1, 893, 593	0	91.00
92.00 Allied health cost	0	3, 711, 867	0. 00000	0 1, 893, 593	0	92.00
93.00 All other Medical Education	0	3, 711, 867	0. 00000	1, 893, 593	0	93. 00

Health Financial Systems	IU HEALTH PAOLI HOSP	I TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Pr	ovi der	CCN: 151306	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Data/Tima Dra	paradi
				To 12/31/2014	Date/Time Pre 5/28/2015 11:	
		Ti tl	e XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description			Ratio of Cos		I npati ent	
'			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				392, 302		30.00
31. 00 03100 INTENSIVE CARE UNIT				0		31.00
32. 00 03200 CORONARY CARE UNIT				0		32.00
33. 00 03300 BURN INTENSI VE CARE UNIT				0		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T				0		34.00
40. 00 04000 SUBPROVI DER - I PF				0		40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER				0		41. 00 42. 00
43. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY				0		43.00
ANCI LLARY SERVI CE COST CENTERS						43.00
50. 00 05000 OPERATING ROOM			0. 56214	6 18, 543	10, 424	50.00
51. 00 05100 RECOVERY ROOM			0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 51445		1, 909	52.00
53. 00 05300 ANESTHESI OLOGY			0. 00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 16002		6, 940	1
55. 00 05500 RADI OLOGY-THERAPEUTI C			0. 00000		0	55.00
56. 00 05600 RADI 0I SOTOPE			0. 00000		0	56.00
57.00 05700 CT SCAN			0. 00000	0	0	57.00
58. 00 05800 MRI			0. 00000	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 00000	0	0	59.00
60. 00 06000 LABORATORY			0. 29064	6 122, 650	35, 648	60.00
60. 01 06001 BL00D LABORATORY			0. 00000	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0. 00000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0. 00000		0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY			0. 11724		3, 271	64.00
65. 00 06500 RESPI RATORY THERAPY			0. 74434		44, 931	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 51557		5, 871	66.00
67. 00 06700 OCCUPATI ONAL THERAPY			0.00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY			0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY			0.00000		0	69. 00 70. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 00000 0. 94128		100, 052	70.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 68115		0 100,032	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 27601		33, 561	73.00
74. 00 07400 RENAL DIALYSIS			0. 00000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)			0. 00000		ő	75.00
75. 01 07501 CARDI AC REHAB			1. 87286		0	75. 01
OUTPATIENT SERVICE COST CENTERS				<u></u>		
88. 00 08800 RURAL HEALTH CLINIC			0.00000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0. 00000	0	0	89. 00
90. 00 09000 CLI NI C			0. 00000	0	0	90.00
91. 00 09100 EMERGENCY			0. 35684	5 44, 926	16, 032	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART			2. 15915	4 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS			0.00000	0	0	
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED			0. 00000		0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD			0.00000		0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0. 00000		0	98.00
200.00 Total (sum of lines 50-94 and 96-98)		(1)		560, 738	258, 639	
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges (li	ne 61)		E40 730		201.00
202.00 Net Charges (line 200 minus line 201)			l	560, 738	I	202. 00

