Heal th Financial	Systems
-------------------	---------

IU HEALTH PAOLI HOSPITAL

In Lieu of Form CMS-2552-10

This report is	required by I aw (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider CCN: 15-1306		Worksheet S Parts I-III Date/Time Prepared: 5/24/2017 10:40 am
PART I - COST	REPORT STATUS			
Provi der	 [X] Electronically filed cost report 		Date: 5/24/20	17 Time: 10:40 am
use only	2. [] Manually submitted cost report			
	3. [0]If this is an amended report enter the number 4. [F]Medicare Utilization. Enter "F" for full or "L		esubmitted this co	ost report
Contractor use only	 5. [1] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended (5) Amended (6) Date Received: (6) Date Received: (7) Contractor No. (8) Date Received: (9) Date Received: (1) Date Received: (1) Date Received: (2) Date Received: (3) Date Received: (4) Report for 	n this Provider CCN 12.		

PART II - CERTIFICATION

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 (15-1306) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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.

(0)				
(SI	α	ne	d)	

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

05/24/2017 Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-24, 480	-92, 333	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	7, 399	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
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
200.00	Total	0	-17,081	-92, 333	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.

PLI	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	TA	Provi de	er CCN: 1	5-1306	Period: From 01/01	/2016	Worksh Part I	eet S-2	2
									Date/T		
	1.00	2.	00		3.00			4.00	5/23/2	017 12:	41 0
	Hospital and Hospital Health Care Co	mplex Address:									
	Street: 642 WEST HOSPITAL ROAD	PO Box:									1
0	City: PAOLI	State: I Component Na		p Code CCN	: 47454 CBSA	Provi der	ty: ORANGE Date	Payme	ent Syst	tem (P	2
		component na		mber	Number	Type	Certified		, 0, or		
								V	XVIII	XI X]
	Uponital and Uponital Deced Company	1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
0	<u>Hospital and Hospital-Based Componen</u> Hospital	IU HEALTH PAOLI		1306	99915	1	07/01/200	1 N	0	Р	3
0		HOSPITAL		1000	,,,,,,		0,7017200				
C	Subprovider - IPF										4
	Subprovider - IRF Subprovider - (Other)										5
	Swing Beds - SNF	IUHP SWING BEDS	15	Z306	99915		07/01/200	I N	0	N	7
	Swing Beds - NF										8
)	Hospital-Based SNF										9
00 00	Hospi tal -Based NF Hospi tal -Based OLTC										10
00	Hospital-Based HHA										12
00	Separately Certified ASC										13
00	Hospi tal -Based Hospi ce										14
00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15
00	Hospi tal -Based (CMHC) I		-								17
00	Renal Dialysis										18
00	Other						From	.	To		19
							1.0		2.		1
)0	Cost Reporting Period (mm/dd/yyyy)						01/01/2	2016		/2016	20
00	Type of Control (see instructions)						2				21
00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	/ing navmen	ts for	disnron	ortionate	N N		N	J	22
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil				2.106(c)	(2) (Pi ckl	е				
D1	amendment hospital?) In column 2, en Did this hospital receive interim un				s cost r	oportina	N		N	J	22
01	period? Enter in column 1, "Y" for y						IN IN			v	22
	reporting period occurring prior to										
	for no for the portion of the cost r (see instructions)	eporting period o	occurring o	n or a	fter Oct	ober 1.					
)2	is this a newly merged hospital that	requires final u	uncompensat	ed car	e paymen	ts to be	N		Ν	J	22
	determined at cost report settlement						s				
	or "N" for no, for the portion of th		• •								
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on of the	COST F	eporting	period o	'n				
	Did this hospital receive a geograph								M	l l	22
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column						e				
	cost reporting period occurring on o										
	hospital contain at least 100 but no			unted	n accor	dance wit	h				
00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			/or 25	bel ow?	In column		2	Ν	J	23
	1, enter 1 if date of admission, 2 i							-			
	method of identifying the days in th										
	used in the prior cost reporting per		In-State	In-St		N <u>r for no</u> Nut-of		Medi ca	id 0)ther	
			Medi cai d	Medi c		State		HMO da		di cai d	
			paid days	eligi			Medicaid		0	days	
				unpa day		id days	eligible unpaid				
			1.00	2.0		3.00	4. 00	5.00		6.00	1
0	If this provider is an IPPS hospital		0		0	0	0		0		24
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu	t unpaid days in									
		column 6.			0	0	o		o		25
	column 5, and other Medicaid days in	a in_stata							01		
00			0								20
00	column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	in-state umn 2,	0								20
00	column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	in-state umn 2, 3, out-of-state	U								20

		LI HOSPITAL			eu of Form CN	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	A I A	Provider CC	F	eriod: rom 01/01/2016		
			1	o 12/31/2016	5/23/2017 1	12:41 pm
				Urban/Rural S	5 Date of Geo 2.00	ogr
26.00 Enter your standard geographic classification (not wa			inning of the		2	26.00
 cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or 	age) sta r "2" fo	atus at the enc or rural. If ap			2	27.00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0	35.00
				Begi nni ng: 1. 00	Endi ng: 2.00	
36.00 Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number	1.00	2.00	36.00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	ls MDH status		0	37.00
37.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N		37.01
38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.						38.00
				Y/N	Y/N	
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec	i)? Ente	er in column 1	"Y" for yes	1.00 N	2.00 N	39.00
40.00 [Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	or "N" nadjus	for no. (see i tment? Enter "Y	nstructions) " for yes or	N	N	40.00
no in column 2, for discharges on or after October 1.		,		V 1.0		
Prospective Payment System (PPS)-Capital						
45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for (di sproporti onat	e share in acc	cordance N	N N	45.00
46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N N	46.00
47.00 Is this a new hospital under 42 CFR §412.300 PPS capi 48.00 Is the facility electing full federal capital payment Teaching Hospitals						
56.00 Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" 1	for yes N		56.00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	r yes o th of th Y", comp	r "N" for no ir nis cost report plete Worksheet	n column 1. lf ing period? l	column 1 Enter "Y"		57.00
58.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15–1, chapter 21, §2148? If yes,			ins' services a	as		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes 60.00 Are you claiming nursing school and/or allied health	s, compl costs t	ete Wkst. D-2, for a program t	hat meets the	N N		59.00 60.00
provider-operated criteria under §413.85? Enter "Y"	Y/N	IME	Direct GME	I ME	Direct GMI	E
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.0		. 00 61. 00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0. OC	0.0	d		61.01
 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of 		O. OC	0.0	þ		61.02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. OC	0. 0	c		61. 03
instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	þ		61.04
current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0. OC	0.0	d		61.05

JSPITAL AND HUSPIT	AL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA	Provider CC		riod: om 01/01/2016	Worksheet S-2 Part I	
					To			
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3. 00	4.00	5.00	
used for cap	ount of ACA §5503 aw relief and/or FTEs ral surgery. (see in	that are nonprimary		0.00	0.00			61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
specialty, in for each new column 1, the program code,	n line 61.05, speci f any, and the numbe program. (see instr e program name, ente enter in column 3, punt and enter in co ed count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
1.20 Of the FTEs i program speci residents fou instructions; enter in colu 3, the IME F	in line 61.05, speci alty, if any, and t reach expanded prog) Enter in column 1, umn 2, the program c	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0. 00	61.
							1.00	
		Ith Resources and Ser						
		s that your hospital funding (see instruc		I IN THIS COST	reporting peri	od for which	0.00	62.
during in thi	s cost reporting pe	s that rotated from a riod of HRSA THC proc sidents in Nonprovide	gram. (s	ee instruction		your hospital	0.00	62.
3.00 Has your faci	lity trained reside	umn 1. If yes, comple	ettings	during this co		eriod? Enter	N	63.
					Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				-	Si te 1.00	2.00	3.00	
		r FTE Residents in No July 1, 2009 and befor			his base year	is your cost r	eporting	
4.00 Enter in colu in the base resident FTE settings. En resident FTE	umn 1, if line 63 is year period, the num s attributable to ro nter in column 2 the s that trained in yo	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	y train -primar all nor non-pr columr instruc	ed residents ry care provider imary care 3 the ratio tions)	0. 00	0. 00	0. 000000	64.
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
00 Enter in cal	mp 1 if line (2	1.00		2.00	3.00	4.00	5.00 0.000000	45
is yes, or ye trained resid year period, associated wi FTEs for eacl program in wi residents. En the program o column 3, the unweighted pu residents at rotations occ	dents in the base the program name th primary care n primary care nich you trained ther in column 2, code, enter in				0.00	0.00	0.00000	05.

Financial Systems			1			
AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provider C	F	rom 01/01/2016	Part I	pared:
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Year FTE Residents ir	n Nonprovider Setting				
Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident 3 the ratio of	0.00	0. 00	0. 000000	66. 00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
Fatan in column 1, the average	1.00	2.00	3.00	4.00	5.00	(7.00
Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00		67.00
				1.0	0 2 00 3 00	
Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no	ychiatric Facility (I			provider? N	0	70.00
recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	ves or "N" for r s in a new teach ves or "N" for r	no. (see ni ng no.		
Is this facility an Inpatient Re	habilitation Facility	/(IRF), or does it c	contain an IRF	N		75.00
If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42	0	76.00
					1.00	
Is this a LTCH co-located within "Y" for yes and "N" for no.				period? Enter	N N	80. 00 81. 00
Is this a new hospital under 42 Did this facility establish a ne	w Other subprovider ((excluded unit) under			N	85. 00 86. 00
Is this hospital a "subclause (I			(1)(B)(iv)(II)?	'Enter "Y"	N	87.00
				V	XIX	
Title V and XIX Services				1.00	2.00	
Does this facility have title V		hospital services? E	nter "Y" for	N	Y	90.00
Is this hospital reimbursed for	title V and/or XIX th			N	N	91.00
Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certificat			N	92.00
			nd XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the	applicable column.			N	N	94.00
	Section 5504 of the ACA Current beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + Column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility P Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facility Is this facility an Inpatient Re subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega Long Term Care Hospital PPS Is this a long term care hospita Is this a long term care hospita Is this a litt co-located within "Y" for yes and "N" for no. TEFRA Providers Is this nospital a "subclause (I for yes or "N" for no in the subla this facility have title V yes or "N" for no in the applica Is this hospital a "subclause (I for yes or "N" for no in the subclause (I for yes or "N" for no is this hospital reimbursed for full or in part? Enter "Y" for yes Does this facility have title V yes or "N" for no in the poes title V or XIX reduce capit Does title V or XIX reduce capit Does title V or XIX reduce capit	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA Section 5504 of the ACA Current Year FTE Residents in beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primar FTEs that trained in your hospital. Enter in column 2 the number of unweighted non-primar FTEs that trained in your hospital. Enter in column 3 (column 1 divided by (column 1 + column 2)). (see instructions occurring in all non-provider settings. Enter in column 2, the program name associated with each of your primary care programs in which you train edresidents. Enter in column 3, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 4, the number of unweighted primary care resident for (column 3 divided by (colum 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IEnter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an agreent cost report filed on or before November 15, 24 24 CR 412.424 (d)(1)(ii)(C)) Colum 2; Did this facility train residents in a cordance with 42 CFR 412.424 (d)(1)(ii)(C) Colum 2; Did this facility train residents in a CFR 412.424 (d)(1)(ii)(C)? Enter "Y" for yes or "N" for no. If line 75 yes: Column 1: Did the facility have an agreent cost reporting period ending on or before November 15, 24 24 CR 412.424 (d)(1)(ii)(C)? Colum 2; Did this facility train residents in a CFR 412.424 (d)(1)(ii)(C)? Colum 2; Did this facility train residents in a CFR 412.424 (d)(1)(C)(D)? Enter "Y" for yes or "N" for no.	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C Section 5504 of the ACA Current Year FIE Residents in Nonprovider Setting Description Beignming on or after July 1, 200 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in colum 3 the ratio of (column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Name Program Code Nuch Chaines Column 1, the program name associated with each of your primary care programs in which you trained residents. Program Name Enter in column 1, the program code in trained residents. Enter in column 3 the number of unweighted primary care residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of numelent Psychiatric Facility (IPF), or does it contents of your primary care programs in will of the of (column 3 the ratio of (column 3 the ratio of (column 3 the ratio of your specified primary care instructions) Inpatient Psychiatric Facility PPS Is this facility an inpatient Psychiatric Facility (IPF), or does it contents of your primery care programs in accordance with 42 CFR 412.424 (d) (1)(11)(1) (C) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d) (1)(11)(1)(2)? Column 7: for yes and "N" for no. If line 70 yes; column 1: Did the facility have an approved GME teaching recent cost reporting priod	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCR: 15-1306 Provider CCR: 15-130	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CX: 15-336 Period: To 12/2016 Period:	ALL AND MODERIAL HEALTAL CASE COMPLEX INFINITE CATION DATA Provider COX 15-1300 <

lealth Financial Systems IU HEALTH PAO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	Period: From 01/01/2 To 12/31/2	2016	u of For Workshe Part I Date/Ti 5/23/20	et S-2 me Pre	2 epared:
			V		XI 2		
			1.00		2.0		
5.00 If line 94 is "Y", enter the reduction percentage in the apple.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N		0. C N		95.00 96.00
7.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	•	n.	0.00		0. C	0	97.00
05.00 Does this hospital qualify as a critical access hospital (CA 06.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	Y N				105. 0 106. 0
07.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col- reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see insti	ructions) lf	N				107.0
08.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y		Deenir		108.0
	Physi cal 1.00	Occupational 2.00	Speech 3.00	1	Respir 4.0		-
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N		N		109. 0
10.00 Did this hospital participate in the Rural Community Hospit: the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for		1. C N		110. 0
			-	1.00	0 2.00	3.00	_
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider	. If column 2 i nt for long te	is "E", enter rm care (inclu	in column des	N		0	115. 0
Pub. 15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insu- no.			"N" for	N N			116. 0 117. 0
18.00 is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	if the policy	is	1			118.0
		Premi ums	Losses	5	Insura	ance	
		1.00	2.00		3. C		_
18.01 List amounts of malpractice premiums and paid losses:		49,00	3	0		(0118.0
			1.00		2.0	0	-
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein. 19.00 D0 NOT USE THIS LINE			N				118.0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y ualifies for th	" for yes or he Outpatient	N		N		120. 0
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y				121.0
22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.			N				122. 0
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" fo	or yes and "N"	for no. If	N				125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 3		fication date					126. 0
27.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 3	ter the certifi 2.						127.0
 28.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 29.00 If this is a Medicare certified lung transplant center, entitied 	2.						128.0
column 1 and termination date, if applicable, in column 2.							130. 0
		tification					
 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, en 	lumn 2. r, enter the co lumn 2.	erti ficati on					131. 0

	X IDENTIFICATION DATA	I HOSPITAL Provider CCN:	15-1306	Peri od:		u of Form CMS Worksheet S	
	A IDENTIFICATION DATA	TTOVIDET CON.	13-1300	From 01/0	1/2016 1/2016	Part I	repared:
						0/20/2017 11	
				1. (00	2.00	
33.00 If this is a Medicare certified of in column 1 and termination date,	if applicable, in column 2						133.00
4.00 If this is an organ procurement or and termination date, if applicabl All Providers		e OPO number in (column 1				134.00
0.00 Are there any related organization chapter 10? Enter "Y" for yes or '	'N" for no in column 1. If	yes, and home of	fice costs	Y	,	15H059	140. 00
are claimed, enter in column 2 the 1.00			15)		3.00		
If this facility is part of a chai			143 the n			of the	
home office and enter the home off 1.00 Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WIS	CONSIN PHYSICIAN	Contract	or's Numbe	er: 0810	1	141.00
12.00Street: 340 WEST TENTH STREET	PO Box:	RVICES					142.00
3.00 City: INDIANAPOLIS	State: IN		Zip Code		4620	4	142.00
				•	1020		110.00
						1.00	
14.00 Are provider based physicians' cos	sts included in Worksheet A	?				Y	144.00
				1. (20	2.00	_
15.00 If costs for renal services are cl	aimed on Wkst A line 74	are the costs fo	or.	1.0		2.00 N	145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	' for yes or "N" for no in o clude Medicare utilization	column 1. If colu	umn 1 is			Ň	143.00
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	gy changed from the previous n column 1. (See CMS Pub. 19			N	l		146. 0
						1 00	_
17.00Was there a change in the statisti	cal basis? Enter "V" for y	es or "N" for no				1.00 N	147.00
18.00 Was there a change in the order of						N	148.00
19.00Was there a change to the simplifi				no.		N	149.00
	-	Part A	Part B	Titl		Title XIX	_
Does this facility contain a provi	der that qualifies for an	1.00	2.00	3.	00	4.00	_
Does this facility contain a provi or charges? Enter "Y" for ves or '		1.00 exemption from t	2.00 he applica	3. tion of t	00 he lowe	4.00 r of costs	-
or charges? Enter "Y" for yes or '		1.00 exemption from t	2.00 he applica	3. tion of t	00 he Lowe FR §413	4.00 r of costs	
<u>or charges? Enter "Y" for yes or '</u> 55.00 Hospi tal 66.00 Subprovi der - IPF		1.00 exemption from t nt for Part A an Y N	2.00 he applica d Part B. Y N	3.0 1tion of t (See 42 C) N	00 he Lowe FR §413 I	4.00 r of costs .13) N N	155. 00 156. 00
or charges? Enter "Y" for yes or ' 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF		1.00 exemption from t nt for Part A an Y	2.00 he applica d Part B. Y	3.0 Ition of t (See 42 C	00 he Lowe FR §413 I	4.00 r of costs .13) N	155. 00 156. 00 157. 00
or charges? Enter "Y" for yes or ' 55.00 Hospi tal 66.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER		1.00 exemption from t nt for Part A an Y N N N	2.00 he applica d Part B. Y N N N	3. ution of the second	00 he Lowe FR §413 J J	4.00 r of costs .13) N N N	155. 00 156. 00 157. 00 158. 00
or charges? Enter "Y" for yes or ' 55.00 Hospi tal 66.00 Subprovi der - I PF 57.00 Subprovi der - I RF 58.00 SUBPROVI DER 59.00 SNF		1.00 exemption from t nt for Part A an Y N N Y	2.00 he applica d Part B. Y N N N	3. u ition of th (See 42 C N N N	00 he Lowe FR §413 J J	4.00 r of costs .13) N N N	155.00 156.00 157.00 158.00 158.00 159.00
or charges? Enter "Y" for yes or ' 55.00 Hospi tal 66.00 Subprovi der - I PF 57.00 Subprovi der - I RF 88.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY		1.00 exemption from t nt for Part A an Y N N N	2.00 he applica d Part B. Y N N Y N	3.0 Ition of the See 42 C M M M M	00 he Lowe FR §413 J J J	4.00 r of costs .13) N N N N	155.00 156.00 157.00 158.00 159.00 160.00
or charges? Enter "Y" for yes or ' 55.00 Hospi tal 66.00 Subprovi der - I PF 57.00 Subprovi der - I RF 88.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY		1.00 exemption from t nt for Part A an Y N N Y	2.00 he applica d Part B. Y N N N	3. u ition of th (See 42 C N N N	00 he Lowe FR §413 J J J	4.00 r of costs .13) N N N	155.00 156.00 157.00 158.00 159.00 160.00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 88.00 SUBPROVIDER 99.00 SNF 60.00 HOME HEALTH AGENCY		1.00 exemption from t nt for Part A an Y N N Y	2.00 he applica d Part B. Y N N Y N	3.0 Ition of the See 42 C M M M M	00 he Lowe FR §413 J J J	4.00 r of costs .13) N N N N	155.00 156.00 157.00 158.00 159.00 160.00
or charges? Enter "Y" for yes or ' 55.00 Hospi tal 56.00 Subprovi der - I PF 57.00 Subprovi der - I RF 58.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Mul ti campus	"N" for no for each compone	1.00 exemption from t nt for Part A an Y N N Y N	2.00 he applica d Part B. Y N N Y N N	3. 1 ttion of tl (See 42 C N N N N N	00 he Iowe FR §413 I I I I	4.00 r of costs .13) N N N N N N 1.00	155.00 156.00 157.00 158.00 159.00 160.00 161.00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 88.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica	"N" for no for each compone	1.00 exemption from t nt for Part A an Y N N Y N	2.00 he applica d Part B. Y N N Y N N	3. 1 ttion of tl (See 42 C N N N N N	00 he Iowe FR §413 I I I I	4.00 r of costs .13) N N N N N N	155.00 156.00 157.00 158.00 159.00 160.00 161.00
or charges? Enter "Y" for yes or ' 55.00 Hospi tal 56.00 Subprovi der - I PF 57.00 Subprovi der - I RF 58.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Mul ti campus	"N" for no for each compone	1.00 exemption from t nt for Part A an Y N N Y N Or more campuses	2.00 he applica d Part B. Y N Y N Y N S in diffe	3.1 Ition of ti (See 42 C N N N N N N N N	00 he I owe FR §413 I I I I I S?	4.00 r of costs .13) N N N N N N 1.00	155.00 156.00 157.00 158.00 159.00 160.00 161.00 161.00
or charges? Enter "Y" for yes or ' 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica	"N" for no for each compone ampus hospital that has one Name	1.00 exemption from t nt for Part A an Y N Y N Y N or more campuses	2.00 he applica d Part B. Y N Y N N s in diffe State Zi	3.1 Ition of ti (See 42 C N N N N N N N N N N Prent CBSAs	00 he I owe FR §413 I I I I I S? CBSA	4.00 r of costs .13) N N N N N N 1.00 T.00	155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	"N" for no for each compone	1.00 exemption from t nt for Part A an Y N N Y N Or more campuses	2.00 he applica d Part B. Y N Y N N s in diffe State Zi	3.1 Ition of ti (See 42 C N N N N N N N N N P Code	00 he I owe FR §413 I I I I I S?	4.00 r of costs .13) N N N N N 1.00 FTE/Campus 5.00	155. 00 156. 00 157. 00 158. 00 159. 00 160. 00 161. 00 165. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 88.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 50.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column	"N" for no for each compone ampus hospital that has one Name	1.00 exemption from t nt for Part A an Y N Y N Y N or more campuses	2.00 he applica d Part B. Y N Y N N s in diffe State Zi	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I I S? CBSA	4.00 r of costs .13) N N N N N 1.00 FTE/Campus 5.00	155. 00 156. 00 157. 00 158. 00 159. 00 160. 00 161. 00 165. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 88.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 50.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	"N" for no for each compone ampus hospital that has one Name	1.00 exemption from t nt for Part A an Y N Y N Y N or more campuses	2.00 he applica d Part B. Y N Y N N s in diffe State Zi	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I I S? CBSA	4.00 r of costs .13) N N N N N 1.00 FTE/Campus 5.00	155. 00 156. 00 157. 00 158. 00 159. 00 160. 00 161. 00 165. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	"N" for no for each compone ampus hospital that has one Name	1.00 exemption from t nt for Part A an Y N Y N Y N or more campuses	2.00 he applica d Part B. Y N Y N N s in diffe State Zi	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I I S? CBSA	4.00 r of costs .13) N N N N N 1.00 FTE/Campus 5.00	155. 00 156. 00 157. 00 159. 00 160. 00 161. 00 165. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	"N" for no for each compone ampus hospital that has one Name	1.00 exemption from t nt for Part A an Y N Y N Y N or more campuses	2.00 he applica d Part B. Y N Y N N s in diffe State Zi	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I I S? CBSA	4.00 r of costs .13) N N N N N 1.00 FTE/Campus 5.00	155. 00 156. 00 157. 00 159. 00 160. 00 161. 00 165. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	"N" for no for each compone ampus hospital that has one Name	1.00 exemption from t nt for Part A an Y N Y N Y N or more campuses	2.00 he applica d Part B. Y N Y N N s in diffe State Zi	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I I S? CBSA	4.00 r of costs .13) N N N N N 1.00 TE/Campus 5.00 0.0	155. 00 156. 00 157. 00 159. 00 160. 00 161. 00 165. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	"N" for no for each compone ampus hospital that has one Name 0	1.00 exemption from t nt for Part A an Y N Y N Y N Or more campuses County 1.00	2.00 he applica d Part B. Y N Y N S in diffe State Zi 2.00	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I I S? CBSA	4.00 r of costs .13) N N N N N 1.00 FTE/Campus 5.00	155. 00 156. 00 157. 00 159. 00 160. 00 161. 00 165. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI	"N" for no for each compone ampus hospital that has one Name 0 T) incentive in the America	1.00 exemption from t nt for Part A an Y N Y N or more campuses County 1.00	2.00 he applica d Part B. Y N Y N S in diffe State Zi 2.00 ei nvestmen	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I I S? CBSA	4.00 r of costs .13) N N N N 1.00 TE/Campus 5.00 0.1	155. 00 156. 00 157. 00 158. 00 159. 00 160. 00 161. 00 165. 00 165. 00 166. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user	<pre>"N" for no for each compone ampus hospital that has one Name 0 T) incentive in the America r under §1886(n)? Enter "Y</pre>	1.00 exemption from t nt for Part A an Y N Y N Y N Y N Y N Y N Or more campuse: County 1.00 n Recovery and R " for yes or "N"	2.00 he applica d Part B. Y N Y N Y N S in diffe State Zi 2.00 ei nvestmen for no.	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I S? CBSA 4.00	4.00 r of costs .13) N N N N N 1.00 TE/Campus 5.00 0.0	155. 00 156. 00 157. 00 159. 00 160. 00 161. 00 165. 00 165. 00 166. 00 166. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10	<pre>"N" for no for each compone ampus hospital that has one Name 0 T) incentive in the America r under §1886(n)? Enter "Y 05 is "Y") and is a meaning</pre>	1.00 exemption from t nt for Part A an Y N Y N Y N Y N Y N Y N In Recovery and R " for yes or "N" full user (line 16)	2.00 he applica d Part B. Y N Y N Y N S in diffe State Zi 2.00 ei nvestmen for no.	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR §413 I I I I S? CBSA 4.00	4.00 r of costs .13) N N N N 1.00 TE/Campus 5.00 0.1	155. 00 156. 00 157. 00 159. 00 160. 00 161. 00 165. 00 165. 00 166. 00 166. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC 65.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 If this provider a meaningful user 68.00 If this provider is a CAH (line 10	<pre>"N" for no for each compone "N" for no for each compone ampus hospital that has one Name 0 T) incentive in the America r under §1886(n)? Enter "Y 55 is "Y") and is a meaning HT assets (see instruction:</pre>	1.00 exemption from t nt for Part A an Y N Y N Y N Or more campuses County 1.00 n Recovery and R " for yes or "N" ful user (line 16)	2.00 he applica d Part B. Y N Y N S in diffe State Zi 2.00 einvestmen for no. 57 is "Y")	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR <u>\$413</u> J J J J S? CBSA 4.00	4.00 r of costs .13) N N N N 1.00 TE/Campus 5.00 0.1	155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00
or charges? Enter "Y" for yes or ' 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	<pre>"N" for no for each compone "N" for no for each compone ampus hospital that has one Name 0 T) incentive in the America r under §1886(n)? Enter "Y 25 is "Y") and is a meaning HIT assets (see instruction: not a meaningful user, does</pre>	1.00 exemption from t nt for Part A an Y N Y N Y N Y N Or more campuses County 1.00 1.00 n Recovery and R "for yes or "N" ful user (line 16 s) this provider quitable	2.00 he applica d Part B. Y N Y N S in diffe State Zi 2.00 ei nvestmen for no. 67 is "Y") ualify for	A ct ct contact contac	00 he I owe FR <u>\$413</u> J J J J S? CBSA 4.00	4.00 r of costs .13) N N N N N 1.00 FTE/Campus 5.00 0.0	155. 00 156. 00 157. 00 159. 00 160. 00 161. 00 165. 00 165. 00 166. 00 166. 00 166. 00 167. 00 00 166. 00
or charges? Enter "Y" for yes or ' 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC	<pre>"N" for no for each compone ampus hospital that has one Name 0 T) incentive in the America r under §1886(n)? Enter "Y 25 is "Y") and is a meaning HIT assets (see instruction not a meaningful user, does ? Enter "Y" for yes or "N" user (line 167 is "Y") and</pre>	1.00 exemption from t nt for Part A an Y N Y N Y N Y N Or more campuses County 1.00 1.00 r for yes or "N" ful user (line 16) this provider que for no. (see instants)	2.00 he applica d Part B. Y N Y N S in diffe State Zi 2.00 einvestmen for no. 67 is "Y") ualify for	3.1 iti on of ti (See 42 C N N N N N N N N N N N N N	00 he I owe FR \$413 I I I I S? CBSA 4.00	4.00 r of costs .13) N N N N 1.00 TTE/Campus 5.00 0.0	155. 0(156. 0(157. 0(159. 0(159. 0(160. 0(161. 0(165. 0(165. 0(000 166. 0(167. 0(0168. 0(