	nciai Systems – Tu health Pauli hu				u or form CMS-2	
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151306	Peri od:	Worksheet D-3	
			00N 4F700/	From 01/01/2014		
		Component	CCN: 15Z306	To 12/31/2014		
		T	\0.01.1.1	0 1 0 1 011	5/28/2015 11:	53 am
		II TI		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
				Ŭ	col . 2)	
		Ì	1. 00	2. 00	3.00	
I NPAT	TENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS			0		30.00
						1
1	INTENSIVE CARE UNIT			0		31.00
1	CORONARY CARE UNIT			0		32.00
33.00 03300	BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400	SURGICAL INTENSIVE CARE UNIT			0		34.00
40.00 04000	SUBPROVI DER - I PF			0		40.00
	SUBPROVI DER - I RF			0	J	41.00
	SUBPROVI DER			0		42.00
1	NURSERY			0		43.00
						43.00
	LARY SERVICE COST CENTERS	1	0.5/04	1/		
i i	OPERATING ROOM		0. 5621			
i i	RECOVERY ROOM		0. 00000			51.00
	DELIVERY ROOM & LABOR ROOM	ļ	0. 5144!	55 0	0	52.00
53.00 05300	ANESTHESI OLOGY		0.0000	00	0	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C		0. 1600	27 1, 871	299	54.00
	RADI OLOGY-THERAPEUTI C		0.0000			1
	RADI OI SOTOPE		0. 00000			56.00
					_	
	CT SCAN		0. 00000			57.00
58.00 05800			0. 00000			58. 00
59.00 05900	CARDI AC CATHETERI ZATI ON		0. 00000	00	0	59.00
60.00 06000	LABORATORY		0. 2906	16 828	241	60.00
60. 01 06001	BLOOD LABORATORY		0.0000	00	0	60. 01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000	00 0	0	61.00
	WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	62.00
	BLOOD STORING, PROCESSING & TRANS.		0. 00000			63.00
-					1	1
	I NTRAVENOUS THERAPY		0. 1172		0	64.00
1	RESPI RATORY THERAPY		0. 7443			1
66.00 06600	PHYSI CAL THERAPY		0. 5155	73 1, 762	908	66.00
67.00 06700	OCCUPATIONAL THERAPY		0.0000	00	0	67.00
68.00 06800	SPEECH PATHOLOGY		0.0000	00	0	68.00
69. 00 06900	ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
	ELECTROENCEPHALOGRAPHY		0.0000		0	1
1	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 94128			1
						1
	IMPL. DEV. CHARGED TO PATIENTS		0. 6811!		0	
	DRUGS CHARGED TO PATIENTS		0. 2760		l	73.00
74. 00 07400	RENAL DIALYSIS		0. 00000	00	0	74.00
75. 00 07500	ASC (NON-DISTINCT PART)		0.0000	00	0	75. 00
75. 01 07501	CARDI AC REHAB		1. 8728	50 0	0	75. 01
	TIENT SERVICE COST CENTERS	•		"		1
	RURAL HEALTH CLINIC		0.0000	00	0	88. 00
i i	FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
90.00 09000			0.00000		l .	1
91.00 09100			0. 3568		l .	1
	OBSERVATION BEDS (NON-DISTINCT PART		2. 1591!	54 0	0	92.00
	REIMBURSABLE COST CENTERS					1
94.00 09400	HOME PROGRAM DIALYSIS		0.0000	00	0	94.00
95.00 09500	AMBULANCE SERVICES	l				95.00
	DURABLE MEDICAL EQUIP-RENTED		0.0000	00 0	0	96.00
	DURABLE MEDICAL EQUIP-SOLD	ļ	0. 00000			1
	OTHER REIMBURSABLE COST CENTERS	ŀ	0. 00000		Ö	1
	Total (sum of lines 50-94 and 96-98)	ŀ	0.0000		_	1
200.00		(1:00 (1)		9, 787		200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(iine 6i)		0		201.00
202. 00	Net Charges (line 200 minus line 201)	l		9, 787	I	202. 00

Heal th I	Financial Systems	IU HEALTH PAOLI H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
	NT ANCILLARY SERVICE COST APPORTIONMENT			CCN: 151306	Peri od:	Worksheet D-3	
					From 01/01/2014	Doto /Time Dro	nonod.
					To 12/31/2014	Date/Time Pre 5/28/2015 11:	
-			Ti t	le XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description			Ratio of Cos		I npati ent	
	· ·			To Charges	Program	Program Costs	
					Charges	(col. 1 x	
						col . 2)	
				1. 00	2. 00	3. 00	
_	NPATIENT ROUTINE SERVICE COST CENTERS			ı	200 775	ı	
	03000 ADULTS & PEDIATRICS				208, 775		30.00
	D3100 INTENSIVE CARE UNIT				0		31.00
1	03200 CORONARY CARE UNIT				0		32.00
1	D3300 BURN INTENSIVE CARE UNIT D3400 SURGICAL INTENSIVE CARE UNIT				0		33. 00 34. 00
1	04000 SUBPROVI DER - I PF				0		40.00
	04100 SUBPROVI DER - I RF						41.00
	04200 SUBPROVI DER				0		42.00
1	04300 NURSERY				172, 592		43.00
-	ANCILLARY SERVICE COST CENTERS			·	,		
	05000 OPERATING ROOM			0. 56214	16 314, 832	176, 982	50.00
51.00	D5100 RECOVERY ROOM			0. 00000		0	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM			0. 51445	308, 736	158, 831	52.00
53.00	D5300 ANESTHESI OLOGY			0. 00000	00	0	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C			0. 16002	27 29, 859	4, 778	54.00
	D5500 RADI OLOGY-THERAPEUTI C			0. 00000		0	55.00
	D5600 RADI OI SOTOPE			0. 00000		0	56.00
1	D5700 CT SCAN			0. 00000		0	57.00
	05800 MRI			0.00000		0	58.00
	05900 CARDI AC CATHETERI ZATI ON			0.00000		0	59.00
1	06000 LABORATORY			0. 29064	·	41, 464	60.00
	06001 BLOOD LABORATORY			0.00000		0	60.01
1	D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY D6200 WHOLE BLOOD & PACKED RED BLOOD CELL			0. 00000 0. 00000		0	61.00
	06300 BLOOD STORING, PROCESSING & TRANS.			0.00000		0	63.00
	06400 INTRAVENOUS THERAPY			0. 11724			64.00
	06500 RESPIRATORY THERAPY			0. 74434		19, 491	65.00
	06600 PHYSI CAL THERAPY			0. 51557		444	66.00
1	06700 OCCUPATI ONAL THERAPY			0. 00000		0	67.00
1	06800 SPEECH PATHOLOGY			0. 00000		0	68.00
69.00	06900 ELECTROCARDI OLOGY			0. 00000	00	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY			0. 00000	00	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 94128	36, 797	34, 636	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 68115		0	72.00
1	07300 DRUGS CHARGED TO PATIENTS			0. 27601		36, 651	
	07400 RENAL DI ALYSI S			0.00000		0	74.00
	D7500 ASC (NON-DISTINCT PART)			0.00000		•	75.00
	07501 CARDI AC REHAB			1. 87286	50 0	0	75. 01
	DUTPATIENT SERVICE COST CENTERS			0.0000	20	0	00 00
	D8800 RURAL HEALTH CLINIC D8900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000		1	
	09000 CLINIC			0. 00000 0. 00000		0	1
	09100 EMERGENCY			0. 35684			
	09200 OBSERVATION BEDS (NON-DISTINCT PART			2. 15915		0	1
	OTHER REIMBURSABLE COST CENTERS			2. 10710	51 0		72.00
	09400 HOME PROGRAM DIALYSIS			0.00000	00 0	0	94.00
	09500 AMBULANCE SERVICES						95.00
	09600 DURABLE MEDICAL EQUIP-RENTED			0. 00000	00	0	1
	09700 DURABLE MEDICAL EQUIP-SOLD			0. 00000	00 0	0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS			0. 00000	00	0	98. 00
200.00	Total (sum of lines 50-94 and 96-98)				1, 112, 766		
201. 00	Less PBP Clinic Laboratory Services-Pr	ogram only charges	(line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)				1, 112, 766		202. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151306	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 11:53 am