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFIC	ATION DATA	Provider CCN: 15-1306	Period: From 01/01/2016	Worksheet S-2 Part I	2
			To 12/31/2016		
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning da period respectively (mm/dd/yyyy)	ate and ending dat	te for the reporting	10/01/2016	12/31/2016	170.00
			1.00	2.00	-
171.00 If line 167 is "Y", does this provider have a	ny days for indiv	viduals oprolled in	1.00 V		3171.00
"Y" for yes and "N" for no in column 1. If co 1876 Medicare days in column 2. (see instruct	Wkst. S-3, Pt. I, olumn 1 is yes, er	line 2, col. 6? Enter		23	

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2016 To 12/31/2016		eparec
				Y/N	Date	
			-	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	r all dates in t	he	_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c	olumn 2 (see	instructions)			'··
	reporting porrou. In yes, enter the date or the change in e	01 dill1 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	1
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit rec	onciliation.				
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	S N		6.
00	the legal operator of the program?					-
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7. 8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	IS.		N		9.
0. 00	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.	or renewed in t	ne current	N		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.
					Y/N	_
					1.00	_
	Bad Debts	· · · ·				- 40
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 13.
. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	°yes, see ins	tructions.	Ν	14.
_	Bed Complement					
. 00	Did total beds available change from the prior cost reporti				<u>N</u>	15.
			rt A	Par		
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/01/2017	Y	04/01/2017	17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

Health Financial Systems

IU HEALTH PAOLI HOSPITAL

In Lieu of Form CMS-2552-10

From 01/01/2016 Par	orksheet S-2	
To 12/31/2016 Dat	Part II Date/Time Prepare	
	/23/2017 12: 4	11 pm
DescriptionY/N01.00	Y/N 3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R N Report data for Other? Describe the other adjustments: N	N	20.00
Y/N Date Y/N	Date	
1.00 2.00 3.00	4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions. N N		21.00
	1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
Capital Related Cost	•	~~ ~~
22.00 Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?	N	24.00
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	Ν	27.00
Interest Expense		
28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	Ν	31.00
Purchased Servi ces		
32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Ν	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
Provi der-Based Physi ci ans		
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?	Y	34.00
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based	Y	35.00
physicians during the cost reporting period? If yes, see instructions.	Date	
1.00	2.00	
Home Office Costs		
36.00 Were home office costs claimed on the cost report? Y		36.00
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Y If yes, see instructions.		37.00
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of N the provider? If yes, enter in column 2 the fiscal year end of the home office.		38.00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N see instructions.		39.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.		40.00
1.00 2.00		
Cost Report Preparer Contact Information		
41.00 Enter the first name, last name and the title/position RHONDA UTTER held by the cost report preparer in columns 1, 2, and 3,		41.00
respectively. 42.00 Enter the employer/company name of the cost report INDIANA UNIVERSITY HEALTH		42.00
43.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER®IUHEALTH. OR)RG	43.00
report preparer in columns 1 and 2, respectively.		+3.00

Heal th	Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-1306	Period: From 01/01/2016	Worksheet S-2 Part II	
			_		To 12/31/2016		pared: 41 pm
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the ti	itle∕position	DI RECTOR				41.00
	held by the cost report preparer in column	ns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cos	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addre	ess of the cost					43.00
	report preparer in columns 1 and 2, respec	cti vel y.					

Heal th	Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-1306	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Prep 5/23/2017 12:4	pared: 41 pm	
						I/P Days / O/P Visits / Trips		
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V		
		1.00	2.00	3.00	4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	25	9, 1		0	1.00	
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00	
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 beds) (see instructions)		25	9, 1	50 11, 616. 00		7.00	
8.00	INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.00	
9.00	CORONARY CARE UNIT						9.00	
10.00	BURN INTENSIVE CARE UNIT						10.00	
11.00	SURGICAL INTENSIVE CARE UNIT						11.00	
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00	NURSERY	43.00				0	13.00	
14.00	Total (see instructions)		25	9, 1	50 11, 616. 00	0	14.00	
15.00	CAH visits					0	15.00	
16.00	SUBPROVIDER - IPF						16.00	
17.00	SUBPROVIDER - IRF						17.00	
18.00	SUBPROVI DER						18.00	
19.00	SKILLED NURSING FACILITY						19.00	
20.00	NURSING FACILITY						20.00	
21.00	OTHER LONG TERM CARE						21.00	
22.00	HOME HEALTH AGENCY	101.00				0	22.00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00	
24.00	HOSPI CE						24.00	
24.10	HOSPICE (non-distinct part)	30.00					24.10	
25.00	CMHC - CMHC						25.00	
26.00	RURAL HEALTH CLINIC	88.00				0	26.00	
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26. 25	
27.00	Total (sum of lines 14-26)		25				27.00	
28.00	Observation Bed Days					0	28.00	
29.00	Ambulance Trips						29.00	
30.00	Employee discount days (see instruction)						30.00	
31.00	Employee discount days - IRF						31.00	
32.00	Labor & delivery days (see instructions)		0		0		32.00	
32.01	Total ancillary labor & delivery room						32.01	
	outpatient days (see instructions)							
33.00	LTCH non-covered days						33.00	

10351 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2016 To 12/31/2016		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	117	2	48	34		1.0
2.00	HMO and other (see instructions)	47	261				2.0
3.00	HMO I PF Subprovi der	47	201				3.0
1.00	HMO I RF Subprovi der	0	0				4.0
5.00	Hospital Adults & Peds. Swing Bed SNF	18	0	1	18		5.0
5.00	Hospital Adults & Peds. Swing Bed NF	10	0		23		6.0
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	135	2	52			7.0
3. 00	INTENSIVE CARE UNIT	0	0		0		8.0
. 00	CORONARY CARE UNIT						9.0
0. 00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		4	20)3		13.0
4.00	Total (see instructions)	135	6	72	28 0.00	119.05	14.0
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16. (
7.00	SUBPROVIDER - IRF						17. (
8.00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19. (
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23. (
4.00	HOSPICE						24.0
4. 10	HOSPICE (non-distinct part)	0	0		0		24. 1
5.00	CMHC - CMHC		_		_		25.0
6.00	RURAL HEALTH CLINIC	0	0		0 0.00		
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	119.05	
8.00	Observation Bed Days		82	88	37		28.0
9.00	Ambul ance Trips	0					29.0
0.00	Employee discount days (see instruction)				0		30.0
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	0		0		32.0
2. 01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)				1		1

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CCN: 15-1306		Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Prep 5/23/2017 12:4	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		0		14 3 2 126	200	1.00 2.00
3.00 4.00 5.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0		3.00 4.00 5.00
6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						6.00 7.00 8.00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\end{array}$	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0		14 3	200	14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00
22.00 23.00 24.00 24.10 25.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0.00					22.00 23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0.00 0.00 0.00					26.00 26.25 27.00 28.00 29.00
30. 00 31. 00 32. 00 32. 01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)						30. 00 31. 00 32. 00 32. 01

Heal th	Financial Systems IU HEALTH PAOLI	HOSPI TAL		In Lie	eu of Form C	:MS-2	552-10		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-1306	Peri od:	Worksheet	S-10)		
				From 01/01/2016 To 12/31/2016					
							n più		
					1.00				
	Uncompensated and indigent care cost computation								
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by li	ne 202 colum	1 8)	0.350)190	1.00		
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				3, 791,	164	2.00		
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplement	10	Y Y		3.00 4.00				
4.00 5.00	If line 4 is "no", then enter DSH or supplemental payments fr		IT OIL MEULCAL	1 :		0	4.00 5.00		
6.00	Medicaid charges				15, 836,	-	6.00		
7.00	Medicaid cost (line 1 times line 6)				5, 545,		7.00		
8.00	Difference between net revenue and costs for Medicaid program	nes 2 and 5: if	1, 754,		8.00				
	< zero then enter zero)	(.,,				
	Children's Health Insurance Program (CHIP) (see instructions	for each lin	ne)						
9.00	Net revenue from stand-alone CHIP					0	9.00		
10.00	Stand-alone CHIP charges					0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)					0	11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9; i	f < zero then		0	12.00		
	enter zero) Other state or local government indigent care program (see in	structions f	For each line		<u> </u>				
13.00	Net revenue from state or local indigent care program (Not in					0	13.00		
14.00	Charges for patients covered under state or local indigent ca						14.00		
11.00	10)	re program (Ĩ	11.00		
15.00	State or local indigent care program cost (line 1 times line	14)				0	15.00		
16.00	Difference between net revenue and costs for state or local i	ndigent care	e program (lii	ne 15 minus line		0	16.00		
	13; if < zero then enter zero)	_			l				
	Uncompensated care (see instructions for each line)		• •						
17.00 18.00	Private grants, donations, or endowment income restricted to					0	17.00 18.00		
18.00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid , CHIP and state and loc			(cum of lines	1, 754,	- 1			
19.00	(8, 12 and 16)	ar murgent		s (sum of filles	1,754,	4/7	19.00		
			Uni nsured	Insured	Total (col.	. 1			
			patients	pati ents	+ col. 2)				
			1.00	2.00	3.00				
	Charity care charges for the entire facility (see instruction		2, 416, 6						
21.00	Cost of patients approved for charity care (line 1 times line	20)	846, 2						
22.00	Partial payment by patients approved for charity care		27,6			098	22.00		
23.00	Cost of charity care (line 21 minus line 22)		818, 6	35 15, 833	834,	468	23.00		
					1.00				
24.00	Does the amount in line 20 column 2 include charges for patie	nt davs bevo	ond a length o	of stav limit	N		24.00		
	imposed on patients covered by Medicaid or other indigent car		J						
27.00									
	Non-Medicare and non-reimbursable Medicare bad debt expense (829,		28.00		
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (line	e 1 times line	28)	290,		29.00		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 124,		30.00		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30) 2,879,353 31.00								

Health Financial Systems	IU HEALTH PAOL				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO	CN: 15-1306 P	eriod: rom 01/01/2016	Worksheet A	
			T		Date/Time Pre 5/23/2017 12:	
Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS		0	0	776, 025	776, 025	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP		0	-	453, 871	453, 871	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	30, 289 345, 843	68, 651 4, 654, 922		1, 231, 621 -155, 396	1, 330, 561 4, 845, 369	4.00 5.00
7.00 00700 OPERATION OF PLANT	363, 556	1, 158, 708		-659, 966	4, 843, 309 862, 298	
7. 01 00701 UTI LI TI ES	0	0	0	380, 668	380, 668	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	0	60, 020		0	60, 020	
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY	176, 358 181, 954	150, 097 164, 594		-51, 571 -226, 211	274, 884 120, 337	9.00 10.00
11. 00 01100 CAFETERI A	0	04, 574	0	165, 189	165, 189	
13.00 01300 NURSING ADMINISTRATION	540, 526	175, 140		-227, 246	488, 420	
13. 01 01301 HOUSE SUPERVI SORS	386, 948	89, 116 23, 151		-57, 106 399, 087	418, 958	
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	578 221, 261	1, 462, 593		-1, 375, 880	422, 816 307, 974	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	12, 901	12, 901	-4, 490	8, 411	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	338, 477	93, 980	432, 457	-39, 140	393, 317	19.00
30. 00 03000 ADULTS & PEDIATRICS	915, 608	793, 793	1, 709, 401	-409, 931	1, 299, 470	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
43.00 04300 NURSERY	75, 182	17, 267	92, 449	-8, 855	83, 594	43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	423, 541	412, 124	835, 665	-313, 940	521, 725	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	108, 700	0			120, 535	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	689, 170	1,074,986			1, 112, 081	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	19, 121 61, 751	1, 280, 328 40, 224			1, 295, 394 82, 367	1
65. 00 06500 RESPIRATORY THERAPY	295, 421	127, 362			331, 101	
66. 00 06600 PHYSI CAL THERAPY	497, 834	237, 438	735, 272	-103, 973	631, 299	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	26, 480	26, 480	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	13, 705 1, 346, 232	13, 705 1, 346, 232	
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 07501 CARDI AC REHAB	0	0	0	0	0	75.00 75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	46, 916	39, 537	86, 453	-14, 452	72, 001	76.97
OUTPATIENT SERVICE COST CENTERS	· · · ·		-	-		
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 0			0	
90. 00 09000 CLINIC	0	29, 855			29, 855	
91. 00 09100 EMERGENCY	1, 191, 427	1, 530, 991			2, 369, 969	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS	1					110.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 910, 461	0 13, 697, 778		0 36, 687	0 20, 644, 926	113.00 118.00
NONREI MBURSABLE COST CENTERS	0, 710, 101	10,077,770	20,000,207	00,007	20, 011, 720	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
190. 01 19001 VI SI TI NG SPECI ALTY CLI NI C 190. 02 19002 OUTREACH	0 107, 032	1, 036 56, 699		-1, 011 -22, 808	25 140, 923	190.01
190. 03 19003 FOUNDATI ON	0	6, 558		-22,008		190.02
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0	11, 345		-2, 257		190.05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH	0	11, 035 0	11, 035 0	-10, 611 0		190. 06 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	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, 017, 493	13, 784, 451	20, 801, 944	0	20, 801, 944	1200.00

RECLASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CCN:	15-1306	Peri od:	Worksheet A	
					From 01/01/2016 To 12/31/2016	Date/Time Pr	
	Cost Center Description	Adjustments	Net Expenses		I	5/23/2017 12	2:41 pi
	bost benter bescription		or Allocation				
		6.00	7.00				
	NERAL SERVICE COST CENTERS	71 950	047 075				1
	D200 CAP REL COSTS-BEDG & FIXT	71,850	847, 875				1.
	0300 OTHER CAP REL COSTS	40, 360 0	494, 231 0				3.
	0400 EMPLOYEE BENEFITS DEPARTMENT	-245, 087	1,085,474				4.
	0500 ADMINISTRATIVE & GENERAL	1, 216, 315	6, 061, 684				5.
	0700 OPERATION OF PLANT	1, 210, 313	862, 298				7.
	0701 UTI LI TI ES	0	380, 668				7.
	0800 LAUNDRY & LINEN SERVICE	Ö	60, 020				8
	0900 HOUSEKEEPING	Ö	274, 884				9
	000 DI ETARY	0	120, 337				10
1	100 CAFETERI A	-39,431	125, 758				11
	300 NURSING ADMINISTRATION	9, 484	497, 904				13
	301 HOUSE SUPERVI SORS	0	418, 958				13
	400 CENTRAL SERVICES & SUPPLY	-5	422, 811				14
5.00 01	500 PHARMACY	0	307, 974				15
5.00 01	600 MEDI CAL RECORDS & LI BRARY	86, 325	94, 736				16
	700 SOCI AL SERVI CE	0	0				17
	900 NONPHYSI CLAN ANESTHETI STS	0	393, 317				19
-	IPATIENT ROUTINE SERVICE COST CENTERS						_
	3000 ADULTS & PEDIATRICS	-272, 188	1,027,282				30
	100 I NTENSI VE CARE UNI T	0	0				31
	I 300 NURSERY	0	83, 594				43
	000 OPERATING ROOM	-925	520, 800				50
	200 DELIVERY ROOM & LABOR ROOM	,23	120, 535				52
	5400 RADI OLOGY-DI AGNOSTI C	-14, 212	1, 097, 869				54
	0000 LABORATORY	-14, 477	1, 280, 917				60
	400 I NTRAVENOUS THERAPY	0	82, 367				64
1	500 RESPI RATORY THERAPY	0	331, 101				65
5. 00 06	600 PHYSI CAL THERAPY	0	631, 299				66
1.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26, 480				71
2.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 705				72
	300 DRUGS CHARGED TO PATIENTS	0	1, 346, 232				73
	301 DRUGS CHARGED TO PATIENTS	0	0				73
	400 RENAL DIALYSIS	0	0				74
	500 ASC (NON-DI STINCT PART)	0	0				75
	CARDIAC REHAB	0	0				75
	7697 CARDI AC REHABI LI TATI ON	-600	71, 401				76
	ITPATIENT SERVICE COST CENTERS	0	0				88
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89
	0000 CLINIC	0	29, 855				90
	100 EMERGENCY	-430, 023	1, 939, 946				91
	200 OBSERVATION BEDS (NON-DISTINCT PART	,00,020	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				92
	HER REIMBURSABLE COST CENTERS						
	2500 AMBULANCE SERVICES	0	0				95
01.0010	100 HOME HEALTH AGENCY	0	o				101
	ECIAL PURPOSE COST CENTERS						
	300 INTEREST EXPENSE	0	0				113
18.00	SUBTOTALS (SUM OF LINES 1-117)	407, 386	21, 052, 312				118
	NREIMBURSABLE COST CENTERS	0	0				190
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		25				190
	002 OUTREACH		140, 923				190
	003 FOUNDATI ON		6, 558				190
	004 SPRING VALLEY FAMILY PRACTICE	0	0, 550				190
	005 PAOLI FAMILY PRACTICE	0	9, 088				190
	006 OTHER PROPERTY	0	424				190
	2100 RESEARCH	o	0				191
	2200 PHYSICIANS' PRIVATE OFFICES	o	0				192
	2300 NONPAID WORKERS	o	0				193
00.00	TOTAL (SUM OF LINES 118-199)	407, 386	21, 209, 330				200

Heal th Financial	Systems
RECLASSI FI CATI ON	S

 IU HEALTH PAOLI HOSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-1306
 Period: From 01/01/2016
 Worksheet A-6

	STELCATIONS			Provider C	From 01/01/2016 To 12/31/2016	Date/Time Pr	
		Increases				5/23/2017 12	2: 41 pr
	Cost Center	Line #	Salary	Other			
	2.00 A - EMPLOYEE BENEFITS	3.00	4.00	5.00			_
)	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 232, 592			1.
)		0.00	0	0			2.
)		0.00	0	0			3.
)		0.00	0	0			4.
))		0.00 0.00	0	0 0			5.
)		0.00	0	0			7.
)		0.00	0	0			8.
)		0.00	0	0			9.
00		0.00	0	0			10.
00 00		0.00 0.00	0	0 0			11.
00		0.00	0	0			13.
00		0.00	0	0			14.
00		0.00	0	0			15.
00		0.00	0	0			16.
00 00		0.00 0.00	0	0			17.
00		0.00	0	0			10.
0		0.00	0	0			20.
	TOTALS		0	1, 232, 592			
	B - BILLABLE DRUGS	70.00		4 9 4 4 9 9 9			
))	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	1, 346, 232 0			1.
)		0.00	0	0			3.
	TOTALS		0	1, 346, 232			
	C - BILLABLE SUPPLIES	45.00					
))	PHARMACY NONPHYSICIAN ANESTHETISTS	15.00 19.00	0	497 28			1.
)	ADULTS & PEDIATRICS	30.00	0	3, 533			3.
)	NURSERY	43.00	0	3, 445			4.
)	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	26, 480			5.
)	PATI ENTS EMERGENCY	91.00	0	4, 773			6.
,	TOTALS		— — — 0				0.
	D - CAPITAL RELATED COSTS						
)	CAP REL COSTS-BLDG & FIXT	1.00	0	603, 372			1.
)	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	0	453, 871 0			2.
)		0.00	0	0			4.
)		0.00	0	0			5.
)		0.00	0	0			6.
)		0.00	0	0			7.
))		0.00 0.00	0	0 0			8.
,)0		0.00	0	0			10.
00		0.00	0	0			11.
00		0.00	0	0			12.
00		0.00	0	0			13.
00 00		0.00 0.00	0	0 0			14.
00		0.00	0	0			16.
00		0.00	0	0			17.
00		0.00	0	0			18.
0 0		0.00 0.00	0	0			19. 20.
0		0.00	0	0			20.
0		0.00	0	0			22.
0		0.00	0	0			23.
0	TOTALS	0.00					24.
	E - IMPLANT SUPPLIES		U	1, 057, 243			-
)	I MPL. DEV. CHARGED TO	72.00	0	13, 705			1.
	PATI ENTS						
	TOTALS		0	$ \frac{0}{12,705}$			2.
	F - LEASE EXPENSE		U	13, 705			-
)	CAP REL COSTS-BLDG & FIXT	1.00	0	172, 653			1.
	TOTALS			172, 653			
	G - NON-BILLABLE DRUGS	15 00		07 00-			
))	PHARMACY	15.00 0.00	0	27, 025 0			1.
		0.00	V	0			_ ∠.