			To 12/31/2014	Date/Time Pre 5/28/2015 11:	
		Title XVIII	Hospi tal	Cost	
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			6, 361, 824	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2.00
3. 00 4. 00	PPS payments Outlier payment (see instructions)			0	3. 00 4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	•
6.00	Line 2 times line 5			0	6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	•
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IN	/ col 13 line 200		0	8. 00 9. 00
10.00	Organ acqui si ti ons	7, 3311 10, 11110 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 361, 824	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	ol. 4)		0	•
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	avment for services or	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e)		_		
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	
19. 00	Excess of customary charges over reasonable cost (complete only	/if line 18 exceeds l	ine 11) (see	0	•
	instructions)		, (****		
20. 00					20.00
21. 00	instructions) 00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)				21.00
22. 00					22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			35, 604	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions	s)	3, 116, 566	•
27. 00	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 2	22 and 23} (for	3, 273, 272	27. 00
28. 00	CAH, see instructions) Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			3, 273, 272	1
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			5, 965 3, 267, 307	1
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)		3, 201, 301	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	
34.00	Allowable bad debts (see instructions)			979, 977	1
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		744, 783 837, 374	1
37. 00	Subtotal (see instructions)	.01.01.0)		4, 012, 090	37.00
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 30	Partial or full credits received from manufacturers for replace		ıcti ons)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
40.00	Subtotal (see instructions)				40.00
40. 01 41. 00					40. 01 41. 00
42. 00					42.00
43.00	Balance due provider/program (see instructions)			46, 172	1
44. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	318, 296	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	1
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)			0	1

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/28/2015	11:53 am Health Financial Systems 10 He Provi der CCN: 151306

					5/28/2015 11:	53 am
		Ti tl	e XVIII	Hospi tal	Cost	
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3.00	4, 00	
1. 00	Total interim payments paid to provider		746, 19)2	3, 885, 676	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
	Provider to Program		•			
3. 50 3. 51 3. 52 3. 53	ADJUSTMENTS TO PROGRAM			0 0 0 0 0	0 0 0	3. 50 3. 51 3. 52 3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 54 3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		746, 19	02	3, 885, 676	4.00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 00
E 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 01 5. 02 5. 03				0	0	5. 01 5. 02 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 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		245, 02	25	46, 172	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6.02
7.00	Total Medicare program liability (see instructions)		991, 21	7	3, 931, 848	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2. 00	
8. 00	Name of Contractor					8.00

Health Financial Systems 10 He Provi der CCN: 151306 | Peri od: From 01/01/2014 | Part | From 01/01/2014 | Part | Date/Time Prepared: 5/28/2015 11: 53 am

					5/28/2015 11:	53 am
				ving Beds - SNF		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		14, 399		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	
3. 03			0		0	
3. 04			0		0	
3. 05			0		0	3.05
	Provi der to Program		_		_	
3. 50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			0		0	
3. 53			0		0	
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4 00	3. 50-3. 98)		14 200		0	1 4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		14, 399		0	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					-
5. 00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5. 02			Ō		Ö	
5. 03			0		0	
	Provider to Program				<u>'</u>	
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 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		4, 357		0	6.01
6. 02	SETTLEMENT TO PROGRAM		4, 337			
7. 00	Total Medicare program liability (see instructions)		18, 756			
,. 00	Trotal modificate program frability (see instructions)		10,730	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8.00
				i I	1	

Heal th	Financial Systems	IU HEALTH PAOLI HO	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151306 Period:					
				To 12/31/2014	Date/Time Pre	
-					5/28/2015 11:	53 am_
			Title XVIII	Hospi tal	Cost	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDA					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION	ON AND CALCULATION				
1.00	Total hospital discharges as defined in AARA	A §4102 from Wkst. S	S-3, Pt. I col. 15 line	e 14	386	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6	sum of lines 1, 8-1	12		381	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col	. 6. line 2			26	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8	sum of lines 1, 8-1	12		845	4.00
5.00	Total hospital charges from Wkst C, Pt. I, o	col. 8 line 200			54, 996, 790	5.00
6.00	Total hospital charity care charges from Wks	st. S-10, col. 3 lin	ne 20		3, 425, 390	6.00
7. 00	CAH only - The reasonable cost incurred for	the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	o	7.00
	line 168	•	03			
8. 00	Calculation of the HIT incentive payment (se	ee instructions)			ol	8.00
9.00	Sequestration adjustment amount (see instruc	ctions)			ol	9. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					0	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH						
30.00	Initial/interim HIT payment adjustment (see	instructions)			0	30.00
31. 00 Other Adjustment (specify)					ol	
	3 '1 3'	nus line 30 and lin	ne 31) (see instruction	ns)	0	32.00
	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)					