	Financial Systems		IU HEALTH PAOL		In Lieu of Form CN	
RECLASS	SIFICATIONS			Provider CCN: 15-1306	Period: Worksheet / From 01/01/2016	A-6
					To 12/31/2016 Date/Time I	Prepared [.]
					5/23/2017	
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	TOTALS		0	27, 025		
1 00	H - NON-BILLABE MED SUPPLIES	11.00		404 407		
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	404, 127		1.00
2.00		0.00 0.00	0	0 0		2.00
3.00 4.00		0.00	0	0		3.00
4.00 5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	o	o		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	o		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	TOTALS		0	404, 127		
	I - COO/CNO					
1.00	ADMI NI STRATI VE & GENERAL	5.00	154,970	<u>0</u>		1.00
	TOTALS		154, 970	0		_
1.00	J - UTILITIES UTILITIES	7.01	0	380, 668		1.00
1.00	TOTALS	<u> </u>	<u>o</u>	380, 668		1.00
	K - MARKETING COSTS		U	380, 888		
1.00	OUTREACH	190.02	0	2, 725		1.00
1.00	TOTALS		<u>0</u>	2, 725		1.00
	L - OBSTETRI CS		9	2,725		
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11, 835		1.00
2.00	NURSERY	43.00		8, 186		2.00
	TOTALS			20, 021		2.00
	M - CAFETERIA					
1.00	CAFETERIA	11.00	105, 268	59, 921		1.00
	TOTALS	+	105, 268	59, 921		
	Grand Total: Increases		260, 238	4, 755, 668		500.00

IU HEALTH PAOLI HOSPITAL

	Financial Systems		IU HEALTH PAOL	I HOSPITAL		In Lieu of Form CMS	5-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1306	Period: Worksheet A- From 01/01/2016	-6
						To 12/31/2016 Date/Time Pr	
		Decreases				5/23/2017 12	2:41 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	F.	
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60, 599		0	1.00
2.00	OPERATION OF PLANT	7.00	0	55, 427		0	2.00
3.00 4.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	44, 875 50, 827		0	3.00 4.00
4.00 5.00	NURSING ADMINISTRATION	13.00	0	70, 145		0	5.00
6.00	HOUSE SUPERVI SORS	13.00	0	57, 106		0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	25		0	7.00
8.00	PHARMACY	15.00	0	27, 873	8	0	8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	14, 656		0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	273, 100		0	10.00
11.00	OPERATING ROOM	50.00	0	88, 960		0	11.00
12.00 13.00	RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00	0	130, 878 164		0	12.00 13.00
13.00	INTRAVENOUS THERAPY	64.00	0	12, 936		0	13.00
15.00	RESPI RATORY THERAPY	65.00	0	41, 671		0	15.00
16.00	PHYSI CAL THERAPY	66.00	0	87, 928		0	16.00
17.00	CARDIAC REHABILITATION	76.97	0	10, 368		0	17.00
18.00	EMERGENCY	91.00	0	180, 192		0	18.00
19.00	VISITING SPECIALTY CLINIC	190.01	0	9		0	19.00
20.00	OUTREACH	190.02		24,853		Ō	20.00
			0	1, 232, 592	2		_
1.00	B – BILLABLE DRUGS ADMINI STRATI VE & GENERAL	5.00	0	2		0	1.00
2.00	PHARMACY	15.00	0	1, 345, 791		0	2.00
3.00	LABORATORY	60.00		439		0	3.00
	TOTALS		<u>0</u>	1, 346, 232		7	
	C - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	38		0	1.00
2.00	OPERATING ROOM	50.00	0	36, 591		0	2.00
3.00		54.00	0	1, 747		0	3.00
4.00 5.00	PHYSICAL THERAPY	66. 00 0. 00	0	380 C		0	4.00 5.00
6.00		0.00	0			0	6.00
0.00	TOTALS		— — — <u> </u>	38, 756	,		0.00
	D - CAPITAL RELATED COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	803		9	1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	74, 275		9	2.00
3.00	OPERATION OF PLANT	7.00	0	223, 754		0	3.00
4.00 5.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	689 8, 153		0	4.00 5.00
6.00	NURSING ADMINI STRATI ON	13.00	0	1, 975		0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	Ő	3, 226		0	7.00
8.00	PHARMACY	15.00	0	10, 779		0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	4, 489		0	9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	18, 897		0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	71, 121		0	11.00
12.00	NURSERY	43.00	0	1, 300		0	12.00
13.00	OPERATING ROOM	50.00	0	77, 993		0	13.00
14. 00 15. 00	RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00	0	460, 114 1, 563		0	14.00 15.00
16.00	INTRAVENOUS THERAPY	64.00	0	1, 628		0	16.00
17.00	RESPI RATORY THERAPY	65.00	Ő	30, 548		0	17.00
18.00	PHYSICAL THERAPY	66.00	0	4, 863		0	18.00
19.00	CARDIAC REHABILITATION	76.97	0	2, 554	ļ	0	19.00
20.00	EMERGENCY	91.00	0	46, 033		0	20.00
21.00	VISITING SPECIALTY CLINIC	190.01	0	1, 001		0	21.00
22.00	OUTREACH	190.02	0	308		0	22.00
23.00 24.00	PAOLI FAMILY PRACTICE OTHER PROPERTY	190. 05 190. 06	0	2, 257 8, 920		0	23.00 24.00
24.00	TOTALS	190.00		1, 057, 243			24.00
	E - IMPLANT SUPPLIES	l	0	1,007,240	, 		-
1.00	OPERATING ROOM	50.00	0	13, 524	ļ	0	1.00
2.00	EMERGENCY	91.00		181		0	2.00
	TOTALS		0	13, 705)		
	F - LEASE EXPENSE						
1.00	ADMI NI STRATI VE & GENERAL		<u>0</u>	172,653		9	1.00
			0	172, 653			-
1.00	G - NON-BILLABLE DRUGS PHARMACY	15.00	0	53	2	0	1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	26, 366		0	2.00
3.00	LABORATORY	60.00	0	606		0	3.00
	TOTALS			27, 025		7	
	·						

IU HEALTH PAOLI HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1306

 Period:
 Worksheet A-6

 From 01/01/2016
 Date/Time Prepared:

 To
 12/31/2016
 Date/Time Prepared:

							5/23/2017 12:41 pm
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - NON-BILLABE MED SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	168			1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	112	0		2.00
3.00	OPERATION OF PLANT	7.00	0	117	0		3.00
4.00	HOUSEKEEPI NG	9.00	0	6, 007	0		4.00
5.00	DI ETARY	10.00	0	2, 042	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	156	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 751	0		7.00
8.00	PHARMACY	15.00	0	18, 906	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	1	0		9.00
10.00	NONPHYSI CI AN ANESTHETI STS	19.00	0	5, 615	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	49, 222	0		11.00
12.00	NURSERY	43.00	o	19, 186	0		12.00
13.00	OPERATING ROOM	50.00	0	96, 872			13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	32, 970			14.00
15.00	LABORATORY	60.00	0	1, 283			15.00
16.00	INTRAVENOUS THERAPY	64.00	0	5,044			16.00
17.00	RESPI RATORY THERAPY	65.00	0	19, 463			17.00
18.00	PHYSICAL THERAPY	66.00	0	10, 802			18.00
19.00	CARDI AC REHABI LI TATI ON	76.97	0	1, 530			19.00
20.00	EMERGENCY	91.00	0	130, 816			20.00
21.00	VI SI TI NG SPECIALTY CLINIC	190.01	0	1 1	0		21.00
22.00	OUTREACH	190.02	0	372	-		22.00
23.00	OTHER PROPERTY	190.06	0	1, 691			23.00
20.00	TOTALS		— — — o	404, 127			23.00
	I - COO/CNO			404, 127			
1.00	NURSI NG ADMI NI STRATI ON	13.00	154, 970	0	0		1.00
1.00	TOTALS		154, 970	0	•		1.00
	J - UTILITIES		101, 770	0		L	
1.00	OPERATION OF PLANT	7.00	0	380, 668	0		1.00
	TOTALS			380, 668			
	K - MARKETING COSTS			000,000			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 725	0		1.00
	TOTALS			2,725			
	L - OBSTETRI CS			2//20			
1.00	ADULTS & PEDIATRICS	30.00	0	20, 021	0		1.00
2.00		0.00	0	20, 021	0		2.00
2.00	TOTALS			20,021			2.00
	M - CAFETERIA						
1.00	DI ETARY	10.00	105, 268	59, 921	0		1.00
	ITOTALS — — — —		105, 268	<u>59,921</u>			
500, 00	Grand Total: Decreases		260, 238	4, 755, 668			500.00
500.00		· · · · · · · · · · · · · · · · · · ·	200,200	., , 000	I	I	1000.00

Heal th	Financial Systems	IU HEALTH PAOI	I HOSPITAI		Inlie	eu of Form CMS-2	2552-10
	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CC		Period: From 01/01/2016 Fo 12/31/2016	Worksheet A-7 Part I	pared:
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	148,000	0	(0 0	0	1.00
2.00	Land Improvements	438, 464	0	(0 0	0	2.00
3.00	Buildings and Fixtures	4, 741, 722	0	(0 0	0	3.00
4.00	Building Improvements	253, 197	624, 525	(0 624, 525	0	4.00
5.00	Fixed Equipment	6, 375, 003	474, 413	-6, 849, 41	6 -6, 375, 003	0	5.00
6.00	Movable Equipment	4, 019, 720	7, 303, 036	-22, 57	7 7, 280, 459	0	6.00
7.00	HIT designated Assets	0	0	(0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15, 976, 106	8, 401, 974	-6, 871, 99	3 1, 529, 981	0	8.00
9.00	Reconciling Items	0	0	(0 0	0	9.00
10.00	Total (line 8 minus line 9)	15, 976, 106	8, 401, 974	-6, 871, 993	1, 529, 981	0	10.00
		Endi ng Bal ance	Fully				
		Ŭ	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES					
1.00	Land	148,000	0				1.00
2.00	Land Improvements	438, 464	0				2.00
3.00	Buildings and Fixtures	4, 741, 722	0				3.00
4.00	Building Improvements	877, 722	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	11, 300, 179	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	17, 506, 087	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	17, 506, 087	0				10.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1306	Peri od:	Worksheet A-7	
				From 01/01/2016 To 12/31/2016		narad
				10 12/31/2010	5/23/2017 12:	41 pm
		SI	UMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	C	D	0 0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	C	D	0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	C)	0 0	0	3.00
	SUMMARY O	F CAPITAL				
			_			
Cost Center Description		Total (1) (sum	า			
	Capi tal -Rel ate					
	d Costs (see	through 14)				
	instructions)	15.00	-			
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES I a	and 2			1
1.00 CAP REL COSTS-BLDG & FIXT	0					1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0					2.00
3.00 Total (sum of lines 1-2)	0	[C	וי			3.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	F			Period: From 01/01/2016 To 12/31/2016		
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	6, 205, 908				0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	11, 300, 179				0	2.00
3.00 Total (sum of lines 1-2)	17, 506, 087		111000100		0	3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		0		0 047 075	0	4 00
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0 847, 875	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 494, 231	0	2.00
3.00 Total (sum of lines 1-2)	0	U	I JMMARY OF CAPI	0 1, 342, 106	0	3.00
		50	JWWARY OF CAPT			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	12.00	13.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	847, 875	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-		0 0	494, 231	2.00
3.00 Total (sum of lines 1-2)	0	-		0 0	1, 342, 106	3.00
			I		.,	

ADJUST	Financial Systems MENTS TO EXPENSES		IU HEALTH PAO	Provi der CCN: 15-1306	Period: From 01/01/2016	u of Form CMS-2 Worksheet A-8	
					To 12/31/2016	Date/Time Pre 5/23/2017 12:	
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00		
	COSTS-MVBLE EQUIP (chapter 2)			CAP REL CUSIS-MUBLE EQUIP		0	
3.00	Investment income - other (chapter 2)		0		0.00	0	
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 suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service		0		0.00	0	8.00
9.00 10.00	(chapter 21) Parking lot (chapter 21) Provider-based physician	A-8-2	0 -2, 097, 801		0.00	0 0	
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	4, 097, 946			0	12.00
	Laundry and linen service Cafeteria-employees and guests		0		0.00 0.00	0 0	
15.00	Rental of quarters to employee		0		0.00	0	
16.00	and others Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19.00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	*** Cost Center Deleted ***	0. 00 67. 00	0	29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions) Adjustment for speech pathology costs in excess of	A-8-3		*** Cost Center Deleted ***			31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest	А	-141, 592	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BENEFITS EXPENSE ADJUSTMENT TO BUDGET	A A		EMPLOYEE BENEFITS DEPARTMEN ADMINISTRATIVE & GENERAL	T 4.00 5.00	0	33. 00 33. 01

Health Financial Systems			IU HEALTH PAC	LI HOSPITAL	In Lie	In Lieu of Form CMS-2552-10		
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 12:		
				Expense Classification or	n Worksheet A			
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.		
		1.00	2,00	3.00	4,00	5, 00		
33. 02	HAF FEES	A	-307, 490	ADMI NI STRATI VE & GENERAL	5.00	0	33.02	
33.03	OTHER INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00	9	33.03	
33.04	OTHER INCOME	В	-11, 703	ADMINISTRATIVE & GENERAL	5.00	0	33.04	
33.05	OTHER INCOME	В	-504	CAFETERIA	11.00	0	33.05	
33.06	OTHER INCOME	В	-38, 927	CAFETERI A	11.00	0	33.06	
33.07	OTHER INCOME	В	-1, 828	NURSING ADMINISTRATION	13.00	0	33.07	
33.08	OTHER INCOME	В	-5	CENTRAL SERVICES & SUPPLY	14.00	0	33.08	
33.09	OTHER INCOME	В	-5, 553	MEDICAL RECORDS & LIBRARY	16.00	0	33.09	
33. 10	OTHER INCOME	В	-20	ADULTS & PEDIATRICS	30.00	0	33.10	
33. 11	OTHER INCOME	В	-925	OPERATING ROOM	50.00	0	33.11	
33. 12	OTHER INCOME	В	-347	RADI OLOGY-DI AGNOSTI C	54.00	0	33.12	
33. 13	ACCRUED PTO TO HOME OFFICE	A	-25, 374	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.13	
33.14	RECRUI TI NG EXP	A	-161, 020	ADMINISTRATIVE & GENERAL	5.00	0	33.14	
33. 15	UNWONTED SITUATIONS	A	618	ADMINISTRATIVE & GENERAL	5.00	0	33.15	
33. 16	INVESTMENT FEES	A	29, 108	ADMINISTRATIVE & GENERAL	5.00	0	33.16	
50.00	TOTAL (sum of lines 1 thru 49)		407, 386				50.00	
	(Transfer to Worksheet A,							
	column 6, line 200.)							

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

Heal th	Financial Systems	IU HEALTH PA	OLI HOSPITAL	In Lie	In Lieu of Form CMS-2552-10		
STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HON	ME Provider CCN: 15-1306	Period: From 01/01/2016			
				To 12/31/2016	Date/Time Pre 5/23/2017 12:		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost			
					Wks. A, column		
-					5		
	1.00	2.00	3.00	4.00	5.00		
	A. COSTS INCURRED AND ADJUSTA HOME OFFICE COSTS:	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED		
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	74, 250	0	1.00	
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	181, 952	0	2.00	
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1, 015, 865	0	3.00	
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	2, 799, 085	3, 549, 612	3.01	
3.02	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	35, 541	35, 541	3. 02	
3.03	5.00	ADMINISTRATIVE & GENERAL	BLOOMINGTON A&G ALLOCATION	2, 475, 494	111, 946	3.03	
3.04	7.00	OPERATION OF PLANT	SHARED EMPLOYEES	17, 736	17, 736	3.04	
3.05	8.00		SHARED EMPLOYEES	15, 415	15, 415	3.05	
3.08			SHARED EMPLOYEES	14, 268		3.08	
3.09	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	11, 337	25	3.09	
3.10	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	91, 878	0	3.10	
3.11	60.00	LABORATORY	SHARED EMPLOYEES	1, 201, 180	1, 201, 180	3. 11	
3.12	65.00	RESPI RATORY THERAPY	SHARED EMPLOYEES	12, 281	12, 281	3.12	
4.00			SHARED EMPLOYEES	52, 472	52, 472	4.00	
4.01			SHARED EMPLOYEES	13, 904	13, 904	4.01	
4.02			SHARED EMPLOYEES	29, 326		4.02	
4.03		EMERGENCY	SIP ER ALLOCATION	2, 169, 930	1, 060, 262	4.03	
5.00	TOTALS (sum of lines 1-4).			10, 211, 914	6, 113, 968	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/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1.00	2.00	3.00	4.00	5.00			
B. INTERRELATIONSHIP TO 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 B	0.00 U HEALTH BLOOM	0.00	6.00
7.00 B	0.00 IU HEALTH	100.00	7.00
8.00 C	0.00 IUH SIP	0.00	8.00
9.00	0.00	0.00	9.00
10.00	0.00	0.00	10.00
100.00 G. Other (financial or			100.00
non-financial) specify:			

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

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

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

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

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATE OFFICE COSTS	O ORGANIZATIONS AND HOME	Provider CCN: 15-1306	From 01/01/2016	Worksheet A-8-1 Date/Time Prepared:

			5/23/2017 12:	41 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
			TS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	74, 250			1.00
2.00	181, 952			2.00
3.00	1, 015, 865			3.00
3.01	-750, 527	0		3. 01
3.02	0	0		3. 02
3.03	2, 363, 548	0		3.03
3.04	0	0		3. 04
3.05	0	0		3.05
3.08	0	0		3.08
3.09	11, 312	0		3.09
3.10	91, 878	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	1, 109, 668	0		4.03
5.00	4, 097, 946			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the 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 s	should be	i ndi cated	in column 4	4 of this part.	
	Related Organization(s)								
	and/or Home Office								
	Type of Business	1							
	51								
	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.

rerinbu		
6.00	HOSPI TAL	6.00
7.00	HOME OFFICE	7.00
8.00	PHYSICIAN GROUP	8.00
9.00		9.00
10.00		10.00
100.00		100.00
(1) 115	• the following symbols to inc	icate interrelationship to related organizations

(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 Syste	ems	IU HEALTH PA	OLI HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C	CCN: 15-1306	Period: From 01/01/2016 To 12/31/2016		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	272, 168			0 0	, s	
2.00		RADI OLOGY-DI AGNOSTI C	13, 865			0 0	-	
3.00		LABORATORY	14, 477	14, 477		0 0	0	
4.00		CARDIAC REHABILITATION	600			0 0	0	
5.00		EMERGENCY	2, 013, 569		473, 87	3 0	0	
6.00		ADMINISTRATIVE & GENERAL	257, 000	257, 000		0 0	0	
7.00	0.00		0	0		0 0	0	
8.00	0.00		0	-		0 0	0	
9.00	0.00		0	0		0 0	0	
10.00	0.00		0	0		0 0	0	
200.00			2, 571, 679		473, 87		0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		ADULTS & PEDIATRICS	0.00			0 0		1.00
2.00		RADI OLOGY-DI AGNOSTI C	0					
3.00		LABORATORY	0				, s	
4.00		CARDI AC REHABI LI TATI ON	0	0			0	
5.00		EMERGENCY		0			0	
6.00		ADMINISTRATIVE & GENERAL		0		°	0	
7.00	0.00			0			0	
8.00	0.00			0			0	
9.00	0.00		0			-	0	
10.00	0.00		0	-			0	
200.00	0.00		0	0			0	
200100	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200100
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0	° °		272, 168		1.00
2.00		RADI OLOGY-DI AGNOSTI C	0			0 13, 865		2.00
3.00		LABORATORY	0	°		0 14,477		3.00
4.00		CARDIAC REHABILITATION	0	-		006 00		4.00
5.00		EMERGENCY	0			1, 539, 691		5.00
6.00		ADMINISTRATIVE & GENERAL	0	0		201,000		6.00
7.00	0.00		0			0 0		7.00
8.00	0.00		0	0		0		8.00
9.00	0.00		0			0 0		9.00
10.00	0.00		0			0 0		10.00
200.00	I		0	0		2, 097, 801		200.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: rom 01/01/2016	Worksheet B Part I	
			Т	o 12/31/2016	Date/Time Pre 5/23/2017 12:	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost Allocation			BENEFI TS DEPARTMENT		
	(from Wkst A			<u>DEI / III III III III III III III III III</u>		
	<u>col.7)</u> 0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS	0.47.075	0.17, 075				1.00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP	847, 875 494, 231	847, 875	494, 231			1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 085, 474	837	547			4.00
5.00 00500 ADMINISTRATIVE & GENERAL	6, 061, 684	102, 269	66, 795		6, 308, 649	5.00
7. 00 00700 OPERATI ON OF PLANT 7. 01 00701 UTI LI TI ES	862, 298 380, 668	62, 350 0	40, 724 0		1, 021, 923 380, 668	
8.00 00800 LAUNDRY & LINEN SERVICE	60, 020	4, 328	2, 827	-	67, 175	•
9.00 00900 HOUSEKEEPI NG	274, 884	11, 123			320, 704	•
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	120, 337 125, 758	23, 298 14, 498			170, 781 166, 100	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	497, 904	7, 516			570, 302	13.00
13. 01 01301 HOUSE SUPERVI SORS	418, 958	0	0		479, 148	•
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	422, 811 307, 974	29, 574 16, 864	19, 316 11, 015		471, 791 370, 270	
16.00 01600 MEDICAL RECORDS & LIBRARY	94, 736	18, 033			124, 547	
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	393, 317	0	0	52, 650	445, 967	19.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 027, 282	97, 882	63, 932	142, 423	1, 331, 519	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0	-	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	83, 594	3, 607	2, 356	11, 695	101, 252	43.00
50. 00 05000 OPERATI NG ROOM	520, 800	86, 947	56, 790	65, 882	730, 419	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	120, 535	17, 124			165, 752	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	1, 097, 869 1, 280, 917	84, 163 26, 588			1, 344, 203 1, 327, 845	
64. 00 06400 I NTRAVENOUS THERAPY	82, 367	5, 771	3, 769		101, 512	
65. 00 06500 RESPI RATORY THERAPY	331, 101	4, 097	2, 676		383, 827	65.00
66. 00 06600 PHYSI CAL THERAPY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	631, 299 26, 480	35, 965 0	23, 490 0		768, 192 26, 480	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 705	0	0	-	13, 705	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 346, 232	0	0	0	1, 346, 232	
73. 01 07301 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	73.01
75. 00 07500 ASC (NON-DI STINCT PART)	0	0		0	0	75.00
75. 01 07501 CARDI AC REHAB	0	0	0	0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	71, 401	13, 142	8, 584	7, 298	100, 425	76.97
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	-	0	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	29, 855 1, 939, 946	1, 370 58, 426			32, 120 2, 221, 859	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 737, 740	50, 420	30, 101	105, 520	2, 221, 039	
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVI CES 101.00 10100 HOME HEALTH AGENCY	0	0 0			0	95.00 101.00
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
113.00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	21, 052, 312	725, 772	474, 038	1, 070, 209	20, 893, 367	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190.01 19001 VISITING SPECIALTY CLINIC	25	29, 213	19, 081			190. 01
190. 02 19002 OUTREACH 190. 03 19003 FOUNDATI ON	140, 923 6, 558	15, 710 1, 702	0 1, 112	16, 649	173, 282	190. 02 190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0, 558	1, 702	0	0		190.03
190.05 19005 PAOLI FAMILY PRACTICE	9, 088	34, 623	0	0	43, 711	190. 05
190. 06 19006 OTHER PROPERTY	424	40, 855	0	0		190.06
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191.00 192.00
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments		~	_			200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	21, 209, 330	0 847, 875	494, 231	0 1, 086, 858		201. 00 202. 00
	2.,207,000	011,010	1 171,201	., 000, 000	2.,20,,000	1-02.00

	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST #	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/23/2017 12:	pared: 41 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.00	7.00	7.01	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	6, 308, 649					5.00
7.00	00700 OPERATION OF PLANT	432, 662	1, 454, 585				7.00
7.01	00701 UTI LI TI ES	161, 167	0	541, 83	5		7.01
8.00	00800 LAUNDRY & LINEN SERVICE	28, 441	11, 902	3, 71	0 111, 228		8.00
9.00	00900 HOUSEKEEPI NG	135, 780	30, 588	9, 53		496, 607	9.00
10.00	01000 DI ETARY	72, 305	64, 073	19, 97		22, 430	10.00
11.00		70, 323	39, 872	12, 42		13, 958	
13.00	01300 NURSI NG ADMI NI STRATI ON	241, 454	20, 670 0	6, 44	0 0	7, 236	13.00
13.01 14.00	01301 HOUSE SUPERVI SORS 01400 CENTRAL SERVI CES & SUPPLY	202, 862 199, 747	81, 330	25, 35	-	0	13.01 14.00
15.00	01500 PHARMACY	156, 765	46, 378	25, 35		0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	52, 731	49, 592	15, 45		17, 360	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	188, 814	0		0 0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	563, 739	269, 186	83, 90	5 30, 008	94, 234	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
43.00	04300 NURSERY	42, 868	9, 918	3, 09	2 0	3, 472	43.00
F0.00	ANCI LLARY SERVICE COST CENTERS	200.245	220 111	74.52	0 11 174	02 705	
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	309, 245 70, 176	239, 111 47, 092	74, 53 14, 67		83, 705 16, 486	50.00 52.00
52.00	05400 RADI OLOGY-DI AGNOSTI C	569, 109	231, 455	72, 14		81, 025	52.00
60.00	06000 LABORATORY	562, 183	73, 118	22, 79		25, 596	60.00
64.00	06400 I NTRAVENOUS THERAPY	42, 978		4, 94		5, 555	64.00
65.00	06500 RESPI RATORY THERAPY	162, 505	11, 267	3, 51		3, 944	65.00
66.00	06600 PHYSI CAL THERAPY	325, 237	7, 895	30, 83		34, 624	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 211	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 802	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	569, 968	0		0 0	0	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART) 07501 CARDIAC REHAB	0	0		0 0	0	75.00
75. 01 76. 97	07501 CARDIAC REHABILITATION	42, 518	36, 142	11, 26	0 0	12, 652	75.01 76.97
70. 77	OUTPATIENT SERVICE COST CENTERS	42, 510	50, 142	11,20	0	12,032	/0. //
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00	09000 CLINIC	13, 599	3, 769	1, 17	5 0	1, 319	90.00
91.00	09100 EMERGENCY	940, 688	160, 677	50, 08	4 40, 415	56, 248	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS						05 00
	09500 AMBULANCE SERVICES	0	0		0 0		95.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	U		0 0	0	101.00
113 00	11300 INTEREST EXPENSE						113.00
118.00		6, 174, 877	1, 449, 904	480, 31	2 111, 228	479, 844	1
	NONREI MBURSABLE COST CENTERS	6, 1, 1, 6, 7	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100701			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19001 VISITING SPECIALTY CLINIC	20, 457	0	25, 04	2 0	0	190. 01
190.02	19002 OUTREACH	73, 364	0		0 0	15, 124	190. 02
	19003 FOUNDATI ON	3, 968	4, 681	1, 45	9 0		190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0		0 0		190. 04
	19005 PAOLI FAMILY PRACTICE	18, 506	0		0 0		190.05
	19006 OTHER PROPERTY	17, 477	0	35, 02	0		190.06
	19100 RESEARCH	0	0				191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0		0 0		192.00 193.00
200.00		0	0		0	0	200.00
200.00		0	0		0	Ο	200.00
201.00		6, 308, 649	1, 454, 585	541, 83	5 111, 228		
	· · · · · · · · · · · · · · · · · · ·	2,000,017	.,	0.1,00	, 220		

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2016 o 12/31/2016	Worksheet B Part I Date/Time Pre 5/23/2017 12:	pared: 41 pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	HOUSE SUPERVI SORS	CENTRAL SERVI CES & SUPPLY	
	10.00	11.00	13.00	13.01	14.00	
GENERAL SERVICE COST CENTERS	1 1					
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 UTILITIES 8.00 00800						1.00 2.00 4.00 5.00 7.00 7.01 8.00
9. 00 00900 HOUSEKEEPING 10. 00 11. 00 01100 CAFETERIA	349, 561 0	302, 681				9.00 10.00 11.00
13.00 01300 NURSING ADMINISTRATION	0	20, 198	866, 303			13.00
13. 01 01301 HOUSE SUPERVI SORS	0	17, 004		699, 014		13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	72		0	778, 291	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	13, 046		0	34, 096 0	15.00 16.00
17.00 01700 SOCIAL SERVICE	0		0	0	0	17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	6, 521	-	0	10, 348	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	349, 561	57, 776		258, 062	84, 622	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	3, 632	20, 104	16, 222	29, 154	43.00
50. 00 05000 OPERATI NG ROOM	0	21, 952	121, 517	98, 051	247, 189	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	5, 251		23, 454	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	38, 100	0	0	64, 302	54.00
60. 00 06000 LABORATORY	0	1, 618		0	2, 376	
64. 00 06400 I NTRAVENOUS THERAPY	0	2,632			9, 342	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	17, 102		0	36, 048	65.00 66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24, 107 C		0	20, 709 0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73.01
74.00 07400 RENAL DI ALYSI S	0	C	0	0	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	C	0	0	0	75.00
75. 01 07501 CARDI AC REHAB 76. 97 07697 CARDI AC REHABI LI TATI ON	0	2, 575		0	0 2, 834	75.01
OUTPATIENT SERVICE COST CENTERS	0	2,070	y 0	U0	2,034	/0. 7/
88.00 08800 RURAL HEALTH CLINIC	0	C	0 0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	89.00
90. 00 09000 CLINIC	0	C	0 0	0	0	
91.00 09100 EMERGENCY	0	65, 256	361, 226	291, 470	233, 450	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	C	0	0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	C				101.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 I NTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	349, 561	296, 842	866, 303	699, 014	774, 470	113.00 118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0 0	0	0	190. 00
190. 01 19001 VI SI TI NG SPECIALTY CLI NI C	0	C	0		0	190. 01
190. 02 19002 OUTREACH	0	5, 839	0	0		190. 02
190. 03 19003 FOUNDATI ON	0	C	0	0		190.03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	C	0	0		190. 04 190. 05
190. 05 19005 PAOLI FAMILY PRACTICE 190. 06 19006 OTHER PROPERTY	0			0		190.05 190.06
190. 00 19000 OTHER PROPERTY 191. 00 19100 RESEARCH	0	ſ		0		190.08
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C	o o	0		192.00
193.00 19300 NONPALD WORKERS	0	C	0	0		193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	C	0	0		201.00
202.00 TOTAL (sum lines 118-201)	349, 561	302, 681	866, 303	699, 014	778, 291	J202. 00

Health Financial Systems	IU HEALTH PAOI	I HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	10 1121211 1710	Provi der C		eriod: rom 01/01/2016	Worksheet B	2002 10
			T		Part I Date/Time Pre	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	<u>5/23/2017 12:</u> Subtotal	41 pm
		RECORDS &		ANESTHET I STS		
	15.00	LI BRARY 16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS			1			
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATI ON OF PLANT 7. 01 00701 UTI LI TI ES						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
13. 01 01301 HOUSE SUPERVI SORS						13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	635, 011					14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	259, 688				16.00
17.00 01700 SOCIAL SERVICE 19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	1 <u>0</u>	051,050		19.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	24, 850			3, 467, 283	
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0	0 1, 343	0		0 231, 057	
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	1, 545	0	<u> </u>	231,037	43.00
50.00 O5000 OPERATING ROOM	0	30, 991	0		2, 619, 836	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0	5, 066 41, 777			379, 540 2, 461, 363	
60. 00 06000 LABORATORY	207	35, 562	-	0	2, 051, 296	
64.00 06400 I NTRAVENOUS THERAPY	0	5, 559		-	214, 717	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	3, 780 6, 787		-	621, 985 1, 225, 949	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	976		0	38, 667	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	516			20, 023	
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 DRUGS CHARGED TO PATIENTS	634, 804 0	27, 224 0	-	0	2, 578, 228 0	
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	
75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 07501 CARDI AC REHAB	0	0	0	0	0	
75. 01 07501 CARDI AC REHAB 76. 97 07697 CARDI AC REHABI LI TATI ON	0	1, 079	0		0 209, 491	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0 0	
90. 00 09000 CLINIC	0	149			52, 131	•
91. 00 09100 EMERGENCY	0	74, 029	0	0	4, 495, 402	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95.00 09500 AMBULANCE SERVICES	0	0			0	95.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	635, 011	259, 688	0	651, 650	20, 666, 968	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN		0	0	ol		190.00
190. 01 19001 VISITING SPECIALTY CLINIC	0	0				190.00
190. 02 19002 OUTREACH	0	0	0	0	268, 298	
190.03 19003 FOUNDATION 190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 03 190. 04
190. 05 19005 PAOLE FAMILY PRACTICE	0	0	0	0	62, 217	190. 05
190. 06 19006 OTHER PROPERTY	0	0	0	О	96, 910	190.06
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191.00 192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments		-		0		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0 635, 011	0 259, 688	0		0 21, 209, 330	201. 00 202. 00
		20,, 500			_, _0, 000	1

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL	In lieu of Fo	orm CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	TO HEALTH THE	Provi der CCN: 15-1306	Period: Workst	neet B
			From 01/01/2016 Part I To 12/31/2016 Date/	Fime Prepared:
			5/23/2	2017 12:41 pm
Cost Center Description	Intern & Residents Cost	Total		
	& Post			
	Stepdown			
	Adjustments 25.00	26.00		
GENERAL SERVICE COST CENTERS				
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 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL				4.00
7.00 00700 OPERATION OF PLANT				7.00
7. 01 00701 UTI LI TI ES				7.01
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				9.00 10.00
11. 00 01100 CAFETERIA				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
13. 01 01301 HOUSE SUPERVI SORS				13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY				14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY				16.00
17. 00 01700 SOCIAL SERVICE				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS				19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 4 (7 2 2 2 2		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSIVE CARE UNIT	0	3, 467, 283 0		30.00 31.00
43. 00 04300 NURSERY	0	231, 057		43.00
ANCI LLARY SERVI CE COST CENTERS		· · ·		
50.00 05000 OPERATI NG ROOM	0	2, 619, 836		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	379, 540		52.00 54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	2, 461, 363 2, 051, 296		60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	214, 717		64.00
65. 00 06500 RESPI RATORY THERAPY	0	621, 985		65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 225, 949		66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	38, 667 20, 023		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 578, 228		73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00 07400 RENAL DI ALYSI S	0	0		74.00
75. 00 07500 ASC (NON-DISTINCT PART) 75. 01 07501 CARDIAC REHAB	0	0		75.00 75.01
76. 97 07697 CARDI AC REHABILI TATI ON	0	209, 491		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 90. 00 09000 CLI NI C	0	0 52, 131		89.00 90.00
91. 00 09100 EMERGENCY	0	4, 495, 402		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	0	0 0		95.00 101.00
SPECIAL PURPOSE COST CENTERS	0	0		101.00
113.00 11300 INTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	20, 666, 968		118.00
NONREI MBURSABLE COST CENTERS		0		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 VISITING SPECIALTY CLINIC	0	0 93, 818		190. 00 190. 01
190. 02 19002 OUTREACH	0	268, 298		190. 02
190. 03 19003 FOUNDATI ON	0	21, 119		190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0 62 217		190.04
190. 05 19005 PAOLI FAMILY PRACTICE 190. 06 19006 OTHER PROPERTY	0	62, 217 96, 910		190. 05 190. 06
191. 00 19100 RESEARCH	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
193.00 19300 NONPAID WORKERS	0	0		193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	0	21, 209, 330		202.00
		•		

Heal th	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO		eriod: rom 01/01/2016 p 12/31/2016	Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/23/2017 12:	41 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	·					
1.00 2.00 4.00 5.00 7.00 7.01	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	000000000000000000000000000000000000000	837 102, 269 62, 350 0	40, 724 0	1, 384 169, 064 103, 074 0 7 165	1, 384 99 72 0	1.00 2.00 4.00 5.00 7.00 7.01
8.00 9.00 10.00 11.00 13.00 13.01	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01301 HOUSE SUPERVISORS		4, 328 11, 123 23, 298 14, 498 7, 516 0	7, 265 15, 217 9, 470	7, 155 18, 388 38, 515 23, 968 12, 425 0	0 35 15 21 76 77	8.00 9.00 10.00 11.00 13.00 13.01
14.00 15.00 16.00 17.00 19.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0 0 0 0	29, 574 16, 864 18, 033 0 0	11, 015	48, 890 27, 879 29, 811 0 0	0 44 0 0 67	14.00 15.00 16.00 17.00 19.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	97, 882	63, 932	161, 814	181	30. 00
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	0 3, 607	0 2, 356	0 5, 963	0 15	31.00 43.00
50. 00 52. 00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	86, 947 17, 124	56, 790 11, 185	143, 737 28, 309	84	50. 00 52. 00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	84, 163 26, 588		139, 134 43, 954	136 4	54.00 60.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	5, 771 4, 097	3, 769 2, 676	9, 540 6, 773	12 58	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	35, 965	23, 490	59, 455	99	66.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0 0	0	0 0	0 0	71. 00 72. 00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00 73.01
74.00 75.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00 75.01	07500 ASC (NON-DISTINCT PART) 07501 CARDIAC REHAB	0	0	0	0	0 0	75. 00 75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	13, 142	8, 584	21, 726	9	76. 97
	08800 RURAL HEALTH CLINIC	0	0		0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 1, 370	0 895	0 2, 265	0	89.00 90.00
91.00 92.00	09100 EMERGENCY	0	58, 426		96, 587 0	237	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				U		92.00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	0 0		0 0	0	95.00 101.00
	SPECIAL PURPOSE COST CENTERS		0		0	0	
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	0	725, 772	474, 038	1, 199, 810	1, 363	113. 00 118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190.01	19001 VISITING SPECIALTY CLINIC	0	29, 213	19, 081	48, 294	0	190. 01
	19002 OUTREACH 19003 FOUNDATI ON	0	15, 710 1, 702		15, 710 2, 814		190. 02 190. 03
190.04	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190. 04
	19005 PAOLI FAMILY PRACTICE 19006 OTHER PROPERTY	0	34, 623 40, 855		34, 623 40, 855		190. 05 190. 06
191.00	19100 RESEARCH	0	0	0	.0, 000	0	191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19300 NONPALD WORKERS	0	0	0	0		192. 00 193. 00
200.00	Cross Foot Adjustments		0	0	0		200. 00
201.00 202.00		0	0 847, 875	0 494, 231	0 1, 342, 106		201. 00 202. 00

Heal th	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE		UTILITIES	LAUNDRY &	5/23/2017 12: HOUSEKEEPI NG	41 pm
		& GENERAL 5.00	PLANT 7.00	7.01	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	7.01	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	169, 163					5.00
7.00 7.01	00700 OPERATION OF PLANT 00701 UTILITIES	11,602	114, 748				7.00 7.01
8.00	00800 LAUNDRY & LINEN SERVICE	763					8.00
9.00	00900 HOUSEKEEPI NG	3, 641	2, 413			24, 553	9.00
10.00	01000 DI ETARY	1, 939				1, 109	
11.00		1,886				690	
13.00 13.01	01300 NURSI NG ADMI NI STRATI ON 01301 HOUSE SUPERVI SORS	6, 475 5, 440		51		358 0	13.00 13.01
	01400 CENTRAL SERVICES & SUPPLY	5, 356		-		0	14.00
15.00	01500 PHARMACY	4, 204	3, 659			0	15.00
	01600 MEDI CAL RECORDS & LI BRARY	1, 414	3, 912			858	16.00
	01700 SOCIAL SERVICE	0	-	-		0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	5, 063	0	0	0	0	19.00
30.00	03000 ADULTS & PEDIATRICS	15, 117	21, 236	670	2, 398	4, 657	30.00
	03100 I NTENSI VE CARE UNI T	0				0	31.00
43.00	04300 NURSERY	1, 150	782	25	0	172	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	8, 292 1, 882	18, 863 3, 715			4, 139 815	1
52.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 002	18, 259			4, 006	
60.00	06000 LABORATORY	15, 075				1, 266	
64.00	06400 I NTRAVENOUS THERAPY	1, 152	1, 252	39	0	275	64.00
65.00	06500 RESPI RATORY THERAPY	4, 358				195	
66.00	06600 PHYSI CAL THERAPY	8, 721	623			1, 712	66.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	301	0		0	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15, 284	0	-	0	0	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	75.00
75. 01 76. 97	07501 CARDI AC REHAB 07697 CARDI AC REHABI LI TATI ON	0	0 2, 851	0 90		0 626	75.01 76.97
70. 77	OUTPATIENT SERVICE COST CENTERS	1,140	2,001	70	<u> </u>	020	70.97
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	1
90.00		365		9	0	65	90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	25, 217	12, 675	400	3, 228	2, 781	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
	09500 AMBULANCE SERVI CES	0					95.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	1	[112 00
113.00		165, 576	114, 379	3, 831	8, 887	23 724	113.00 118.00
110.00	NONREI MBURSABLE COST CENTERS	100,070	111,077	0,001	0,007	20,721	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
	19001 VISITING SPECIALTY CLINIC	549					190.01
	19002 OUTREACH 19003 FOUNDATI ON	1,967		-			190. 02 190. 03
	19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE	106		12			190.03
	19005 PAOLI FAMILY PRACTICE	496		0			190.04
190.06	19006 OTHER PROPERTY	469		279		0	190. 06
	19100 RESEARCH	0	0	0			191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00 193. 00
193.00 200.00	19300 NONPAID WORKERS Cross Foot Adjustments	0	0			0	200.00
200.00		0	0	0	0	0	200.00
202.00		169, 163	114, 748	4, 322	8, 887		202.00