Health Financial Systems	IU HEALTH PAOLI H	OSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 151306		Worksheet E-2
		Component CCN: 15Z306	From 01/01/2014 To 12/31/2014	
				5/28/2015 11:53 am

		component con: 152306	10 12/31/2014	5/28/2015 11:	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		15, 152	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A,		3, 987	0	3.00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instru				
4. 00	Per diem cost for interns and residents not in approved teachir	ig program (see		0. 00	4.00
	instructions)				
5.00	Program days		7	0	5.00
6. 00	Interns and residents not in approved teaching program (see ins			0	6. 00
7.00	Utilization review - physician compensation - SNF optional meth	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		19, 139	0	0.00
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		19, 139	0	1
11. 00	Deductibles billed to program patients (exclude amounts applica	ıble to physician	0	0	11.00
	professional services)				
	Subtotal (line 10 minus line 11)		19, 139	0	
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0	0	13.00
	for physician professional services)			_	
	80% of Part B costs (line 12 x 80%)				14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14	.)	19, 139	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instru	icti ons)	0	0	
	Total (see instructions)		19, 139	0	
	Sequestration adjustment (see instructions)		383	0	
	Interim payments		14, 399	0	
	Tentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, ar		4, 357	0	
23. 00	Protested amounts (nonallowable cost report items) in accordanc §115.2	e with CMS Pub. 15-2,	949	0	23.00

Health Financial Systems	IU HEALTH PAOLI HOS	SPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	F	Provi der CCN: 151306	From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/28/2015 11:53 am

				5/28/2015 11:	53 am
		Title XVIII	Hospi tal	Cost	
			1.00		
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE F	PART A SERVICES - COST	T REI MBURSEMENT		
1.00	Inpatient services			1, 075, 164	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2.00
3. 00	Organ acquisition			0	3.00
4. 00	Subtotal (sum of lines 1 through 3)				4.00
5. 00	Primary payer payments			1, 075, 164 0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 085, 916	1
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1,000,710	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7.00
8. 00	Ancillary service charges			0	8.00
9. 00	Organ acquisition charges, net of revenue			Ö	9.00
10.00				0	10.00
10.00	Customary charges			0	10.00
11. 00		avment for services on	a charge hasis	0	11.00
12. 00	Amounts that would have been realized from patients liable for				12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services of	on a charge basis		12.00
13. 00				0. 000000	13 00
14. 00	Total customary charges (see instructions)			0.000000	14.00
15. 00					•
13.00	instructions)	y II IIIle 14 exceeds II	116 0) (366	0	13.00
16. 00	Excess of reasonable cost over customary charges (complete only	wifline 6 exceeds lin	ne 14) (see	0	16.00
10.00	instructions)	y II IIIIc o cacceds III	10 14) (300	· ·	10.00
17 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	17. 00
.,, 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	401.01.07			
18. 00		line 49)		0	18. 00
19. 00				1, 085, 916	•
20. 00	Deductibles (exclude professional component)			128, 864	•
21. 00				0	1
22. 00	Subtotal (line 19 minus line 20 and 21)			957, 052	
23. 00	Coi nsurance			0	23.00
24. 00	Subtotal (line 22 minus line 23)			957, 052	
25. 00				71, 571	1
26. 00	Adjusted reimbursable bad debts (see instructions)	cs) (see Thisti deti ons)		54, 394	1
27. 00				50, 562	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	actions)		1, 011, 446	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1,011,440	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	\		0	29.50
29. 99	Recovery of Accelerated Depreciation)		0	29. 99
30.00	Subtotal (see instructions)			1, 011, 446	
30. 00				20, 229	1
31. 00				746, 192	1
31.00				746, 192	32.00
32.00	Tentative settlement (for contractor use only) Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			245, 025	•
34.00	Protested amounts (nonallowable cost report items) in accordance	,	chapter 1		1
34.00	§115. 2	Se with GWS Pub. 15-2,	спартег т,	53, 794	34.00
	13110.2			ļ	I