2.00 00200 CAP REL COSTS-AVRUE EQUIP	Heal th 1	Financial Systems	IU HEALTH PAOL	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Conter Description DIETARY CAFETERIA MMINISTRATION HOUSE MMINISTRATION HOUSE SERVICE SA SUPPLY CENTRAL SUPPLY 10.00 01000 CAP FEL COST-SUDUE 6 FIXT 10.00 13.00 13.01 14.00 10.00 03000 CAP FEL COST-SUDUE 6 FIXT 14.00 10.00 13.01 14.00 10.00 03000 CAP FEL COST-SUDUE 6 FIXT 10.00 10.00 10.01 10.00 11.00 13.01 14.00 10.00 03000 CAP FEL COST-SUDUE 6 FIXT 10.00	ALLOCAT	ION OF CAPITAL RELATED COSTS		Provider C	Fr	rom 01/01/2016	Part II Date/Time Pre	pared: 41 pm
ELNERAL SERVICE COST CENTERS 10.00 11.00 13.00 13.01 14.00 1.00 00100 CAP REL COSTS BLG & FIXT		Cost Center Description	DI ETARY	CAFETERI A			CENTRAL SERVI CES &	
1: 00 00100 CAP ELC COSTS-BUDE & FIVT 00400 EWPLOYEE BENEFITS DEPARTMENT 004000 EWPLOYEE BENEFITS DEPARTMENT 004000 EWPLOYEE BENEFITS DEPARTMENT 004000 EWPLOYEE BENEFITS DEPARTMENT 004000 OPERATION OF PLANT 1: 001000 DITUDITULI ILE 004000 DITALE SERVICE 004000 DITALE SERVICE 0: 004000 DIFARM 0: 01100 CAFFERIA A LINEN SERVICE 0: 01500 PHARAMCY 0: 01500 DHARAMCY 0: 05000 DHARAMCY 0:			10.00	11.00	13.00	13.01		
2.00 00200 CAP REL COSTS-AWBLE COSTS-AWBLE TOJE FAULENT 00500 ADMI INSTRATIVE & CENERAL 5.00 00500 ADMI INSTRATIVE & CENERAL 1 7.01 00701 UTLLITES 0 8.00 00800 ADMI INSTRATIVE & CENERAL 1 7.01 00701 UTLLITES 0 8.00 00800 DELAMRY & LINEN SERVICE 1 9.00 00900 DELAMRY & LINEN SERVICE 1 11.00 01100 CARTERIA ADMI NISTRATION 0 2.9,000 11.00 01100 CHARTERIA ADMI NISTRATION 0 2.9,000 11.00 01100 CHARTERIA SERVICES AS LIBRARY 0 1,07 0 0,080 10.00 01000 INMENISCIAL RECORDS & LIBRARY 0 </td <td>-</td> <td></td> <td>1 1</td> <td></td> <td>1</td> <td></td> <td></td> <td></td>	-		1 1		1			
19:00 ODOL NORPHYSIC IAN AMESTHETI STS O 642 O 00 809 1 10:00 03000 ADULTS & PEDIATRI CS 66,791 5,690 8,493 2,655 6,618 3 31:00 03100 INTERSIVE CARE UNI T 0 358 534 167 2,280 4 ANCILLARY SERVICE COST CENTERS 0 358 534 167 2,280 4 ANCILLARY SERVICE COST CENTERS 0 3517 772 241 0 5 60.0 5.020 0 5,029 5 0 0 5,029 5 0 0 5,029 5 0 0 5,029 5 0 0 0 5,029 5 0 0 0 5,029 5 6 0 66,00 66,00 66,00 1,684 0 0 2,819 6 6 6 6,600 0 0 0 0 0 7 7 0 0 0	2.00 4.00 5.00 7.01 8.00 9.00 10.00 11.00 13.00 13.01 0 15.00 16.00	D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMI NI STRATI VE & GENERAL D0700 OPERATI ON OF PLANT D0701 UTI LITIES D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 HURSI NG D1400 CENTRAL D1400 CENTRAL D1400 PHARMACY D1400 MEDI CAL RECORDS LI BRARY	0 0 0 0 0	1, 989 1, 675 7 1, 285 C	23,005 0 0 0 0 0	0 0 0	2, 667 0	15.00 16.00
INPATI ENT. ROUTINE SERVICE COST CENTERS 0			-	-	-	-		
30.00 03000 ADULTS & PEDIATRICS 46,791 5,690 8,493 2,655 6,618 3 43.00 04300 NURSERY 0 358 534 167 2,280 4 AACULLARY SERVICE COST CENTERS 0 358 534 167 2,280 4 ANCILLARY SERVICE COST CENTERS 0 358 534 167 2,280 4 ANCILLARY SERVICE COST CENTERS 0 357 772 241 0 5 50.00 05000 RADIOLOGO/PERATING ROOM 0 517 772 241 0 5 60.00 0000 LABORATORY 0 159 0 0 186 6 64.00 06000 INTRAVENUS THERAPY 0 2,374 0 0 2,819 6 6 6 0 0 0 0 0 0 7 7.00 7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 7 7 7 7 7 7 7			0	642	0	0	809	19.00
31.00 03100 1NTENSIVE CARE UNIT 0 0 0 0 0 0 0 334 43.00 04300 NURSERY 0 358 534 167 2,280 4 50.00 05000 OPERATI NG ROM 0 2,162 3,227 1,009 19,333 5 51.00 05200 DELI VERY ROM & LABOR ROM 0 517 772 241 0 5 54.00 05200 DELI VERY ROM & LABOR ROM 0 517 772 241 0 5 60.00 06000 CABORATORY 0 159 0 0 186 6 61.00 05000 RESPI RATORY THERAPY 0 2,8374 0 0 1,620 6 71.00 0700 IMPL DEV CHARGED TO PATIENTS 0 0 0 0 0 7 7 7 0 7 7 0 0 0 0 7 7 0 7 0 7 0 7 7 0 0 0 0 7 7 0 7 0 7			16 701	5 600	8 103	2 655	6 618	30.00
43.00 DO 356 534 167 2,280 4 ANCILLARY SERVICE COST CENTERS			1					1
ANCI LLARY SERVICE COST CENTERS 50.00 OGOOO OPEEATING ROOM 0 2, 162 3, 227 1, 009 19, 333 5 52.00 05000 OPEEATING ROOM 0 517 772 241 0 5 54.00 05000 DELIVERY ROOM & LABOR ROOM 0 517 772 241 0 5 60.00 06000 LABORATORY 0 159 0 0 166 60.00 06000 LABORATORY 0 1.684 0 0 2.819 66.00 06600 PHSI CAL THERAPY 0 2.374 0 0 1.620 71.00 07100 IMPL CAL SUPPATIENTS 0 0 0 0 0 7 73.00 07300 INCICS CHARGED TO PATIENTS 0 0 0 0 0 0 7 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 7 7 7 0 0 0 0 7 7 7 0				-		-	-	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 517 772 241 0 5 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 3,752 0 0 5,029 5 64.00 06400 LABORATORY 0 159 0 0 186 6 65.00 06500 RESPIRATORY THERAPY 0 259 387 121 731 6 66.00 06500 RESPIRATORY THERAPY 0 2,374 0 0 2,819 6 67.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 7 7 2.01 0,7300 DRUGS CHARGED TO PATIENTS 0 <td< td=""><td>A</td><td>ANCI LLARY SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	A	ANCI LLARY SERVICE COST CENTERS						
54.00 05400 RADI 0 LOGY -DI AGNOSTI C 0 3,752 0 0 5,029 5 60.00 06000 LABORATORY 0 159 0 0 186 6 64.00 06400 INTRAVENUS THERAPY 0 259 387 121 731 6 65.00 06500 RESPI RATORY THERAPY 0 1,684 0 0 2,819 6 64.00 0600 HYSI CAL THERAPY 0 2,374 0								
60.00 06000 LABORATORY 0 159 0 0 186 6 64.00 06500 IRTAVENOUS THERAPY 0 259 387 121 731 6 65.00 06500 RESPI RATORY THERAPY 0 1.684 0 0 2.819 6 66.00 06000 HUSI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 7 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 7 7 0.0 7300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 7 7 0.0 75.00 0.0 0			0					
64.00 06400 INTRAVENOUS THERAPY 0 259 387 121 731 6 65.00 06500 RESPIRATORY THERAPY 0 1,684 0 0 2,819 6 66.00 06600 PHYSICAL THERAPY 0 2,374 0 0 0 0 7 0 71.00 0			0			-		1
65.00 06500 RESPIRATORY THERAPY 0 1, 684 0 0 2, 819 6 66.00 06600 PHYSI CAL THERAPY 0 2, 374 0 0 1, 620 6 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 7 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 7 73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0 0 7 74.00 07400 RENAL DI ALYSI S 0 0 0 0 7 75.01 07501 CARDI AC REHABI LI TATI ON 0 254 0 0 7 75.01 07697 CARDI AC REHABI LI TATI ON 0 254 0 0 2227 7 76 07697 CARDI AC REHABI LI TATI ON 0 254 0			0			-		1
66.00 06600 PHYSI CAL THERAPY 0 2, 374 0 0 1, 620 6 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0			0					1
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 7 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 7 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 7 73.00 07301 DRUGS CHARGED TO PATIENTS 0 0 0 0 7 74.00 07400 RENAL DI ALYSIS 0 0 0 0 7 75.00 07501 CARDI AC REHAB 1ALYSIS 0 0 0 7 76.07 07501 CARDI AC REHABILITATION 0 254 0 0 222 7 00TPATIENT SERVICE COST CENTERS 0 0 0 0 0 8 8 0 8800 0800 RURAL HEALTH CLINIC 0 0 0 0 0 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 0 0 0 0<			0			-		1
73.00 07300 DRUGS CHARGED TO PATIENTS 0			0			0		1
73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 7 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 7 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 7 75.01 07501 CARDI AC REHAB 117110N 0 254 0 0 222 7 76.97 07697 (CARDI AC REHABILLITATION 0 254 0 0 222 7 90 008900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 8 8 0 0 0 0 0 8 8 0 0 0 0 0 0 0 0 0 0 0 9 9 9 0			0	C		0	0	1
74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 7 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 7 75.01 07501 CARDI AC REHAB 0 0 0 0 0 7 76.97 CARDI AC REHABILITATION 0 254 0 0 2227 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 8 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 8 90.00 09000 CLINIC 0 0 0 0 0 8 90.00 090000 CLINIC 0 0 0 0 9 9 00 09100 EMERGENCY 0 6, 427 9, 592 2, 999 18, 258 9 95.00 09500 ABBULANCE SERVICES 0 0 0 0 0 0 10 010100 HORE MERGENCY 0 0 0 0 0 0			0	C		0	-	
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 7 75.01 07501 CARDI AC REHAB 0 0 0 0 7 76.97 O7697 CARDI AC REHABILITATION 0 254 0 0 222 7 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 8 0 0 0 0 0 8 8 0 0 0 0 0 0 8 8 0 08900 RURAL HEALTH CLINIC 0			0	C		0		
75. 01 07501 CARDIAC REHAB 0 0 0 0 7 76. 97 07697 CARDIAC REHABILITATION 0 254 0 0 222 7 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 222 7 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 8 90. 00 09000 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 8 90. 00 09000 CLINIC 0 0 0 0 0 0 0 9 91. 00 09100 EMERGENCY 0 6, 427 9, 592 2, 999 18, 258 9 92. 00 09200 0BSEVATION BEDS (NON-DISTINCT PART 0			0			0		
76.97 O7697 CARDIAC REHABILITATION O 254 O O 222 7 88.00 OBBOO RURAL HEALTH CLINIC O O O 0 8 8 0 08900 FEDERALLY QUALIFIED HEALTH CENTER O O 0			0		, i i i i i i i i i i i i i i i i i i i	0		1
88.00 08800 RURAL HEALTH CLINIC 0<						-		1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 9 90.00 09000 CLINIC 0 0 0 0 0 9 91.00 09100 EMERGENCY 0 6,427 9,592 2,999 18,258 9 92.00 09SERVATI ON BEDS (NON-DI STINCT PART 0 6,427 9,592 2,999 18,258 9 95.00 09500 AMBULANCE SERVICES 0 </td <td>C</td> <td>DUTPATIENT SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	C	DUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC 0 0 0 0 0 0 0 9 9 91.00 09100 EMERGENCY 0 6, 427 9, 592 2, 999 18, 258 9 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 6, 427 9, 592 2, 999 18, 258 9 0 09500 AMBULANCE SERVICES 0 0 0 0 9 101.00 10100 HOME HEALTH AGENCY 0						0		
91.00 09100 EMERGENCY 0 6,427 9,592 2,999 18,258 9 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 9 10 0 0 0 0 0 0 9 9 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td><td></td></td<>						0		
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 9 0THER REIMBURSABLE COST CENTERS 0 0 0 0 9 95.00 09500 AMBULANCE SERVI CES 0			0			Ű		
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 9 101.00 10100 HOME HEALTH AGENCY 0			0	0, 427	7, 372	2, 777	10, 200	92.00
95.00 09500 AMBULANCE SERVICES 0 </td <td></td> <td></td> <td>1 1</td> <td></td> <td></td> <td></td> <td></td> <td>12.00</td>			1 1					12.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 11 118.00 SUBTOTALS (SUM OF LINES 1-117) 46, 791 29, 234 23, 005 7, 192 60, 572 11 100 INTEREST EXPENSE INTEREST EXPENSE 11 <td>95.00</td> <td>09500 AMBULANCE SERVI CES</td> <td>0</td> <td>C</td> <td>0 0</td> <td>0</td> <td>0</td> <td>95.00</td>	95.00	09500 AMBULANCE SERVI CES	0	C	0 0	0	0	95.00
113.00 INTEREST EXPENSE 11 118.00 SUBTOTALS (SUM OF LINES 1-117) 46,791 29,234 23,005 7,192 60,572 11 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 19 190.01 19001 VI SI TI NG SPECI ALTY CLI NI C 0 0 0 19 190.02 19002 OUTREACH 0 575 0 0 54 190.03 19003 FOUNDATI ON 0 0 0 0 19 190.04 19004 SPRI NG VALLEY FAMILY PRACTICE 0 0 0 0 19			0	C	0	0	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 46,791 29,234 23,005 7,192 60,572 11 NONREL MBURSABLE COST CENTERS			1					110.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 19 190.01 19001 VI SI TI NG SPECIALTY CLINIC 0 0 0 19 190.02 19002 OUTREACH 0 575 0 0 54 19 190.03 19003 FOUNDATI ON 0 0 0 19 190.04 19004 SPRI NG VALLEY FAMILY PRACTICE 0 0 0 19			46 701	20.224	22.005	7 100	40 572	113.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190 190.01 19001 VI SI TI NG SPECIALTY CLINIC 0 0 0 190 190.02 19002 OUTREACH 0 575 0 0 54 19 190.03 19003 FOUNDATI ON 0 0 0 0 19 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 19			40, 791	27, 234	23,005	7, 172	00, 372	1110.00
190.01 VI SI TI NG SPECIALTY CLINIC 0 0 0 19 190.02 19002 OUTREACH 0 575 0 0 54 19 190.03 19003 FOUNDATI ON 0 0 0 0 19 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 19	-		0	C	0	0	0	190.00
190.03 FOUNDATION 0 0 0 0 190 190 190 190 0 0 0 190 190 190 0 0 0 0 190 0 190 0 0 0 190 0 0 0 190 190 0 0 0 190 <	190.011	19001 VISITING SPECIALTY CLINIC	0	C	0	0	0	190. 01
190.04 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0			0	575		0		190. 02
			0			0		190.03
170. UST FOUST FAULT PRACTICE U UUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUU			0			0		190.04
190.06/19006/0THER PROPERTY 0 0 0 0 245/19			0			0		190. 05 190. 06
			0	C C		0		190.08
			0	0	0	0		192.00
			0	C	o o	0		193.00
200.00 Cross Foot Adjustments 20	200.00	Cross Foot Adjustments						200. 00
			0	C	0	0		201.00
202. 00 TOTAL (sum lines 118-201) 46, 791 29, 809 23, 005 7, 192 60, 871 20	202.00	IUIAL (sum lines 118-201)	46, 791	29, 809	23, 005	7, 192	60, 871	J202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH PAOL	Provider C		eriod:	u of Form CMS- Worksheet B	2002-10
					rom 01/01/2016	Part II	epared: 41 pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	
		15.00	16.00	17.00	19.00	24.00	
	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 UTI LI TI ES						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
	01301 HOUSE SUPERVI SORS						13.01
	01400 CENTRAL SERVICES & SUPPLY						14.00
		39, 853 0	24 110				15.00
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	36, 118 0				16.00
	01900 NONPHYSI CLAN ANESTHETI STS	0	C				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	3, 456			279, 776	1
31.00	03100 I NTENSI VE CARE UNI T	0	0			0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	187	0		11, 633	43.00
50.00	05000 OPERATING ROOM	0	4, 311	0		206, 669	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	705			37, 296	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 811	0		193, 501	54.00
60.00	06000 LABORATORY	13	4, 946			71, 553	
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	773			14, 541	
65.00 66.00	06600 PHYSI CAL THERAPY	0	526 944			17, 330 76, 399	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	136			437	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72			228	
	07300 DRUGS CHARGED TO PATIENTS	39, 840	3, 787			58, 911	
	07301 DRUGS CHARGED TO PATIENTS	0	0			0	
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0			0	
	07500 ASC (NON-DISTINCT PART) 07501 CARDIAC REHAB	0	0			0	
	07697 CARDI AC REHABI LI TATI ON	0	150			27, 068	
	OUTPATIENT SERVICE COST CENTERS					-	
	08800 RURAL HEALTH CLINIC	0	C			0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	
90.00	09000 CLINIC 09100 EMERGENCY	0	21 10, 293			3, 022 188, 694	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	10, 275			100, 074	92.00
	OTHER REIMBURSABLE COST CENTERS	1 1		1	11		1
	09500 AMBULANCE SERVICES	0	C				95.00
101.00	10100 HOME HEALTH AGENCY	0	0	0		0	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00		39, 853	36, 118	0	0	1, 187, 058	
110.00	NONREI MBURSABLE COST CENTERS	07,000	00, 110	<u> </u>		1, 107, 000	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0		0	190. 00
	19001 VISITING SPECIALTY CLINIC	0	C				190. 01
	19002 OUTREACH	0	0	, i i i i i i i i i i i i i i i i i i i			190.02
	19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0			190. 03 190. 04
	19005 PAOLI FAMILY PRACTICE	0	0				190.04
	19006 OTHER PROPERTY	0	0	0			190.05
	19100 RESEARCH	0	C	0		0	191.00
191.00	19200 PHYSI CLANS' PRI VATE OFFI CES	1 0	C	0			192.00
192.00		9					
192. 00 193. 00	19300 NONPAI D WORKERS	0	C	0		0	193.00
192.00	19300 NONPAID WORKERS Cross Foot Adjustments	0	C	0	6, 581	0 6, 581	193.00 200.00 201.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL	In lieu of F	orm CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	10 112/12/11 17/02	Provider CCN: 15-1	306 Period: Works	sheet B
			From 01/01/2016 Part To 12/31/2016 Date/	'Time Prepared:
Cost Center Description	Intern &	Total	5/23/	2017 12:41 pm
	Residents Cost			
	& Post			
	Stepdown Adjustments			
	25.00	26.00		
GENERAL SERVICE COST CENTERS	T T			
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500 ADMINI STRATI VE & GENERAL				5.00
7.00 00700 OPERATION OF PLANT				7.00
7. 01 00701 UTI LI TI ES				7.01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8. 00 9. 00
10. 00 01000 DI ETARY				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_SERVI CES & SUPPLY 15. 00 01500 PHARMACY				14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
17.00 01700 SOCIAL SERVICE				17.00
19.00 01900 NONPHYSI CLAN ANESTHETI STS				19.00
30. 00 03000 ADULTS & PEDIATRICS	0	279, 776		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	279, 770		31.00
43.00 04300 NURSERY	0	11, 633		43.00
ANCI LLARY SERVI CE COST CENTERS	1 1	l		
50.00 05000 OPERATING ROOM	0	206, 669		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI 0L0GY-DI AGNOSTI C	0	37, 296 193, 501		52.00 54.00
60. 00 06000 LABORATORY	0	71, 553		60.00
64.00 06400 INTRAVENOUS THERAPY	0	14, 541		64.00
65. 00 06500 RESPI RATORY THERAPY	0	17, 330		65.00
66.00 06600 PHYSICAL THERAPY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76, 399 437		66. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	228		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	58, 911		73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 07501 CARDI AC REHAB	0	0		75.00 75.01
76. 97 07697 CARDIAC REHABILITATION	0	27, 068		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0 3, 022		89.00 90.00
91. 00 09100 EMERGENCY	0	188, 694		90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
OTHER REIMBURSABLE COST CENTERS	1 -1	-1		
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	0	0		95.00 101.00
SPECIAL PURPOSE COST CENTERS	<u>ч</u>	0		101.00
113.00 11300 I NTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 187, 058		118.00
NONREI MBURSABLE COST CENTERS		0		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 VISITING SPECIALTY CLINIC	0	49, 043		190. 00 190. 01
190. 02 19002 OUTREACH	0	19, 075		190.02
190. 03 19003 FOUNDATI ON	0	3, 382		190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190. 05 19005 PAOLI FAMILY PRACTICE 190. 06 19006 OTHER PROPERTY	0	35, 119 41, 848		190. 05 190. 06
190. 00 19000 OTHER PROPERTY 191. 00 19100 RESEARCH	0	41,848		190.08
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	Ö		192.00
193. 00 19300 NONPAI D WORKERS	0	0		193.00
200.00 Cross Foot Adjustments	0	6, 581		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0	1, 342, 106		201.00 202.00
	, V	.,		1202.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH PAC	DLI HOSPITAL Provider CO	CN: 15-1306 P	In Lie eriod:	eu of Form CMS-: Worksheet B-1	2552-10
			F	rom 01/01/2016 o 12/31/2016		nared [.]
					5/23/2017 12:	
	CAPITAL RE	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
			(GROSS			
	1.00	2.00	SALARIES) 4.00	5A	5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	1.00	0/1	0.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT	58, 773					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	58	52, 452 58				2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	7,089				14, 900, 681	5.00
7.00 00700 OPERATION OF PLANT	4, 322				1, 021, 923	7.00
	0	0	C			7.01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	300		C 176, 358	-	67, 175 320, 704	8.00 9.00
10. 00 01000 DI ETARY	1, 615					10.00
11. 00 01100 CAFETERI A	1,005					
13. 00 01300 NURSI NG ADMI NI STRATI ON 13. 01 01301 HOUSE SUPERVI SORS	521		385, 556 386, 948		570, 302 479, 148	13.00 13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY	2,050				471, 791	14.00
15. 00 01500 PHARMACY	1, 169				370, 270	
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	1, 250			-		16.00 17.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS		-	-	-	-	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	-	-				
30. 00 03000 ADULTS & PEDIATRICS	6, 785	6, 785				
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	250	250	C 75, 182	-		31.00 43.00
ANCI LLARY SERVICE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,		1017202	101.00
50.00 05000 OPERATING ROOM	6,027		423, 541			
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	1, 187 5, 834					
60. 00 06000 LABORATORY	1, 843				1	
64.00 06400 I NTRAVENOUS THERAPY	400				101, 512	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	284		295, 421 497, 834		383, 827	65.00 66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,493	2,493	497, 834	0	768, 192 26, 480	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	13, 705	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	C	0	.,	
73. 01 07301 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S				0	-	73.01 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	C	0	-	75.00
75. 01 07501 CARDI AC REHAB	011	0	01/	0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	911	911	46, 916	0	100, 425	76.97
88.00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	95	0 95	C	-	-	89.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	4,050		-	0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	.,	.,	.,,		_,,,	92.00
						05 00
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	0					95.00 101.00
SPECIAL PURPOSE COST CENTERS						101.00
113.00 11300 INTEREST EXPENSE	50.000	50.000	6 000 170	<i>.</i>		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	50, 309	50, 309	6, 880, 172	-6, 308, 649	14, 584, 718	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
190.01 19001 VISITING SPECIALTY CLINIC	2, 025			-		
190. 02 19002 OUTREACH 190. 03 19003 FOUNDATI ON	1, 089		107, 032	0		190. 02 190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0		0		190.03
190.05 19005 PAOLI FAMILY PRACTICE	2, 400		C	0		
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH	2,832		C C	0	41, 279	190. 06 191. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				0		191.00
193.00 19300 NONPALD WORKERS	0	0	C	0		193.00
200.00 Cross Foot Adjustments						200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	847, 875	494, 231	1, 086, 858		6, 308, 649	201. 00 202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 426267	9. 422539			0. 423380	
204.00 Cost to be allocated (per Wkst. B, Part II)			1, 384		169, 163	∠∪4. UU

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2016	Worksheet B-1	
				To 12/31/2016		pared: 41 pm
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00019	8	0. 011353	205.00

Health Financial Systems	IU HEALTH PAC				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2016	Worksheet B-1	
			T	0 12/31/2016	Date/Time Pre 5/23/2017 12:	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
	7.00	7.01	LAUNDRY) 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 UTI LI TI ES 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 13.01 01301 HOUSE SUPERVI SORS 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 19.00 NONPHYSI CI AN ANESTHETI STS INPATI ENT ROUTI NE SERVI CE COST CENTERS	36, 664 0 300 771 1, 615 1, 005 521 0 2, 050 1, 169 1, 250 0 0 0	43, 815 300 771 1, 615 1, 005 521 0 2, 050 1, 169 1, 250 0 0 0	13, 125 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	35, 757 1, 615 1, 005 521 0 0 0 1, 250 0 0	4, 030 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 13.\ 00\\ 13.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ \end{array}$
30. 00 03000 ADULTS & PEDIATRICS	6, 785	6, 785	3, 541	6, 785	4, 030	30.00
31.00 03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	250	250	0	250	0	43.00
50. 00 05000 OPERATI NG ROOM	6,027	6, 027		6, 027	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	1, 187 5, 834	1, 187 5, 834		1, 187 5, 834	0	52.00 54.00
60. 00 06000 LABORATORY	1, 843	1, 843	0	1, 843	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	400 284	400 284		400 284	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	199	2, 493		2,493	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 O7400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 07501 CARDI AC REHAB	0		0	0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	911	911	0	-	0	76.97
	0	0		0	0	
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	88.00 89.00
90. 00 09000 CLINIC	95	95		95	0	•
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4,050	4, 050	4, 769	4, 050	0	91.00 92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	L	<u> </u>	<u> </u>		72.00
95. 00 09500 AMBULANCE SERVICES	0	0				95.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	36, 546	38, 840	13, 125	34, 550	4, 030	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	2, 025		0	0	190. 01
190. 02 19002 0UTREACH 190. 03 19003 FOUNDATI ON	0 118	0	0	1, 089 118		190. 02 190. 03
190. 04 19003 FOUNDATION 190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0		0		190.03
190. 05 19005 PAOLI FAMILY PRACTICE	0	0	0	0		190. 05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH	0	2, 832	0	0		190.06 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191.00
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0	193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	1, 454, 585	541, 835	111, 228	496, 607	349, 561	•
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B,	39. 673385 114, 748	12. 366427 4, 322		13. 888385 24, 553	86. 739702 46. 791	203. 00 204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	3. 129719	0. 098642	0. 677105	0. 686663	11. 610670	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH PAC	Provider C		Period:	u of Form CMS- Worksheet B-1	
					rom 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 12:	
	Cost Center Description	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	(DIRECT NRSING	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	
		11.00	13.00	13.01	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 01\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 01\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 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 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01301 HOUSE SUPERVISORS 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	193, 104 12, 886 10, 848 46 8, 323 C C C 4, 160	99, 843 0 0 0 0 0 0	99, 843 C C C C	420, 214 18, 409 0 0 0 0 0	1, 346, 229 0 0 0	16.00 17.00
30.00	03000 ADULTS & PEDI ATRI CS	36, 860	36, 860	36, 860	45, 689	0	30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	C 2, 317			-	0	
73.00 73.01 74.00 75.00 75.01 76.97 88.00 89.00 90.00 91.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07501 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART	14, 005 3, 350 24, 307 1, 032 1, 679 10, 911 15, 380 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 350 0 1, 679 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 34, 718 0 1, 283 0 5, 044 19, 463 0 11, 181 0 0 0 0 0 0 0 0 0 0 0 0 0		52.00 54.00 60.00 64.00 65.00 66.00 71.00 72.00 73.01 74.00 75.01 75.01 76.97 88.00 89.00 90.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	C	0	(0	0	95.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	C	0	(<u> </u>	0	0	101.00
113.00 118.00	11300 INTEREST EXPENSE	189, 379	99, 843	99, 843	418, 151	1, 346, 229	113. 00 118. 00
190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 191. 00 192. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC 19002 OUTREACH 19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE 19005 PAOLI FAMILY PRACTICE 19006 OTHER PROPERTY 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS Cross Foot Adjustments	0 3, 725 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	1		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00 190.01 190.02 190.03 190.04 190.05 190.06 191.00 192.00 193.00 200.00 201.00
201.00 202.00 203.00	Cost to be allocated (per Wkst. B, Part I)	302, 681 1. 567451				635, 011 0. 471696	202.00
204.00	Cost to be allocated (per Wkst. B, Part II)	29, 809	23, 005	7, 192	60, 871	39, 853	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 154368	0. 230412	0. 072033	0. 144857	0. 029603	205.00

	Financial Systems	IU HEALTH PAC				Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CC		Period: Wor From 01/01/2016	rksheet B-1
					To 12/31/2016 Dat	ce/Time Prepared: 23/2017 12:41 pm
	Cost Center Description	RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	ANESTHETI STS (ASSI GNED TI ME)		
	GENERAL SERVICE COST CENTERS	16.00	17.00	19.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 01\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00701 UTI LI TI ES 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01301 HOUSE SUPERVI SORS 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	59, 016, 515 0	0			$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 01\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	100)	19.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	5, 647, 673	0	()	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	(31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	305, 173	0	()	43.00
50.00	05000 OPERATING ROOM	7, 043, 507	0	100		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 151, 300		(52.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	9, 494, 830		(54.00
64.00	06400 I NTRAVENOUS THERAPY	8, 082, 359 1, 263, 375				60.00 64.00
65.00	06500 RESPI RATORY THERAPY	859,059		(65.00
66.00	06600 PHYSI CAL THERAPY	1, 542, 411	0	()	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	221, 890	0	()	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	117, 331	0	(0	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 DRUGS CHARGED TO PATIENTS	6, 187, 265	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
	07500 ASC (NON-DI STINCT PART)	0	0	(75.00
75.01	07501 CARDI AC REHAB	0	0	()	75.01
76.97	07697 CARDI AC REHABI LI TATI ON	245, 264	0	()	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0				
88.00 89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			88. 00 89. 00
	09000 CLINIC	33, 902	0	(90.00
	09100 EMERGENCY	16, 821, 176		(91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0				95.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0			101.00
113.00	11300 I NTEREST EXPENSE					113.00
118.00		59, 016, 515	0	100		118.00
100.00	NONREI MBURSABLE COST CENTERS	2		-		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC	0	0			190. 00 190. 01
	19002 OUTREACH	0	0	(190.02
190.03	19003 FOUNDATI ON	0	0	(190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	(D	190. 04
	19005 PAOLI FAMILY PRACTICE	0	0		2	190.05
	19006 OTHER PROPERTY 19100 RESEARCH		0			190.06 191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		Ď	192.00
	19300 NONPAI D WORKERS	0	o o)	193.00
200.00						200. 00
201.00	5	0.55		/=		201.00
202.00		259, 688	0	651, 650	נ	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 004400	0. 000000	6, 516. 50000)	203.00
203.00		36, 118		6, 58		203.00
	Part II)					
205.00		0. 000612	0. 000000	65.810000	D	205.00
	11)	l		I	I	I

Health Financial Systems		IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF C	OSTS TO CHARGES		Provider C	CN: 15-1306	Peri od:	Worksheet C	
					From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	narod
					10 12/31/2010	5/23/2017 12:	41 pm
			Title	e XVIII	Hospi tal	Cost	
					Costs		
Cost Center D	escription	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal l owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	SERVICE COST CENTERS	0.447.000					
30.00 03000 ADULTS & PEDI		3, 467, 283		3, 467, 2		0	
31.00 03100 I NTENSI VE CAR	E UNI I	0		001.0	0 0	0	
43.00 04300 NURSERY		231, 057		231, 0	57 0	0	43.00
ANCI LLARY SERVICE (50.00 05000 OPERATI NG ROC		2 (10 02)		2 (10.0		0	50.00
50.00 05000 OPERATING ROC 52.00 05200 DELIVERY ROOM		2, 619, 836 379, 540		2, 619, 8 379, 5		0	50.00 52.00
54. 00 05400 RADI OLOGY-DI A						0	52.00
60. 00 06000 LABORATORY	GNUSTIC	2, 461, 363 2, 051, 296		2, 461, 3 2, 051, 2		0	60.00
64. 00 06400 I NTRAVENOUS T		2,051,290		2,051,2		0	64.00
65. 00 06500 RESPI RATORY T		621, 985	0			0	65.00
66. 00 06600 PHYSI CAL THER		1, 225, 949		1, 225, 9		0	66.00
	IES CHARGED TO PATIENTS	38,667	0	38, 6		0	71.00
72.00 07200 I MPL. DEV. CH		20, 023		20, 0		0	72.00
73. 00 07300 DRUGS CHARGED		2, 578, 228		2, 578, 2		0	73.00
73. 01 07301 DRUGS CHARGED		2, 370, 220		2, 570, 2	0 0	0	73.00
74.00 07400 RENAL DIALYSI		0			0 0	0	74.00
75. 00 07500 ASC (NON-DI ST		0			0 0	0	75.00
75. 01 07501 CARDI AC REHAB		0			0 0	0	75.01
76. 97 07697 CARDI AC REHAB		209, 491		209, 4		0	76.97
OUTPATIENT SERVICE							
88.00 08800 RURAL HEALTH		0			0 0	0	88.00
89.00 08900 FEDERALLY QUA	LIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC		52, 131		52, 1	31 0	0	90.00
91.00 09100 EMERGENCY		4, 495, 402		4, 495, 4	02 0	0	91.00
92.00 09200 OBSERVATION B	EDS (NON-DISTINCT PART	2, 212, 151		2, 212, 1	51	0	92.00
OTHER REI MBURSABLE	COST CENTERS						
95.00 09500 AMBULANCE SER	VICES	0			0 0	0	95.00
101.00 10100 HOME HEALTH A		0			0	0	101.00
SPECIAL PURPOSE COS		1					
113.00 11300 INTEREST EXPE							113.00
	instructions)	22, 879, 119	0				200.00
201.00 Less Observat		2, 212, 151	_	2, 212, 1			201.00
202.00 Total (see in	STRUCTIONS)	20, 666, 968	0	20, 666, 9	58 0	0	202.00

	ncial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/23/2017 12:	epared: 41 pm
			Title	× XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpatient	Total (col.	6 Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	FIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	D ADULTS & PEDIATRICS	1, 040, 400		1, 040, 40	00		30.00
31.00 03100	DINTENSIVE CARE UNIT	0			0		31.00
43.00 04300	D NURSERY	305, 173		305, 17	'3		43.00
ANCI L	LARY SERVICE COST CENTERS						
	OPERATING ROOM	676, 922	6, 366, 585	7, 043, 50	0. 371951	0.00000	50.00
52.00 05200	D DELIVERY ROOM & LABOR ROOM	806, 478	344, 822	1, 151, 30	0. 329662	0.00000	52.00
54.00 05400	D RADI OLOGY-DI AGNOSTI C	45, 908	9, 448, 922	9, 494, 83	0. 259232	0.00000	54.00
60.00 06000	DLABORATORY	355, 004	7,727,355	8, 082, 35	0. 253799	0. 000000	60.00
64.00 06400	INTRAVENOUS THERAPY	0	1, 263, 375	1, 263, 37	0. 169955	0. 000000	64.00
65.00 06500	RESPI RATORY THERAPY	40, 346	818, 713	859, 05	0. 724031	0. 000000	65.00
66.00 06600	PHYSICAL THERAPY	36, 902	1, 505, 509	1, 542, 41	0. 794826	0. 000000	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 347	192, 543	221, 89	0. 174262	0. 000000	71.00
72.00 07200	DIMPL. DEV. CHARGED TO PATIENTS	0	117, 331	117, 33	0. 170654	0.00000	72.00
	D DRUGS CHARGED TO PATIENTS	521, 802	5, 665, 463	6, 187, 26	0. 416699	0.00000	73.00
73.01 07301	1 DRUGS CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	73.01
74.00 07400	RENAL DIALYSIS	0	0		0 0.000000	0. 000000	74.00
75.00 07500	DASC (NON-DISTINCT PART)	0	0		0 0.000000	0. 000000	75.00
75.01 07501	1 CARDI AC REHAB	0	0		0 0.000000	0.00000	75.01
76.97 07697	7 CARDI AC REHABI LI TATI ON	0	245, 264	245, 26	0. 854145	0.00000	76.97
	ATIENT SERVICE COST CENTERS						
88.00 08800	DRURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90.00 09000		0	33, 902	33, 90	1. 537697	0.00000	90.00
91.00 09100	DEMERGENCY	80, 858	16, 740, 318	16, 821, 17	0. 267247	0.00000	91.00
	OBSERVATION BEDS (NON-DISTINCT PART	28, 021	4, 579, 252	4, 607, 27	0. 480143	0.00000	92.00
OTHER	R REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	1	0 0.000000	0. 000000	95.00
101.00 10100	D HOME HEALTH AGENCY	0	0		0		101.00
SPECI	AL PURPOSE COST CENTERS						
113.0011300	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	3, 967, 161	55, 049, 354	59, 016, 51	5		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	3, 967, 161	55,049,354	59, 016, 51	5		202.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1306	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/23/2017 12:41 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	1 1			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS	1			
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000			73.01
74.00 07400 RENAL DIALYSIS	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
75. 01 07501 CARDI AC REHAB	0. 000000			75.01
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS	1			
88.00 08800 RURAL HEALTH CLINIC				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLINIC	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES	0.000000			95.00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS	1			
113.00 11300 INTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	IU HEALTH PAO			In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/23/2017 12:	pared: 41 pm
		Titl	e XIX	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.4/7.000		0.4(7.00		0.4/7.000	
30. 00 03000 ADULTS & PEDIATRICS	3, 467, 283		3, 467, 28		3, 467, 283	
31. 00 03100 I NTENSI VE CARE UNI T	0		221.05	0 0 7 0	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	231, 057		231, 05	/ 0	231, 057	43.00
50. 00 05000 OPERATI NG ROOM	2, 619, 836		2, 619, 83	6 0	2, 619, 836	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	379, 540		379, 54		2, 019, 830	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 461, 363		2, 461, 36		2, 461, 363	•
60. 00 06000 LABORATORY	2, 401, 303		2, 401, 30		2, 401, 303	•
64. 00 06400 I NTRAVENOUS THERAPY	214, 717		214, 71		2,031,270	
65. 00 06500 RESPI RATORY THERAPY	621, 985	0			621, 985	
66. 00 06600 PHYSI CAL THERAPY	1, 225, 949	0	1, 225, 94		1, 225, 949	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38, 667		38, 66		38, 667	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 023		20, 02	3 0	20, 023	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 578, 228		2, 578, 22	8 0	2, 578, 228	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0			0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0			0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	209, 491		209, 49	1 0	209, 491	76.97
OUTPATIENT SERVICE COST CENTERS	-					
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	52, 131		52, 13		52, 131	
91. 00 09100 EMERGENCY	4, 495, 402		4, 495, 40		4, 495, 402	•
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	2, 212, 151		2, 212, 15	1	2, 212, 151	92.00
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
SPECIAL PURPOSE COST CENTERS	0		I	ч	0	
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	22, 879, 119	0	22, 879, 11	9 0	22, 879, 119	
		0				
201.00 Less Observation Beds	2, 212, 151		2, 212, 15	1	2, 212, 151	201.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016	Worksheet C Part I	
				To 12/31/2016		
		Titl	e XIX	Hospi tal	PPS	41 pili
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
			· · ·		Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1,040,400		1, 040, 40	0		30.00
31.00 03100 I NTENSI VE CARE UNI T	0			0		31.00
43. 00 04300 NURSERY	305, 173		305, 17	3		43.00
ANCI LLARY SERVICE COST CENTERS			-	_		
50.00 05000 OPERATING ROOM	676, 922	6, 366, 585	7,043,50	7 0. 371951	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	806, 478	344, 822	1, 151, 30	0 0. 329662	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	45, 908	9, 448, 922	9, 494, 83	0 0. 259232	0. 000000	54.00
60. 00 06000 LABORATORY	355, 004	7,727,355	8, 082, 35	9 0. 253799	0. 000000	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	1, 263, 375	1, 263, 37	5 0. 169955	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	40, 346	818, 713	859, 05	9 0. 724031	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	36, 902	1, 505, 509	1, 542, 41	1 0. 794826	0. 000000	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 347	192, 543	221, 89	0 0. 174262	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	117, 331	117, 33	1 0. 170654	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	521, 802	5, 665, 463	6, 187, 26	5 0. 416699	0. 000000	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0.000000	0. 000000	73.01
74.00 07400 RENAL DIALYSIS	0	0		0.000000	0. 000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0.000000	0. 000000	75.00
75. 01 07501 CARDI AC REHAB	0	0		0.000000	0. 000000	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	245, 264	245, 26	4 0.854145	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS			_			
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0. 000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0.00000	89.00
90. 00 09000 CLINIC	0	33, 902			0.00000	
91. 00 09100 EMERGENCY	80, 858	16, 740, 318			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	28, 021	4, 579, 252	4, 607, 27	3 0. 480143	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	0		0.000000	0. 000000	95.00
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	3, 967, 161	55, 049, 354	59, 016, 51	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	3, 967, 161	55, 049, 354	59, 016, 51	5		202.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1306	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/23/2017 12:41 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 371951			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 329662			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 259232			54.00
60. 00 06000 LABORATORY	0. 253799			60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 169955			64.00
65. 00 06500 RESPI RATORY THERAPY	0. 724031			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 794826			66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 174262			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 170654			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 416699			73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000			73.01
74.00 07400 RENAL DI ALYSI S	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
75. 01 07501 CARDI AC REHAB	0. 000000			75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0.854145			76.97
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 09000 CLINIC	1. 537697			90.00
91.00 09100 EMERGENCY	0. 267247			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 480143			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA		Provider C	CN: 15-1306	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICALD ONLY				From 01/01/2016	Part II	
				To 12/31/2016	Date/Time Pre	pared:
			VIV		5/23/2017 12:	<u>41 pm</u>
	T I I O I		e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost Reduction	
	(Wkst. B, Part		Cost (col. 1		Amount	
	I, col. 26)	TT COL. 20)		-	Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	2, 619, 836	206, 669	2, 413, 16	07 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	379, 540				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 461, 363				0	54.00
60. 00 06000 LABORATORY	2,051,296				0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	2,031,270				0	64.00
65. 00 06500 RESPIRATORY THERAPY	621, 985				0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 225, 949				0	66.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38,667				0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	20, 023				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 578, 228				0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	2, 370, 220	50, 711	2, 517, 5		0	73.00
74. 00 07400 RENAL DI ALYSI S	0				0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0				0	75.00
75. 01 07501 CARDI AC REHAB	0				0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	209, 491	27, 068	182, 42	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	207,471	27,000	102, 42	-5 0	0	10. 11
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	
90. 00 09000 CLINIC	52, 131	3, 022	49, 10	0 0	0	
91. 00 09100 EMERGENCY	4, 495, 402				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 212, 151	178, 498			0	92.00
OTHER REIMBURSABLE COST CENTERS	2,212,101	170, 170	2,000,00		<u> </u>	72.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0			0 0		101.00
SPECIAL PURPOSE COST CENTERS				<u> </u>	<u> </u>	101100
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	19, 180, 779	1, 074, 147	18, 106, 63	32 0	0	200.00
201.00 Less Observation Beds	2, 212, 151					201.00
202.00 Total (line 200 minus line 201)	16, 968, 628					202.00
				1		

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Li	eu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Prepared: 5/23/2017 12:41 pm
			e XIX	Hospi tal	PPS
Cost Center Description		Total Charges			
		(Worksheet C,			
	Operating Cost			6	
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	2, 619, 836	7, 043, 507	0. 3719	51	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	379, 540	1, 151, 300	0. 3296	62	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 461, 363	9, 494, 830	0. 2592	32	54.00
60. 00 06000 LABORATORY	2,051,296	8, 082, 359	0. 2537	99	60.00
64.00 06400 INTRAVENOUS THERAPY	214, 717	1, 263, 375	0. 1699	55	64.00
65. 00 06500 RESPI RATORY THERAPY	621, 985	859, 059	0. 7240	31	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 225, 949	1, 542, 411	0. 7948	26	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38, 667	221, 890	0. 1742	62	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 023	117, 331	0.1706	54	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 578, 228	6, 187, 265	0. 4166	99	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	l c	0.0000	00	73.01
74.00 07400 RENAL DIALYSIS	0	l d	0.0000		74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	l d	0.0000		75.00
75. 01 07501 CARDI AC REHAB	0		0.0000		75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	209, 491	245, 264			76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	00	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				89.00
90. 00 09000 CLINIC	52, 131	33, 902			90, 00
91.00 09100 EMERGENCY	4, 495, 402				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 212, 151				92.00
OTHER REIMBURSABLE COST CENTERS	2/2/2/10/	1,001,270		10	,2100
95. 00 09500 AMBULANCE SERVICES	0	C	0.0000	00	95.00
101.00 10100 HOME HEALTH AGENCY	0				101.00
SPECIAL PURPOSE COST CENTERS	0		0.0000		
113. 00 11300 I NTEREST EXPENSE	1		1		113.00
200.00 Subtotal (sum of lines 50 thru 199)	19, 180, 779	57, 670, 942			200.00
201.00 Less Observation Beds	2, 212, 151				201.00
202.00 Total (line 200 minus line 201)	16, 968, 628				201.00
	10, 700, 020	1 0,, 0, 0, 742	.i	I	1202.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 5/23/2017 12:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	-				
50.00 05000 OPERATI NG ROOM	206, 669				662	
52.00 05200 DELIVERY ROOM & LABOR ROOM	37, 296				6	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	193, 501	9, 494, 830			170	54.00
60. 00 06000 LABORATORY	71, 553	8, 082, 359	0.00885	53 34, 355	304	60.00
64.00 06400 INTRAVENOUS THERAPY	14, 541	1, 263, 375	0. 01151	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	17, 330	859, 059	0. 02017	73 16, 651	336	65.00
66. 00 06600 PHYSI CAL THERAPY	76, 399	1, 542, 411	0. 04953	32 11, 757	582	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	437	221, 890	0.00196	59 2, 285	4	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	228	117, 331	0. 00194	13 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 911	6, 187, 265	0. 00952	92, 171	878	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.00000	0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0	0	0.0000	0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	27,068	245, 264	0. 11036	53 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 0	0	89.00
90. 00 09000 CLINIC	3,022	33, 902	0. 08913	39 0	0	90.00
91.00 09100 EMERGENCY	188, 694	16, 821, 176	0. 0112	4, 396	49	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	178, 498	4, 607, 273	0. 03874		0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1,074,147	57, 670, 942		192, 692	2, 991	200.00

Health Financial Systems	IU HEALTH PAOL	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider C	CN: 15-1306	Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st	U		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	651, 650	0		0 0	651, 650	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0	0	54.00
60. 00 06000 LABORATORY	0	0)	0 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0)	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0)	0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0)	0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0	0		0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0)	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	0 0	0	89.00
90. 00 09000 CLINIC	0	0)	0 0	0	90.00
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						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50-199)	651, 650	0		0 0	651, 650	200. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2016 To 12/31/2016	Part IV Date/Time Pre	narod
				10 12/31/2010	5/23/2017 12:	
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges		Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	I	1	1		-
50. 00 05000 OPERATI NG ROOM	0	7, 043, 507				•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 151, 300				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 494, 830				
60. 00 06000 LABORATORY	0	8, 082, 359			34, 355	
64.00 06400 I NTRAVENOUS THERAPY	0	1, 263, 375	0.00000	0. 000000	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	859, 059	0.00000	0. 000000	16, 651	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 542, 411	0.00000	0. 000000	11, 757	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	221, 890	0.00000	0. 000000	2, 285	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	117, 331	0.00000	0. 000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 187, 265	0.00000	0. 000000	92, 171	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.00000	0. 000000	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0. 000000	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0. 000000	0	75.00
75. 01 07501 CARDI AC REHAB	0	0	0.00000	0. 000000	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	245, 264	0.00000	0. 000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0. 000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0. 000000	0	89.00
90. 00 09000 CLINIC	0	33, 902	0.00000	0. 000000	0	90.00
91.00 09100 EMERGENCY	0	16, 821, 176	0.00000	0. 000000	4, 396	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 607, 273	0.00000	0. 000000		•
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50-199)	0	57, 670, 942			192, 692	200. 00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider C		Period: From 01/01/2016 To 12/31/2016	5/23/2017 12:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Throug Costs (col. <u>x col. 12)</u> 13.00	n		
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			_
ANCI LLART SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 01 73. 01 07301 DRUGS CHARGED TO PATI ENTS 74. 00 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 75. 01 07501 CARDI AC REHAB 74. 01 07501 CARDI AC REHAB 76. 97 07697 CARDI AC REHAB 010404 010404 017041	2,087 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		50.00 52.00 54.00 60.00 64.00 65.00 66.00 71.00 72.00 73.01 74.00 75.00 75.01 76.97
88. 00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0		0		89.00 90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	000	0 0		0 0		91.00 92.00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 200.00 Total (Lines 50-199)	2, 087	0		0		95. 00 200. 00

Health Fina	ncial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
					From 01/01/2016 To 12/31/2016		narod
					10 12/31/2010	5/23/2017 12:	
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS		-			-	
	O OPERATI NG ROOM	0. 371951	0	.,		-	
	O DELIVERY ROOM & LABOR ROOM	0. 329662			0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 259232		2, 746, 57		0	54.00
		0. 253799		2, 443, 14		0	60.00
	O I NTRAVENOUS THERAPY	0. 169955	0	479, 25		0	64.00
	0 RESPI RATORY THERAPY	0. 724031	0	289, 45		0	65.00
	0 PHYSI CAL THERAPY	0. 794826		543, 56		0	66.00
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 174262		35, 32		0	71.00
	O IMPL. DEV. CHARGED TO PATIENTS	0. 170654		22, 45		0	72.00
	O DRUGS CHARGED TO PATIENTS	0. 416699		2, 543, 63	3 1, 450		73.00
	1 DRUGS CHARGED TO PATIENTS	0. 000000			0 0	0	73.01
	O RENAL DI ALYSI S	0. 000000			0 0	0	74.00
	O ASC (NON-DI STI NCT PART)	0. 000000			0 0	0	75.00
	1 CARDI AC REHAB	0. 000000			0 0	-	75.01
	7 CARDIAC REHABILITATION	0. 854145	0	127, 52	6 0	0	76.97
	ATLENT SERVICE COST CENTERS						
	O RURAL HEALTH CLINIC	0.000000				0	
	O FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
		1. 537697	0				90.00
	O EMERGENCY	0. 267247	0				91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 480143	0	2,074,50	2 0	0	92.00
	R REIMBURSABLE COST CENTERS						
	O AMBULANCE SERVICES	0. 000000			0	_	95.00
200.00	Subtotal (see instructions)		0				200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
202.00	Only Charges			17 (01 04	0 0.040		202.00
202.00	Net Charges (line 200 +/- line 201)	1	0	17, 681, 24	0 2,242	0	202.00

Heal th	Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS.	-2552-10
APPORT	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider (CCN: 15-1306	Period: From 01/01/2016	Worksheet D Part V	
					To 12/31/2016	Date/Time Pro 5/23/2017 12	epared: :41 pm
			Ti tl	e XVIII	Hospi tal	Cost	<u> </u>
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
		6.00	7.00				
	ANCI LLARY SERVICE COST CENTERS	(00.14/					50.00
50.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	600, 146		0			
52.00	05400 RADI OLOGY-DI AGNOSTI C	711, 999		0			52.00 54.00
	06000 LABORATORY						60.00
60.00 64.00	06400 I NTRAVENOUS THERAPY	620, 067 81, 451		0			64.00
	06500 RESPIRATORY THERAPY	209, 571		0			65.00
65.00 66.00	06600 PHYSI CAL THERAPY	432,042		0			66,00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	432,042		0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 832		0			72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 059, 929					73.00
	07301 DRUGS CHARGED TO PATIENTS	1,037,727		0			73.00
	07400 RENAL DI ALYSI S	0					74.00
	07500 ASC (NON-DI STI NCT PART)	0		0			75.00
	07501 CARDI AC REHAB			0			75.00
	07697 CARDIAC REHABILITATION	108, 926		0			76.97
10. 71	OUTPATIENT SERVICE COST CENTERS	100,720					
88.00	08800 RURAL HEALTH CLINIC	0		0			88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0			89.00
90.00	09000 CLINIC	3, 835		-			90.00
	09100 EMERGENCY	1, 272, 046		ol			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	996, 058		ol			92.00
	OTHER REIMBURSABLE COST CENTERS	,		-1			
95.00	09500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	6, 106, 057	1, 82	2			200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	6, 106, 057	1, 82	2			202.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-1306	Peri od:	Worksheet D	
		Component	CCN: 15-Z306	From 01/01/2016 To 12/31/2016		nared
		component	CON. 15 2500	10 12/31/2010	5/23/2017 12:	
		Title	× XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 371951	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 329662			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 259232			0 0	0	
60. 00 06000 LABORATORY	0. 253799			0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 169955			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 724031	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0, 794826	0		0 0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 174262	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 170654	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 416699	0		0 0	0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0. 000000	0		0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0.854145	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	07100
90. 00 09000 CLINIC	1. 537697			0 0	0	
91.00 09100 EMERGENCY	0. 267247			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 480143	0		0 0	0	92.00
OTHER REI MBURSABLE COST CENTERS			1			1
95.00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
0nly Charges 202.00 Net Charges (line 200 +/- line 201)		0		0 0	_	202.00
202.00 INEL CHALGES (TITLE 200 +/ - TITLE 201)	I	1 0	1	0	I 0	1202.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1306	Period: Worksheet D		
			CON. 15 7204	From 01/01/2016	Part V	norod.
	Component CCN: 15-Z306		To 12/31/2016	Date/Time Pre 5/23/2017 12:	41 pm	
		Title	XVIII	Swing Beds - SNF		<u> </u>
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
		Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.) 6.00	<u>(see inst.)</u> 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	o	0				60.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	О	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0				73.01
74.00 07400 RENAL DIALYSIS	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
75. 01 07501 CARDI AC REHAB	0	0				75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	0				90.00 91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				91.00
OTHER REIMBURSABLE COST CENTERS	0	0				92.00
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	0				200.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	о	0				202.00
			-			•