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

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

			10	12/31/2014	5/28/2015 11:	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1 00	Purpose Fund	Fund	4 00	
	OUDDENT ACCETO	1.00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	10, 952, 874	0	ol	0	1.00
2. 00	Temporary investments	10, 432, 874		0	0	2.00
3. 00	Notes recei vabl e	٥		0	0	
4. 00	Accounts recei vabl e	6, 576, 411	Ö	Ö	0	4. 00
5.00	Other receivable	0	О	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4, 312, 431	0	0	0	6.00
7.00	Inventory	544, 077		0	0	7. 00
8. 00	Prepai d expenses	255, 270	1	0	0	8. 00
9.00	Other current assets	1, 403, 711		0	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	0 15, 419, 912	1	0 0	0	
11.00	FIXED ASSETS	15, 419, 912	l U	<u> </u>	0	11.00
12. 00	Land	0	0	O	0	12.00
13. 00	Land improvements	Ö		o	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Bui I di ngs	15, 661, 915	0	0	0	15.00
16.00	Accumulated depreciation	-8, 804, 121	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0	0	0	0	20. 00 21. 00
22. 00	Accumulated depreciation			0	0	22.00
23. 00	Major movable equipment	0		0	0	23.00
24. 00	Accumulated depreciation	Ö		o	0	24.00
25. 00	Mi nor equi pment depreciable	o	0	O	0	25. 00
26.00	Accumulated depreciation	0	O	O	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	6, 857, 794	0	0	0	30.00
31. 00	OTHER ASSETS Investments	19, 297, 298	0	ol	0	31.00
32. 00	Deposits on Leases	19, 297, 290		0	0	32.00
33. 00	Due from owners/officers	0		o	0	•
34. 00	Other assets	100	-	Ö	0	34.00
35.00	Total other assets (sum of lines 31-34)	19, 297, 398	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41, 575, 104	0	0	0	36.00
	CURRENT LI ABI LI TI ES		T			
37. 00	Accounts payable	926, 957		0	0	37.00
38.00	Salaries, wages, and fees payable Payroll taxes payable	843, 047	0	0	0	38.00
39. 00 40. 00	Notes and Loans payable (short term)	0		0	0	39. 00 40. 00
41. 00	Deferred income	0		0	0	•
42. 00	Accel erated payments	Ö		J	١	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1, 956, 279		0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3, 726, 283	0	0	0	45. 00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	
47.00	Notes payable Unsecured Loans	0		0	0	•
48. 00 49. 00	Other long term liabilities	35, 567		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49	35, 567		0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3, 761, 850		o	0	
	CAPITAL ACCOUNTS	, , , , , , , , , , , , , , , , , , , ,	· · · · · · · · · · · · · · · · · · ·	- 1		
52.00	General fund balance	37, 813, 254				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	ļ	55.00
56.00	Governing body created - endowment fund balance			0	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
50.00	replacement, and expansion				O ₁	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	37, 813, 254	О	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	41, 575, 104		o	0	1
	59)				ļ	

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH PAOLI HOSPITAL STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 151306 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 11:53 am General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 31, 182, 648 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 7, 051, 889 2.00 2.00 3.00 Total (sum of line 1 and line 2) 38, 234, 537 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0 0 0 0 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 Subtotal (line 3 plus line 10) 38, 234, 537 0 11.00 11.00 12.00 ROUNDI NG 0 12.00 13.00 RELATED PARTY 421, 280 0 13.00 14.00 0 0 0 14.00 15.00 0 15.00 0 16.00 0 16.00 17.00 0 17.00 18.00 Total deductions (sum of lines 12-17) 421, 283 18.00 Fund balance at end of period per balance 19.00 37, 813, 254 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 0 3.00 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 ROUNDI NG 12.00 12.00 13.00 RELATED PARTY 0 13.00 0 14.00 14.00

0

0

0

0

15.00

16.00 17.00

18.00

19.00

15.00

16.00

17.00

18.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet G-2 | From 01/01/2014 | Parts I & II | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | To 12/31/2 Health Financial Systems I STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 151306