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS Provider CCN: 15-1306 Period: From 01/01/2016 Worksheet D Part I 012/31/2016 Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Swing Bed Adjustment Reduced Capital Related Cost (col. 1 - col. 20) Total Patient Days Per Diem (col. 3 / col. 4) 30.00 INPATIENT ROUTINE SERVICE COST CENTERS 279,776 3,877 275,899 1,371 201.24 30.00 INPATIENT ROUTINE SERVICE COST CENTERS 279,776 3,877 275,899 1,371 201.24 30.00 31.00 INTENSIVE CARE UNIT 0 0 203 57.31 43.00 200.00 Total (Lines 30-199) 291,409 287,532 1,574 200.00 Cost Center Description Inpatient Program days Program Capital Cost (col. 5 x col. 6) 1 30.00 30.00 ADULTS & PEDIATRICS 2 402 30.00 30.00 30.00 30.00 ADULTS & PEDIATRICS 2 402 33.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 <	Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
Impart Entr Routrine Service Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Swing Bed Adjustment Reduced Reduced Capital Related Cost (col. 1 - col. 2) Total Patient Days Per Diem (col. 3 / col. 4) IMPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 INDESERY 200.00 INDESERY 200.00 21,633 275,899 1,371 201.24 30.00 30.00 INDESERY 200.00 11,633 11,633 11,633 203 57.31 43.00 200.00 Total (lines 30-199) 201,409 287,532 1,574 200.00 Cost Center Description Inpatient Program days Inpatient Program days 100 1.574 200.00 200.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 30.00 31.00 30.00 30.00 30.00 30.00	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C				
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Swing Bed Adjustment Reduced Capital Related Cost (col. 1 - col. 2) Total Patient Days Per Diem (col. 3 / col. 4) 30.00 ADULTS & PEDIATRICS 279,776 3,877 275,899 1,371 201.24 30.00 43.00 NURSERY 11,633 11,633 203 57.31 43.00 Cost Center Description Inpatient Program days Program Program Capital Cost (col. 5 x col. 6.00 1,574 200.00 30.00 30.00 INPATIENT ROUTINE SERVICE COST CENTERS 11,633 11,633 203 57.31 43.00 200.00 Total (lines 30-199) 291,409 287,532 1,574 200.00 Cost Center Description Inpatient Program days Program Capital Cost (col. 5 x col. 6.00 7.00 30.00 30.00 INPATIENT ROUTINE SERVICE COST CENTERS 2 402 30.00 31.00							
Image: Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Swing Bed Adjustment Reduced Capital Related Cost (col. 1 - col. 20) Total Patient Days Per Diem (col. 3 / col. 4) 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 1.00 2.00 3.00 4.00 5.00 1.00 NURSERY 11,633 203 57.31 30.00 200.00 Total (lines 30-199) 291,409 287,532 1,574 200.00 200.00 Total (lines 30-199) 291,409 287,532 1,574 200.00 Cost Center Description Inpatient Program days Program Capital Cost (col. 5 x col. 6) 5 x col. 6) 5 x col. 6) 5 x col. 6) 3 0.00 1.00 ADULTS & PEDIATRICS 2 402 30.00 31.00 1.01 Inpatient Program days Fregram Capital Cost (col. 5 x col. 6) 5 x col. 6) 30.00 31.00 31.00 <td></td> <td></td> <td></td> <td></td> <td>10 12/31/2016</td> <td></td> <td></td>					10 12/31/2016		
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Swing Bed Adjustment Reduced Capital Related Cost (col. 1 - col. 2) Total Patient Days Per Diem (col. 3 / col. 4) 30.00 ADULTS & PEDI ATRICS 20 3.00 4.00 5.00 31.00 INTENSI VE CARE UNIT 0 0 0 0.00 31.00 32.00 NURSERY 11, 633 111, 633 203 57.31 30.00 200.00 Total (Lines 30-199) 291, 409 287, 532 1, 574 200.00 Cost Center Description Inpatient Program days Inpatient Program Capital Cost (col. 5 x col. 6) 1, 574 200.00 30.00 30.00 ADULTS & PEDI ATRICS 2 402 30.00 31.00 1NPATIENT ROUTINE SERVICE COST CENTERS 2 402 30.00 31.00 30.00 ADULTS & PEDIATRICS 2 402 30.00 31.00 31.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.00 31.00 30.00 31.00 INTENSIVE CARE UNIT 0 <t< td=""><td></td><td></td><td>Ti †I</td><td>e XIX</td><td>Hospi tal</td><td></td><td>41 piii</td></t<>			Ti †I	e XIX	Hospi tal		41 piii
Related Cost (from Wkst. B, Part II, col. 26) Adjustment (col. 1 - col. 2) Capital Related Cost (col. 1 - col. 2) Days 3 / col. 4) INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 279,776 3,877 275,899 1,371 201.24 30.00 JL 00 INTENSIVE CARE UNIT 0 0 0 0 0.00 31.00 43.00 NURSERY 211,633 211,633 203 57.31 43.00 200.00 Total (lines 30-199) 291,409 287,532 1,574 200.00 Cost Center Description Inpatient Program Capital Cost (col. 5 x col. 6) Inpatient Program Capital Cost (col. 5 x col. 6) 30.00 30.00 ADULTS & PEDIATRICS 2 402 30.00 31.00 31.00 INPATIENT ROUTINE SERVICE COST CENTERS 2 402 30.00 31.00	Cost Center Description	Capi tal		1			
Inpatient Routine Service Cost Centers 20 30.00 A.00 5.00 30.00 ADULTS & PEDIATRICS 279,776 3,877 275,899 1,371 201.24 30.00 31.00 INTENSIVE CARE UNIT 0 0 0 0 0.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 30.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Part II, col. 26) (col. 1 - col. 2) (col. 2) (col.							
26) 2) 1.00 2.00 3.00 4.00 5.00 30.00 ADULTS & PEDIATRICS 279,776 3,877 275,899 1,371 201.24 30.00 31.00 INTENSI VE CARE UNIT 0 0 0 0.00 31.00 43.00 NURSERY 11,633 11,633 203 57.31 43.00 200.00 Total (Lines 30-199) 291,409 287,532 1,574 200.00 Cost Center Description Inpatient Program Capital Cost (col. 5 x col. 6) 1 50.00 30.00 30.00 ADULTS & PEDIATRICS 2 402 30.00 31.00 30.00 INPATIENT ROUTINE SERVICE COST CENTERS 2 402 31.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 ADULTS & PEDI ATRI CS 279, 776 3, 877 0 0 0.00 31. 00 0 0.00 0 0.00 31. 00 0 0 0 0 0 0 0 31. 00 0 </td <td></td> <td></td> <td></td> <td>2)</td> <td></td> <td></td> <td></td>				2)			
30.00 ADULTS & PEDIATRICS 279,776 3,877 275,899 1,371 201.24 30.00 31.00 INTENSI VE CARE UNIT 0 0 0 0 0.00 31.00 43.00 NURSERY 11,633 203 57.31 43.00 200.00 Total (Lines 30-199) 291,409 287,532 1,574 200.00 Cost Center Description Inpatient Program days Inpatient Program Capital Cost (col. 5 x col. 6) 1,574 200.00 INPATIENT ROUTINE SERVICE COST CENTERS 6.00 7.00 30.00 31.00 30.00 ADULTS & PEDIATRICS 2 402 30.00 31.00 30.00 INTENSIVE CARE UNIT 0 0 31.00 31.00		1.00	2.00	3.00	4.00	5.00	
31.00 INTENSI VE CARE UNIT 0 0 0.00 31.00 43.00 NURSERY 11,633 11,633 203 57.31 43.00 200.00 Total (Lines 30-199) 291,409 287,532 1,574 200.00 Cost Center Description Inpatient Program days Program Capital Cost (col. 5 x col. 6) 1,574 200.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 2 402 30.00 31.00 NURSERY 4 229 43.00	INPATIENT ROUTINE SERVICE COST CENTERS						
43.00 NURSERY 11,633 203 57.31 43.00 200.00 Total (Lines 30-199) 291,409 287,532 1,574 200.00 Cost Center Description Inpatient Program days Colspan="4">Cost Center Description Inpatient Program days Colspan="4">Cost Center Description Inpatient Program days Colspan="4">Adult Cost (col. 5 x col. 6) 6.00 7.00 7.00 Adult Ts & PEDI ATRI CS 30.00 ADULTS & PEDI ATRI CS 2 402 30.00 31.00 NURSERY 4 229 43.00	30. 00 ADULTS & PEDIATRICS	279, 776	3, 877	275, 89	9 1, 371	201.24	30.00
200. 00 Total (lines 30-199) 291, 409 287, 532 1, 574 200. 00 Cost Center Description Inpatient Program days Inpatient Program Capital Cost (col. 5 x col. 6) Inpatient Program Capital Cost (col. 5 x col. 6) Inpatient Program Capital Cost (col. 5 x col. 6) 1, 574 200. 00 INPATIENT ROUTINE SERVICE COST CENTERS 6. 00 7. 00 30. 00 30. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 43. 00 <td< td=""><td>31.00 INTENSIVE CARE UNIT</td><td>0</td><td></td><td></td><td>0 0</td><td>0.00</td><td>31.00</td></td<>	31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
Cost Center Description Inpatient Program days Inpatient Program Capital Cost (col. 5 x col. 6) Inpatient Program Capital Cost (col. 5 x col. 6) INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 2 402 0 30.00 31.00 31.00 INTENSI VE CARE UNIT 43.00 4 229 43.00	43.00 NURSERY	11, 633		11, 63	3 203	57.31	43.00
INPATIENT ROUTINE SERVICE COST CENTERS Program days Program Capital Cost (col. 5 x col. 6) 30.00 ADULTS & PEDIATRICS 6.00 7.00 31.00 INTENSI VE CARE UNIT 0 0 43.00 NURSERY 4 229	200.00 Total (lines 30-199)	291, 409		287, 53	2 1, 574		200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 30.00 ADULTS & PEDI ATRI CS 2 402 30.00 31.00 INTENSI VE CARE UNI T 0 0 31.00 43.00 NURSERY 4 229 43.00	Cost Center Description	I npati ent	I npati ent				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 30.00 ADULTS & PEDI ATRI CS 2 402 30.00 31.00 INTENSI VE CARE UNI T 0 0 31.00 43.00 NURSERY 4 229 43.00		Program days	Program				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6) 6) 30. 00 ADULTS & PEDI ATRI CS 2 402 30. 00 31. 00 INTENSI VE CARE UNI T 0 0 31. 00 43. 00 NURSERY 44 229 43. 00							
INPATI ENT_ROUTI NE_SERVI CE_COST_CENTERS 6.00 7.00 30.00 ADULTS & PEDI ATRI CS 2 402 30.00 31.00 INTENSI VE_CARE_UNI T 0 0 31.00 43.00 NURSERY 4 229 43.00							
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 ADULTS & PEDI ATRI CS 2 402 30. 00 31. 00 I NTENSI VE CARE UNI T 0 0 31. 00 43. 00 NURSERY 4 229 43. 00				-			
30. 00 ADULTS & PEDIATRICS 2 402 30. 00 31. 00 INTENSI VE CARE UNIT 0 0 31. 00 43. 00 NURSERY 4 229 43. 00		6.00	7.00				
31.00 INTENSIVE CARE UNIT 0 0 31.00 43.00 NURSERY 4 229 43.00			1	1			
43.00 NURSERY 4 229 43.00		2	402				
		0	0 0				
200.00 Total (lines 30-199) 6 631 200.00		4					•
	200.00 Total (lines 30-199)	6	631				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-1306 Period: Trom 01/01/2016 To 12/31/2016 Worksheet D Date/Time Prepared: 1/2/31/2016 Deriod: Date/Time Prepared: 1/2/31/2016 Worksheet D Date/Time Prepared: 1/2/31/2016 Image: Cost Center Description Capital Related Cost (From Wkst, B) Part II, col. 26) Total Charges (Col. 1 + col. 8) Inpatient Cost Center Description Capital Capital (Col. 1 + col. 8) Capital Cost (Col. 1 + col. 8)	Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
Cost Center Description Capital Related Cost (from Wkst. C) Part II, col. 26) Tatic Charges (from Wkst. C) Part I, col. 2) Inpatient Program (charges) Capital Costs (col umn 3 x col umn 4) MACILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROM 05000 OPERATI NG ROM 52.00 206,669 7,043,507 0.029342 0 0 50.00 50.00 05000 OPERATI NG ROM 52.00 ALBOR ROM 640 (Pol Ador Pol AGNOSTI C) 193,501 9,494,830 0.023395 7,349 238 52.00 60.00 06500 RESPI RATORY 71,553 8,082,359 0.00853 2,423 21 60.00 64.00 64.00 06500 RESPI RATORY THERAPY 17,350 8,082,359 0.001969 341 171.00 70.00 0000 KESPI RATORY THERAPY 17,330 859,059 0.01173 0 66.00 66.00 06600 PHYSI CAL THERAPY 76,399 1,542,411 0.049532 0 0 72.00 73.00 07300 INED CARRED TO PATIENTS 58,911 6,187,265 0.09021 1	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			From 01/01/2016 To 12/31/2016	Part II Date/Time Pre 5/23/2017 12:	
Related Cost (From Wkst. B, Part II, col. 26) Program (col. 1 + col. 2) Column 3 x column 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 S0.00 05200 DELIVERY ROM & LABOR ROM 27, 296 1.151, 300 0.023325 7, 349 285.00 54.00 05200 DELIVERY ROM & LABOR ROM 37, 296 1.151, 300 0.023325 7, 349 285.00 54.00 05400 RAIDLOGY-DIAGNOSTIC 193, 501 9, 494, 830 0.020380 0 0 54.00 60.00 66000 LAGONOL LABORATORY 71, 553 8, 082, 359 0.00150 64.00 64.00 64.00 66.00 10.0207-DI AGNOSTIC 91, 542, 411 0.049532 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 73.01 73.01 73.01 73.01 73.01 73.01 73.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
ANCILLARY SERVICE COST CENTERS Column 4) Column 4) 50.00 05000 0PERATING ROOM 20.00 3.00 4.00 50.00 50.00 05000 0PERATING ROOM 206,669 7.043,507 0.029342 0 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 37.296 1.151,300 0.032395 7.349 238 52.00 54.00 05400 RADIOGO-Y-DIAGNOSTIC 193,501 9.494,830 0.020380 0 0 64.00 66.00 06600 LABORATORY 71,553 8.082,359 0.008853 2,423 21 60.00 66.00 06600 PHYSI CAL THERAPY 14,541 1.263,375 0.011510 0 64.00 65.00 05000 RESPI RATORY THERAPY 76,399 1,542,411 0.049532 0 0 65.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 228 117,331 0.001969 341 1 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS <td>Cost Center Description</td> <td>Capi tal</td> <td>Total Charges</td> <td>Ratio of Cos</td> <td>t Inpatient</td> <td>Capital Costs</td> <td></td>	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II, col. 8) 2)							
26) 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 0					. Charges	column 4)	
I. 00 2. 00 3. 00 4. 00 5. 00 ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 206,669 7,043,507 0. 029342 0 0 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 37,296 1,151,300 0.032395 7,349 238 52. 00 54. 00 05400 RADI OLGGY-DI AGNOSTI C 193,501 9,494,830 0.020380 0 0 54. 00 64. 00 06400 I INTRAVENDUS THERAPY 17,553 8,082,359 0.001510 0 64.00 65. 00 06500 RESPI RATORY THERAPY 17,330 859,059 0.02173 0 65.00 64.00 0600 PHSI CAL THERAPY 17,330 859,059 0.02173 0 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 437 221,890 0.001969 341 1 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 58,911 6,187,265 0.009521 1,794 17<3.00			8)	2)			
ANCI LLARY SERVICE COST CENTERS 50.00 05000 DPERATING ROOM 206,669 7,043,507 0.029342 0 0 50.00 52.00 DELVERY ROOM & LABOR ROOM 37,296 1,151,300 0.32395 7,349 238 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 193,501 9,494,830 0.020380 0 0 54.00 60.00 LABORATORY 71,553 8,082,359 0.008853 2,423 21 60.00 64.00 O4001 INTRAVENOUS THERAPY 14,541 1,263,375 0.011510 0 64.00 65.00 06500 RESPI RATORY THERAPY 17,330 859,059 0.20173 0 66.00 71.00 OTIOM MEDI CAL SUPPLIES CHARGED TO PATIENTS 437 221,890 0.001969 341 1 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 288,911 6,187,265 0.09521 1,794 17 73.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0							
50.00 05000 0PERATI NG ROM 206,669 7,043,507 0.029342 0 0 50.00 52.00 05200 DELI VERY ROM & LABOR ROM 37,296 1,151,300 0.32395 7,349 238 52.00 54.00 05000 DAGORADI LOGY-DI AGNOSTI C 193,501 9,494,830 0.202380 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 14,541 1,263,375 0.011510 0 64.00 65.00 06500 RSSPI RATORY THERAPY 14,541 1,263,375 0.20173 0 65.00 66.00 06600 PHYSI CAL THERAPY 76,399 1,542,411 0.49532 0 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 228 117,331 0.01949 341 1 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 28,911 6,187,265 0.009521 1,794 173.00 74.00 07400 RENAL DI ALYSIS 0 0 0.000000 0 75.00 75.00 07500 ASC (NON-DI STI NCT PART) 0		1.00	2.00	3.00	4.00	5.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 37,296 1,151,300 0.032395 7,349 238 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 193,501 9,494,830 0.020380 0 0 54.00 60.00 LABORATORY 71,553 8,082,359 0.008853 2,423 21 60.00 64.00 INTRAVENOUS THERAPY 14,541 1,263,375 0.011510 0 64.00 65.00 06500 RESPI RATORY THERAPY 17,330 859,059 0.020173 0 65.00 66.00 0400 INTRAVENUUS THERAPY 76,399 1,542,411 0.049532 0 0 66.00 71.00 OT100 MEDI LS CHARGED TO PATI ENTS 228 117,331 0.001943 0 72.00 73.01 OT301 DRUGS CHARGED TO PATI ENTS 58,911 6,187,265 0.009521 1,794 17 73.00 73.01 OT301 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 0 73.00 75.00 O7500 ASC (NON-DI STI NCT PART) 0 0 <td></td> <td>T</td> <td>1</td> <td>1</td> <td></td> <td></td> <td></td>		T	1	1			
54.00 05400 RADI OLOGY-DI AGNOSTI C 193, 501 9, 494, 830 0.020380 0 0 54.00 60.00 06000 LABORATORY 71, 553 8, 082, 359 0.008853 2, 423 21 60.00 64.00 0K000 INTRAVENOUS THERAPY 14, 541 1, 263, 375 0.011510 0 66.00 65.00 06500 RESPI RATORY THERAPY 17, 330 859, 059 0.020173 0 66.00 66.00 06600 PHYSI CAL THERAPY 76, 399 1, 542, 411 0.049532 0 66.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 228 117, 331 0.001943 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 228 117, 331 0.001943 0 73.01 73.01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 0 73.01 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 0 73.01 73.01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0.0000						-	
60.00 LABORATORY 71, 553 8, 082, 359 0.008853 2, 423 21 60.00 64.00 06400 INTRAVENOUS THERAPY 14, 541 1, 263, 375 0.011510 0 64.00 65.00 06500 RESPI RATORY THERAPY 17, 330 859, 059 0.020173 0 65.00 66.00 06600 PHYSI CAL THERAPY 76, 399 1, 542, 411 0.049532 0 06.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 437 221, 890 0.001969 341 1 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 58, 911 6, 187, 265 0.09521 1, 794 17 73.00 73.01 07301 DRUGS CHARGED TO PATI ENTS 58, 911 6, 187, 265 0.000000 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0 75.01 75.01 07501 CARDI AC REHAB ILI TATI ON 27, 068 245, 264						238	
64.00 06400 INTRAVENOUS THERAPY 14,541 1,263,375 0.011510 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 17,330 859,059 0.20173 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 76,399 1,542,411 0.049532 0 0 66.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 437 221,890 0.001969 341 1 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 228 117,331 0.001943 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 58,911 6,187,265 0.009521 1,794 17 73.00 74.00 O7400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0 75.00 75.01 07507 CARDI AC REHABI LITATI ON 27,068 245,264		193, 501	9, 494, 830			0	54.00
65.00 06500 RESPI RATORY THERAPY 17, 330 859, 059 0.020173 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 76, 399 1, 542, 411 0.049532 0 0 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 437 221, 890 0.01969 341 1 71.00 0 72.00 0 0 72.00 0 72.00 0 72.00 0 72.00 0 72.00 0 0 72.00 0 0 72.00 0 72.00 0 0 72.00 0 0 0 72.00 0 0 72.00 0 0 0 0 0 72.00 0 73.01 0301 DRUGS CHARGED TO PATIENTS 58,911 6,187,265 0.009521 1,794 17 73.00 73.01 73.01 0301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0 74.00 75.00 75.00 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.01 75.01 75.01 75.01	60. 00 06000 LABORATORY	71, 553	8, 082, 359	0.00885	53 2, 423	21	60.00
66.00 06600 PHYSI CAL THERAPY 76, 399 1, 542, 411 0.049532 0 0 66.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 437 221, 890 0.001969 341 1 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 228 117, 331 0.001943 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 58, 911 6, 187, 265 0.009521 1, 794 17 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 76.97 O7697 CARDI AC REHAB 0 0 0 0.000000 0 75.01 76.97 O7697 CARDI AC REHABI LI TATI ON 27, 068 245, 264 0.110363 0 0 76.97 76.97 OT697 CARDI AC REHABILI TATI ON 27, 068 245, 264 0.110363 0 0 88.00 89.00 </td <td>64.00 06400 I NTRAVENOUS THERAPY</td> <td>14, 541</td> <td>1, 263, 375</td> <td>0. 01151</td> <td>0 0</td> <td>0</td> <td>64.00</td>	64.00 06400 I NTRAVENOUS THERAPY	14, 541	1, 263, 375	0. 01151	0 0	0	64.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 437 221,890 0.001969 341 1 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 228 117,331 0.001943 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 58,911 6,187,265 0.009521 1,794 17 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 58,911 6,187,265 0.000000 0 73.01 74.00 07400 RENAL DIALYSIS 0 0 0.000000 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0 75.01 76.97 CARDI AC REHAB LI TATI ON 27,068 245,264 0.110363 0 0 76.97 008800 RURAL HEALTH CLINIC 0 0 0.000000 0 88.00 89.00 99.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	65. 00 06500 RESPI RATORY THERAPY	17, 330	859, 059	0. 02017	73 0	0	65.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 228 117, 331 0.001943 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 58, 911 6, 187, 265 0.009521 1, 794 17 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.01 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.01 76.97 07697 CARDI AC REHAB 0 0 0.000000 0 75.01 76.97 07697 CARDI AC REHAB LITATION 27, 068 245, 264 0.110363 0 0 76.97 0UTPATIENT SERVICE COST CENTERS 9 0 0.000000 0 0 88.00 89.00 99.00 9900 60 0.000000 0 89.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 <t< td=""><td>66. 00 06600 PHYSI CAL THERAPY</td><td>76, 399</td><td>1, 542, 411</td><td>0. 04953</td><td>32 0</td><td>0</td><td>66.00</td></t<>	66. 00 06600 PHYSI CAL THERAPY	76, 399	1, 542, 411	0. 04953	32 0	0	66.00
73.00 07300 DRUGS CHARGED TO PATIENTS 58,911 6,187,265 0.009521 1,794 17 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 0 74.00 75.01 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0 75.01 76.97 07697 CARDI AC REHAB LI TATI ON 27,068 245,264 0.110363 0 0 76.97 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08300 RURAL HEALTH CLINIC 0 0 0.000000 0 89.00 90.00 09000 CLINIC 3,022 33,902 0.089139 0 90.00 91.00 09100 EMERGENCY 188,694 16,821,176 0.011218 0 0 91.00 <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>437</td> <td>221, 890</td> <td>0.00196</td> <td>59 341</td> <td>1</td> <td>71.00</td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	437	221, 890	0.00196	59 341	1	71.00
73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0 75.01 76.97 07697 CARDI AC REHABILITATION 27,068 245,264 0.110363 0 0 76.97 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 0 88.00 88.00 88.00 88.00 89.00 9000 610.000000 0 88.00 89.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 92.00 9200 0SERVATI ON BEDS (NON-DI STINCT PART 178,498 4,607,273 0.038743 0 0 92.00 95.00 09500 AMBULANC	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	228	117, 331	0. 00194	13 0	0	72.00
74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0 0 75.01 76.97 07697 CARDI AC REHABILI TATI ON 27,068 245,264 0.110363 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0.000000 0 89.00 90.00 09000 CLI NI C 3,022 33,902 0.089139 0 90.00 91.00 09100 EMERGENCY 188,694 16,821,176 0.011218 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 178,498 4,607,273 0.038743 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 </td <td>73.00 07300 DRUGS CHARGED TO PATIENTS</td> <td>58, 911</td> <td>6, 187, 265</td> <td>0. 00952</td> <td>1, 794</td> <td>17</td> <td>73.00</td>	73.00 07300 DRUGS CHARGED TO PATIENTS	58, 911	6, 187, 265	0. 00952	1, 794	17	73.00
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0 0 75.01 76.97 07697 CARDI AC REHABILLITATION 27,068 245,264 0.110363 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 89.00 90.00 09000 CLINIC 3,022 33,902 0.089139 0 90.00 91.00 09100 EMERGENCY 188,694 16,821,176 0.011218 0 0 92.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 178,498 4,607,273 0.038743 0 92.00 0 0 09500 AMBULANCE SERVICES 95.00 95.00	73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.0000	0 0	0	73.01
75. 01 07501 CARDI AC REHAB 0 0 0.000000 0 75. 01 76. 97 07697 CARDI AC REHABILLITATION 27, 068 245, 264 0.110363 0 0 76. 97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 89.00 90.00 09000 CLINIC 3, 022 33, 902 0.089139 0 90.00 91.00 09100 EMERGENCY 188, 694 16, 821, 176 0.011218 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 178, 498 4, 607, 273 0.038743 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 0	0	74.00
76. 97 07697 CARDI AC REHABILITATION 27,068 245,264 0.110363 0 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0	75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 0	0	75.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 89.00 90.00 09000 CLINIC 3,022 33,902 0.089139 0 90.00 91.00 09100 EMERGENCY 188,694 16,821,176 0.011218 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 178,498 4,607,273 0.038743 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	75. 01 07501 CARDI AC REHAB	0	0	0.0000	0 0	0	75.01
88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 0 89.00 90.00 09000 CLINIC 3,022 33,902 0.089139 0 0 90.00 91.00 09100 EMERGENCY 188,694 16,821,176 0.011218 0 0 91.00 92.00 OBSERVATION BEDS (NON-DI STINCT PART 178,498 4,607,273 0.038743 0 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00	76. 97 07697 CARDI AC REHABI LI TATI ON	27,068	245, 264	0. 11036	53 0	0	76.97
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 0 89.00 90.00 09000 CLINIC 3,022 33,902 0.089139 0 0 90.00 91.00 09100 EMERGENCY 188,694 16,821,176 0.011218 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 178,498 4,607,273 0.038743 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	OUTPATIENT SERVICE COST CENTERS						1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 0 89.00 90.00 09000 CLINIC 3,022 33,902 0.089139 0 0 90.00 91.00 09100 EMERGENCY 188,694 16,821,176 0.011218 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 178,498 4,607,273 0.038743 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
91.00 09100 EMERGENCY 188,694 16,821,176 0.011218 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 178,498 4,607,273 0.038743 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 0	0	89.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 178,498 4,607,273 0.038743 0 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00 95.00	90. 00 09000 CLINIC	3, 022	33, 902	0. 08913	39 0	0	90.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	91.00 09100 EMERGENCY	188, 694	16, 821, 176	0.0112	0 0	0	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	178, 498	4, 607, 273	0. 03874	13 0	0	92.00
95. 00 09500 AMBULANCE SERVICES 95. 00							1
200. 00 Total (lines 50-199) 1, 074, 147 57, 670, 942 11, 907 277 200. 00							95.00
	200.00 Total (lines 50-199)	1, 074, 147	57, 670, 942		11, 907	277	200. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Period:	Worksheet D	
				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/23/2017 12:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swing-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 371	0.00		2 0	1	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0.00		0 0	1	31.00
43. 00 04300 NURSERY	203			4 0		43.00
200.00 Total (lines 30-199)	1, 574			6 0	1	200.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV	pared:
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	lursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	651, 650	0		0 0	651, 650	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0	0		0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC	0	0	1	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
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	· · · · · ·		•			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	651, 650	0		0 0	651, 650	
						•