			10 12/31/2014	5/28/2015 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	
		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	1, 106, 00	05	1, 106, 005	1.00
2.00	SUBPROVI DER - I PF		0	0	2.00
3.00	SUBPROVI DER - I RF		0	0	3. 00
4.00	SUBPROVI DER		0	0	4.00
5.00	Swing bed - SNF	3, 79		3, 794	5. 00
6. 00	Swing bed - NF		0	0	6. 00
7. 00	SKILLED NURSING FACILITY		0	0	7. 00
8. 00	NURSI NG FACILI TY		0	0	8. 00
9.00	OTHER LONG TERM CARE	4 400 7	0	0	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	1, 109, 79	99	1, 109, 799	10. 00
11 00	Intensive Care Type Inpatient Hospital Services			1 0	11 00
11. 00 12. 00	INTENSIVE CARE UNIT		0	0	11. 00 12. 00
13. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		0	0	13.00
14. 00	SURGICAL INTENSIVE CARE UNIT		0	0	
15. 00	OTHER SPECIAL CARE (SPECIFY)		o e	0	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	16.00
10.00	11-15)				10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 109, 79	99	1, 109, 799	17.00
18. 00	Ancillary services	3, 336, 42			18.00
19. 00	Outpati ent servi ces	0,000,1	0 873, 461	873, 461	19.00
20.00	· ·		0 0		20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	_	21.00
22. 00	HOME HEALTH AGENCY		0	0	22.00
23. 00	AMBULANCE SERVICES		0 0	0	23. 00
24. 00	CMHC		0	0	24.00
24. 10	CORF		0 0	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P.)		0 0	0	25. 00
26.00	HOSPI CE		0 0	0	26.00
27.00	CASH COLLECTIONS	55	13, 139	13, 694	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 4, 446, 78	50, 563, 703	55, 010, 485	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		19, 525, 255		29. 00
30. 00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34.00			0		34.00
35.00	Table 11111 (.		0		35.00
36.00	Total additions (sum of lines 30-35)	40.00	0		36.00
37. 00 38. 00	DEPRECIATION ADJ HISTORICAL VS GAAP	49, 32			37.00
38.00			0		38. 00 39. 00
40. 00			0		40.00
41.00			0		40.00
41.00	Total deductions (sum of lines 37-41)		49, 321		41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	sfer	19, 475, 934		43.00
10.00	to Wkst. G-3, line 4)		17, 475, 754		10.00
	1,	T .	1	1	

Heal th	Ith Financial Systems IU HEALTH PAOLI HOSPITAL In Lie		u of Form CMS-2552-10			
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 151306				
			From 01/01/2014			
To 12/31/2014					pared: 53 am	
				37 207 2013 11.	JJ dili	
				1. 00		
1. 00	1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				1.00	
2.00	Less contractual allowances and discounts on patients' accounts			28, 893, 227	2.00	
3.00	Net patient revenues (line 1 minus line 2)			26, 117, 258	3.00	
4.00	Less total operating expenses (from Wkst. G-2	2, Part II, line 43)		19, 475, 934	4.00	
5.00	Net income from service to patients (line 3 m	ninus line 4)		6, 641, 324	5.00	
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	7.00 Income from investments			0	7. 00	
8.00	8.00 Revenues from telephone and other miscellaneous communication services			0	8. 00	
9.00	.00 Revenue from television and radio service			0	9. 00	
10.00	Purchase di scounts			0	10.00	
11. 00	Rebates and refunds of expenses			0	11.00	
12.00	Parking lot receipts			0	12.00	
13.00	3.00 Revenue from laundry and linen service			0	10.00	
14.00	1.00 Revenue from meals sold to employees and guests			0	00	
15. 00	00 Revenue from rental of living quarters			0		
16. 00				0	10.00	
17. 00				0	17.00	
18. 00				0	10.00	
	9.00 Tuition (fees, sale of textbooks, uniforms, etc.)			0		
20. 00	Revenue from gifts, flowers, coffee shops, ar	nd canteen		0		
21. 00	Rental of vending machines			0	21.00	
22. 00				0	22.00	
23. 00				0	23. 00	
24. 00	MI SC I NCOME			410, 565	24.00	

410, 565 7, 051, 889

0 27.00

7, 051, 889 29. 00

25. 00 26. 00

28.00

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

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

27.00 OTHER EXPENSES (SPECIFY)