71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 221,890 0.000000 0.000000 341 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 117,331 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 6,187,265 0.000000 0.000000 0 73.00 73.01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 0.000000 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 74.00 75.00 07501 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.01 75.01 07501 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.01 76.97 CARDI AC REHABI LI TATI ON 0 245,264 0.000000 0.000000 0 76.97 0 0 0.000000 0.000000 0 0.000000 0 0 0.000000 0 90.00 0.000000 <	Heal th	Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10									
Interview To 12/31/2016 Date/Time Prepared: 5/32/32/071 Date/Time Prepared: 5/32/32/00 Date/Time Prepared: 5/32/32/00 Date/Time Prepared: 5/32/32/00 Date/Time Prepared: 5/32/32/00 Date/Time Prepared: 5/32/32/00 Date/Time Prepared: 5/32/32/00 Date/Time Prepared: 5/3/32/00 Date/Time Prepared: 5/3/32/07 Date/Time Prepared: 5/3/32/07 <thdate td="" tim="" time="" time<=""><td></td><td></td><td>VICE OTHER PASS</td><td>S Provider C</td><td></td><td></td><td></td><td></td></thdate>			VICE OTHER PASS	S Provider C							
Image: construct of the second seco	THROUG	GH COSTS						narad			
Instrument Title XIX Hespital PPS Cost Center Description Total Outpatient Cost (sum of 4) Total Charges (from Wkst. C, 4) Total Charges (col. 5 + col. 7) Atio of Cost (col. 5 + col. 7) Inpatient Ratio of Cost (col. 5 + col. 7) Inpatient Program (col. 5 + col. 7) Inpatient Progra						10 12/31/2010					
ANCI LLARY SERVICE COST CENTERS Charges (col. 2, 3 and 4) to charges (col. 5 + col. 7) Ratio of cost (som of col. 2, 3 and 4) Part 1, col. 8) Part 1, col. 7) Charges (col. 6 + col. 7) Part 3, col 7, col				Tit	e XIX	Hospi tal					
Cost (sum of col. 2, 3 and 4) Part I, col. 8) (col. 5 + col. 7) to Charges (col. 6 + col. 7) Charges (col. 6 + col. 7) ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 50.00 05000 0PERATING ROOM 0 7.043,507 0.092518 0.000000 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 1.151,300 0.000000 0.000000 0.54.00 64.00 06400 RADIOLOGY-DI AGNOSTIC 0 9.494,830 0.000000 0.000000 0.64.00 65.00 06500 RESPIRATORY 0 8.082,359 0.000000 0.000000 0.64.00 64.00 06400 INTRAVENUUS THERAPY 0 859,059 0.000000 0.000000 0.66.00 65.00 06500 RESPIRATORY THERAPY 0 1,542,411 0.000000 0.000000 0.66.00 71.00 07100 IMEDI CAL SUPPLIES CHARGED TO PATIENTS 0 117,331 0.000000 0.000000 0.73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0.000000		Cost Center Description		Total Charges	Ratio of Cost						
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$				(from Wkst. C,	to Charges		Program				
4) 7) 6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 50.00 50.00 05000 DPERATI ING ROOM 0 7,043,507 0.092518 0.000000 7,043,507 50.00 05200 DELI VERY ROOM & LABOR ROOM 0 1,151,300 0.000000 0.000000 7,49 52.00 54.00 05400 RADI OLOGY-DI AKNOSTI C 0 9,494,830 0.000000 0.000000 0 54.00 60.00 06000 LABORATORY 0 8,082,359 0.000000 0.000000 0 64.00 61.00 06500 RESPI RATORY THERAPY 0 859,059 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,542,411 0.000000 0.000000 0 65.00 71.00 VTI00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 117,331 0.000000 0.000000 0 72.00 73.01 07301 DRUGS CHARGED TO PA					(col. 5 ÷ col		Charges				
6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM 0 7,043,507 0.092518 0.000000 7,349 52.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 1,151,300 0.000000 0.000000 7,349 52.00 64.00 O5400 RADI LLOGY-DI AGNOSTI C 0 9,494,830 0.000000 0.000000 2,423 60.00 60.00 C6500 RESPI RATORY THERAPY 0 1,263,375 0.000000 0.000000 0 64.00 66.00 PHYSI CAL THERAPY 0 1,542,411 0.000000 0.000000 66.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 21,890 0.000000 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 0.000000 73.00 74.00 O7400 RENAL DI ALYSI S 0 0 0.0000000 0.000000 0.73.01			col. 2, 3 and	8)	7)	(col. 6 ÷ col.					
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0 7,043,507 0.092518 0.000000 7,349 52.00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 1,151,300 0.000000 0.000000 7,349 52.00 54. 00 05400 RADI OLGY-DI AGNOSTI C 0 9,494,830 0.000000 0.000000 2,423 60.00 60. 00 06000 LABORATORY 0 8,082,359 0.000000 0.000000 2,423 60.00 64. 00 06400 INTRAVENOUS THERAPY 0 1,243,375 0.000000 0.000000 0.64.00 65.00 06500 RESPI RATORY THERAPY 0 1,542,411 0.000000 0.000000 66.00 66.00 PHYSI CAL THERAPY 0 1,542,411 0.000000 0.000000 0 66.00 73. 00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 117,331 0.000000 0.000000 0 73.01 73. 01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0.000000											
50.00 05000 OPERATING ROOM 0 7,043,507 0.092518 0.000000 7,043,957 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 1,151,300 0.000000 0.000000 7,349 52.00 54.00 RADI OLGCY-DI AGNOSTI C 0 9,448,30 0.000000 0.000000 0.000000 2,423 60.00 CABORATORY 0 8,082,359 0.000000 0.000000 0.000000 2,423 64.00 06400 INTRAVENOUS THERAPY 0 1,263,375 0.000000 0.000000 0 65.00 65.00 06500 RESPI RATORY THERAPY 0 1,542,411 0.000000 0.000000 0 66.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 117,331 0.000000 0.000000 0 73.01 73.01 O7300 DRUGS CHARGED TO PATIENTS 0 6,187,265 0.000000 0.000000 0 73.01 74.00 O7400 RENAL DI ALYSIS 0 0 0.0000000 </td <td></td> <td></td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td>9.00</td> <td>10.00</td> <td></td>			6.00	7.00	8.00	9.00	10.00				
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 151, 300 0.000000 0.000000 7, 349 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 9, 494, 830 0.000000 0.000000 0.000000 2, 423 60.00 64.00 06400 INTRAVENOUS THERAPY 0 8, 082, 355 0.000000 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 1, 263, 375 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 522, 411 0.000000 0.000000 0 65.00 72.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 117, 331 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 0 73.00 73.01 73.01 73.01 73.00 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 <td< td=""><td></td><td></td><td>1</td><td>1</td><td>1</td><td></td><td></td><td>-</td></td<>			1	1	1			-			
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 9, 494, 830 0.000000 0.000000 2, 423 60.00 60.00 06400 INTRAVENOUS THERAPY 0 1, 263, 375 0.000000 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 1, 263, 375 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 542, 411 0.000000 0.000000 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 221, 890 0.000000 0.000000 0 66.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 117, 331 0.000000 0.000000 0 73.00 73.01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 73.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0.0000000 0 75.00 76.97 CARDI AC REHAB </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0								
60.00 06000 LABORATORY 0 8,082,359 0.000000 0.000000 2,423 60.00 64.00 06400 INTRAVENOUS THERAPY 0 1,263,375 0.000000 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 859,059 0.000000 0.000000 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 1,542,411 0.000000 0.000000 0 66.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 21,890 0.000000 0.000000 0 72.00 73.01 07300 DRUGS CHARGED TO PATI ENTS 0 117,331 0.000000 0.000000 73.01 73.01 07300 RUGS CHARGED TO PATI ENTS 0 0 0.000000 0.000000 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 75.00 75.01 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0.000000 0 75.00 76.97 OT697 CARDI AC			0				7, 349				
64.00 06400 INTRAVENOUS THERAPY 0 1, 263, 375 0.000000 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 859, 059 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 542, 411 0.000000 0.000000 0 66.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 221, 890 0.000000 0.000000 0.000000 0 72.00 72.00 O7200 INPL. DEV. CHARGED TO PATIENTS 0 117, 331 0.000000 0.000000 0.72.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0 6, 187, 265 0.000000 0.000000 0.73.01 74.00 O7400 RENAL DI ALYSIS 0 0 0.000000 0.000000 0.000000 0.75.00 75.01 O7501 CARDI AC REHAB 0 0 0 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>-</td> <td></td>			0				-				
65.00 06500 RESPI RATORY THERAPY 0 859,059 0.000000 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,542,411 0.000000 0.000000 341 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 221,890 0.000000 0.000000 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 117,331 0.000000 0.000000 0 72.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0 6,187,265 0.000000 0.000000 1,794 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0.000000 0 73.01 74.00 07400 RENAL DI ALYSIS 0 0 0.000000 0.000000 0 75.00 75.01 07501 CARDIA C REHAB 0 0 0.000000 0.000000 0 75.01 75.01 07697 CARDIA C REHABILITATION 0 245,264 0.000000 0.000000 0 76.97			0								
66.00 06600 PHYSI CAL THERAPY 0 1,542,411 0.000000 0.000000 341 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 221,890 0.000000 0.000000 341 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 117,331 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 6,187,265 0.000000 0.000000 0 73.00 73.01 07301 DRUGS CHARGED TO PATI ENTS 0 6,187,265 0.000000 0.000000 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.01 75.01 07697 CARDI AC REHAB 0 0 0.000000 0.000000 0 76.97 017471 07697 CARDI AC REHABI			0				0				
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 221,890 0.000000 0.000000 341 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 117,331 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 6,187,265 0.000000 0.000000 0 73.00 73.01 07301 DRUGS CHARGED TO PATI ENTS 0 6,187,265 0.000000 0.000000 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 74.00 75.00 07501 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.01 75.01 07697 CARDI AC REHABI LI TATI ON 0 245,264 0.000000 0.000000 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 88.00 88.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>0</td> <td></td>			0				0				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 117, 331 0.000000 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 6, 187, 265 0.000000 0.000000 1, 794 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0.000000 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 74.00 75.00 07501 ASC (NON-DI STI NCT PART) 0 0 0.000000 0.000000 0 75.00 75.01 07697 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.00 76.97 OTGATI CARDI AC REHABILITATI ON 0 245,264 0.000000 0.000000 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 89.00 90.00 099000 CLINIC 0 0.000000 0.000000	66.00		0	1, 542, 411			0	66.00			
73.00 07300 DRUGS CHARGED TO PATIENTS 0 6, 187, 265 0.000000 0.000000 1, 794 73.00 73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0.000000 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.01 76.97 OZAPOT CARDI AC REHABILI TATI ON 0 245, 264 0.000000 0.000000 0 76.97 000000 DRUBAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88.00 88.00 08300 RURAL HEALTH CLINIC 0 0 0.000000 0 88.00 90.00 089000 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0 90.00 91.00 09100 EMERGENCY 0 16, 821, 176 <td>71.00</td> <td>07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>0</td> <td>221, 890</td> <td></td> <td></td> <td>341</td> <td>71.00</td>	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	221, 890			341	71.00			
73.01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0.000000 0 73.01 74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0.000000 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.01 76.97 OR697 CARDI AC REHABILI TATI ON 0 245,264 0.000000 0.000000 0 76.97 0UTPATI ENT SERVI CE COST CENTERS 0 0 0.000000 0.000000 0 88.00 88.00 08800 RURAL HEALTH CLINI C 0 0 0.000000 0.000000 0 88.00 90.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0 90.00 91.00 09100 EMERGENCY 0 16, 821, 176 0.000000 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	117, 331	0. 00000	0.000000	0	72.00			
74.00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0.000000 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.01 76.97 07697 CARDI AC REHABI LI TATI ON 0 245,264 0.000000 0.000000 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 88.00 88.00 08900 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 88.00 90.00 09000 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 0 16, 821, 176 0.000000 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 4, 607, 273 0.000000 0.0000000 92.00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 187, 265	0. 00000	0.000000	1, 794	73.00			
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0.000000 0 75.00 75.01 07501 CARDI AC REHAB 0 0 0.000000 0.000000 0 75.01 76.97 07697 CARDI AC REHABI LI TATI ON 0 245,264 0.000000 0.000000 0 76.97 OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 88.00 89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0 89.00 90.00 09000 CLINIC 0 33,902 0.000000 0 90.00 91.00 09100 EMERGENCY 0 16,821,176 0.000000 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 4,607,273 0.000000 0.000000 0 92.00	73.01	07301 DRUGS CHARGED TO PATIENTS	0	(0. 00000	0.000000	0	73.01			
75. 01 07501 CARDIAC REHAB 0 0 0.000000 0.000000 0 75. 01 76. 97 07697 CARDIAC REHABILITATION 0 245, 264 0.000000 0.000000 0 76. 97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 88. 00 99. 00 0.000000 0.000000 0 89. 00 99. 00 0.000000 0.000000 0 99. 00 99. 00 0.000000 0.000000 0 99. 00	74.00	07400 RENAL DI ALYSI S	0	(0. 00000	0.000000	0	74.00			
76. 97 07697 CARDIAC REHABILITATION 0 245,264 0.00000 0.000000 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 88.00 88.00 0.000000 0.000000 0 88.00 89.00 0.000000 0.000000 0 89.00 90.00 0.000000 0 89.00 90.00 0.000000 0 90.00 99.00 0.000000 0 90.00 <td>75.00</td> <td>07500 ASC (NON-DISTINCT PART)</td> <td>0</td> <td>(</td> <td>0. 00000</td> <td>0. 000000</td> <td>0</td> <td>75.00</td>	75.00	07500 ASC (NON-DISTINCT PART)	0	(0. 00000	0. 000000	0	75.00			
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0.000000 0 89.00 90.00 09000 CLINIC 0 33,902 0.000000 0.000000 0 90.00 91.00 09100 EMERGENCY 0 16,821,176 0.000000 0.000000 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 4,607,273 0.000000 0.000000 0 92.00	75.01	07501 CARDI AC REHAB	0	(0. 00000	0.000000	0	75.01			
88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 000000 0 89.00 90.00 09000 CLINIC 0 33,902 0.000000 0.000000 0 90.00 91.00 09100 EMERGENCY 0 16,821,176 0.000000 0.000000 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 4,607,273 0.000000 0.000000 0 92.00	76.97	07697 CARDI AC REHABI LI TATI ON	0	245, 264	0. 00000	0.000000	0	76.97			
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.0000000 0.0000000 0.00000		OUTPATIENT SERVICE COST CENTERS		_	_						
90. 00 09000 CLINIC 0 33,902 0.00000 0.00000 0 90.00 91. 00 09100 EMERGENCY 0 16,821,176 0.000000 0.000000 0 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 4,607,273 0.000000 0.000000 0 92.00	88.00	08800 RURAL HEALTH CLINIC	0	(0. 00000	0.000000	0	88.00			
91.00 09100 EMERGENCY 0 16, 821, 176 0.000000 0.000000 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 4, 607, 273 0.000000 0.000000 0 92.00	89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0. 00000	0.000000	0	89.00			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 4, 607, 273 0. 000000 0. 000000 0 92. 00	90.00	09000 CLI NI C	0	33, 902	0. 00000	0.000000	0	90.00			
	91.00	09100 EMERGENCY	0	16, 821, 176	0. 00000	0. 000000	0	91.00			
	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 607, 273	0. 00000	0. 000000	0	92.00			
		OTHER REIMBURSABLE COST CENTERS									
								95.00			
200.00 Total (Lines 50-199) 0 57, 670, 942 11, 907 200.00	200.00) Total (lines 50-199)	0	57, 670, 942	2		11, 907	200. 00			

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		CN: 15-1306	Period: From 01/01/2016 To 12/31/2016	5/23/2017 12:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 <u>x col. 10)</u> 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Throug Costs (col. <u>x col. 12)</u> 13.00	h		
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY 66. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 01 73. 01 07301 DRUGS CHARGED TO PATI ENTS 74. 00 74. 00 07400 RENAL DI ALYSI S 75. 01 07501 75. 01 07501 CARDI AC REHAB 74. 00 07697 75. 07 07697 CARDI AC REHAB 101 0107401				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 50.\ 00\\ 52.\ 00\\ 54.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 01\\ 74.\ 00\\ 75.\ 01\\ 76.\ 97\\ \end{array}$
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0 0 0	0 0 0		0 0 0		88.00 89.00 90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
OTHERREI MBURSABLECOSTCENTERS95. 0009500AMBULANCESERVI CES200. 00Total(1 i nes50-199)	0	C		0		95. 00 200. 00

	Financial Systems IU HEALTH PAOLI ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1306	Period: From 01/01/2016	Worksheet D-1			
			To 12/31/2016	5/23/2017 12:4			
	Cost Center Description	Title XVIII	Hospi tal	Cost			
	PART I - ALL PROVIDER COMPONENTS			1.00			
	I NPATI ENT DAYS				1		
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 412 1, 371			
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0			
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	red days)		484			
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	18			
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6		
	reporting period (if calendar year, enter 0 on this line)	5.					
00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	23			
00	Total swing-bed NF type inpatient days (including private roc	om days) after December 3	31 of the cost	0	8		
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	117	Ģ		
00	newborn days)	anly (including private)		10	10		
00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		oom days)	18			
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11		
00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	о	12		
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13		
00	after December 31 of the cost reporting period (if calendar y	year, enter O on this lin	ne)	-			
00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0			
	Nursery days (title V or XIX only)			0			
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost		1 17		
	reporting period	Ũ			18		
. 00	0 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period						
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	137.32	19		
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	he cost	0.00	20		
. 00	reporting period Total general inpatient routine service cost (see instruction	26)		3, 467, 283	21		
. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	3, 407, 283	22		
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportio	na period (line 6	0	23		
	x line 18)						
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost reporti	ng period (line	3, 158	24		
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25		
. 00	x line 20) Total swing-bed cost (see instructions)			48, 049	26		
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 419, 234	27		
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28		
. 00	Private room charges (excluding swing-bed charges)		-	0	29		
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	30		
00	Average private room per diem charge (line 29 ÷ line 3)	,		0. 00 0. 00	32		
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		strons)	0.00 0.00			
00	Private room cost differential adjustment (line 3 x line 35)			0.00	36		
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 419, 234			
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS					
00	Adjusted general inpatient routine service cost per diem (see	-		2, 493. 97			
					1 20		
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		291, 794 0	39		

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH PAOLI	Provider C	CN: 15-1306	Period: From 01/01/2016	u of Form CMS- Worksheet D-1	
					To 12/31/2016		
		1		XVIII	Hospi tal	Cost	41 pi
	Cost Center Description	Total Inpatient Costlr	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42.
. 00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.
. 00	CORONARY CARE UNIT		-			-	44.
. 00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
						1.00	
. 00	Program inpatient ancillary service cost (Wk					80, 712	
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	e instructio	ns)		372, 506	49
. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	0	50
. 00	Pass through costs applicable to Program inp. and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51.
. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	0	
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th						
market basket							59
0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by							60
. 00	which operating costs (line 53) are less that					0	61
	amount (line 56), otherwise enter zero (see		(THES 54 X	00), 01 1% 0	i the target		
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Deceml	per 31 of the	cost report	ing period (See	44, 891	64
	instructions)(title XVIII only)	0			0 1		
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	- 31 of the c	ost reportin	g period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	ll only). For	44, 891	66
	CAH (see instructions)			0)(((((((((((((((((((((((((((((((((((((,	
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through I	December 31 c	f the cost r	eporting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	rember 31 of	the cost ren	orting period	0	68
. 00	(line 13 x line 20)				or tring porrou	0	
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c	5)		71
00	Program routine service cost (line 9 x line	71)		,			72
. 00	Medically necessary private room cost applic			ne 35)			73
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			orksheet B	Part II column		74
	26, line 45)			S. KSHOOL D,			[′]
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	· · · · · · · · · · · · · · · · · · ·					77
00	Aggregate charges to beneficiaries for exces	,	ovider record	s)			79
00	Total Program routine service costs for comp				nus line 79)		80
00	Inpatient routine service cost per diem limi						81
00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs ()				82
. 00	Program inpatient ancillary services (see in		,				84
	Utilization review - physician compensation		s)				85
. 00	Total Program inpatient operating costs (sum		ough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					887	87
	Adjusted general inpatient routine cost per		ine 2)			2, 493. 97	
3. 00			1110 2)				

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
	Title	XVIII	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	279, 776	3, 467, 283	0. 08069	0 2, 212, 151	178, 498	90.00
91.00 Nursing School cost	0	3, 467, 283	0.00000	0 2, 212, 151	0	91.00
92.00 Allied health cost	0	3, 467, 283	0.00000	0 2, 212, 151	0	92.00
93.00 All other Medical Education	0	3, 467, 283	0. 00000	0 2, 212, 151	0	93.00

	Financial Systems IU HEALTH PAOLI HOSP CATION OF INPATIENT OPERATING COST Prov	ITAL vider CCN: 15-1306	In Lie Period: From 01/01/2016	u of Form CMS-2 Worksheet D-1	2552-10
				Date/Time Prep 5/23/2017 12:4	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS	· · · ·			
1.00 2.00	Inpatient days (including private room days and swing-bed days, ex Inpatient days (including private room days, excluding swing-bed a			1, 412 1, 371	1.00
3.00	Private room days (excluding swing-bed and observation bed days).		ivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed da	vs)		484	4.00
5.00	Total swing-bed SNF type inpatient days (including private room da	<i>J i</i>	r 31 of the cost	18	
6.00	reporting period Total swing-bed SNF type inpatient days (including private room da	vs) 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 day reporting period	s) through December	31 of the cost	23	7.00
8.00	Total swing-bed NF type inpatient days (including private room day	s) after December 3	1 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	Program (oveluding	swing bod and	2	9.00
9.00	newborn days)	Frogram (excruding	Swillig-bed and	2	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (through December 31 of the cost reporting period (see instructions		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private r	oom days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to titles V or XIX onl		e room dave)	0	12.00
	through December 31 of the cost reporting period	3 (31	3 /		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX onl after December 31 of the cost reporting period (if calendar year,			0	13.00
14.00	Medically necessary private room days applicable to the Program (e			0	
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			203 4	
10.00	SWING BED ADJUSTMENT			4	10.00
17.00	Medicare rate for swing-bed SNF services applicable to services the reporting period	rough December 31 o	f the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services af	ter December 31 of	the cost		18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services thr	ough December 31 of	the cost	137.32	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services aft	er December 31 of t	he cost	0.00	20.00
	reporting period				
21.00 22.00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31	of the cost report	ing period (line	3, 467, 283 0	21.00 22.00
	5 x line 17)	·	0 1 1	-	
23.00	Swing-bed cost applicable to SNF type services after December 31 c x line 18)	f the cost reportin	g period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 7 x line 19)	of the cost reporti	ng period (line	3, 158	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of	the cost reporting	period (line 8	О	25. 00
26.00	x line 20) Total swing-bed cost (see instructions)			48, 049	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line	21 minus line 26)		3, 419, 234	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and	observation bed ch	arges)	0	28.00
	Private room charges (excluding swing-bed charges)		urges)	0	29.00
	Semi -private room charges (excluding swing-bed charges)			0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ lin Average private room per diem charge (line 29 ÷ line 3)	e 28)		0. 000000 0. 00	
32.00 33.00	Average private room per diem charge (The 29 ÷ The 3) Average semi-private room per diem charge (Line 30 ÷ Line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minus l	ine 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and p 27 minus line 36)	rıvate room cost di	tterential (line	3, 419, 234	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME Adjusted general inpatient routine service cost per diem (see inst			2, 493. 97	38.00
	Program general inpatient routine service cost per drem (see fist Program general inpatient routine service cost (line 9 x line 38)			2, 493. 97 4, 988	
40.00	Medically necessary private room cost applicable to the Program (I	ine 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + li	ne 40)		4, 988	41.00

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1306	Period: From 01/01/2016	Worksheet D-1	2552-
					To 12/31/2016		
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)	231, 057	203	1, 138. 2	21 4		42. (
	Intensive Care Type Inpatient Hospital Units						1 42 4
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.0	0 0	0	43.0
	BURN INTENSIVE CARE UNIT						45.0
	SURGICAL INTENSIVE CARE UNIT						46.
7.00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			3, 845	48.
9.00	Total Program inpatient costs (sum of lines			ns)		13, 386	49.0
	PASS THROUGH COST ADJUSTMENTS						1 50
0. 00	Pass through costs applicable to Program inpa	atient routine s	services (trom	WKST. D, SUM	OF Parts I and	631	50.0
1.00	Pass through costs applicable to Program inpa	atient ancillary	y services (fr	om Wkst. D, s	um of Parts II	277	51.
	and IV)	-					
	Total Program excludable cost (sum of lines					908	
3.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line 5		ated, non-pny	sician anestr	ietist, and	12, 478	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
	Program di scharges					0	
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	na cost and tar	caet amount (l	ing 56 minus	line 53)	0	
	Bonus payment (see instructions)	ng cost and tai	get amount (i		TTHE 33)	0	
	Lesser of lines 53/54 or 55 from the cost re	porting period e	ending 1996, u	pdated and co	mpounded by the	0.00	59.
market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
	If line 53/54 is less than the lower of line				the amount by	0.00	
1.00	which operating costs (line 53) are less that						
l	amount (line 56), otherwise enter zero (see	nstructions)			0		
	Relief payment (see instructions)	ont (coo instruc	ations)			0	
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST						03.
	Medicare swing-bed SNF inpatient routine cos	ts through Decem	mber 31 of the	cost reporti	ng period (See	0	64.
	instructions)(title XVIII only)					_	
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65.
6. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line é	64 plus line 6	5)(title XVII	l only). For	0	66.
	CAH (see instructions)						
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost re	porting period	0	67.
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	rting period	C	68.
5.00	(line 13 x line 20)			the cost rope	a tring por rou		
	Total title V or XIX swing-bed NF inpatient			,		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil					1	70.
	Adjusted general inpatient routine service of	2		• •			71.
	Program routine service cost (line 9 x line						72.
	Medically necessary private room cost application						73.
4.00 5.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient		,		Part II column		74.
J. UU	26, line 45)	Sutine Selvice	CUSIS (ITUM M	UINSHEEL B, F	artir, corunn		/ 5.
	Per diem capital-related costs (line 75 ÷ li						76.
	Program capital-related costs (line 9 x line						77.
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	c)			78.
	Total Program routine service costs for compa			· · ·	us line 79)		80.
	Inpatient routine service cost per diem limit			、			81.
	Inpatient routine service cost limitation (1						82.
	Reasonable inpatient routine service costs (5)				83.
	Program inpatient ancillary services (see in: Utilization review - physician compensation		าร)				84. 85.
	Total Program inpatient operating costs (sum	•					86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				-	
7.00	Total observation bed days (see instructions))				887	
	Adjusted general inpatient routine cost per	di a m (1 !	11			2, 493. 97	88.

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: 41 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	279, 776	3, 467, 283	0. 08069	0 2, 212, 151	178, 498	90.00
91.00 Nursing School cost	0	3, 467, 283	0.00000	0 2, 212, 151	0	91.00
92.00 Allied health cost	0	3, 467, 283	0.00000	0 2, 212, 151	0	92.00
93.00 All other Medical Education	0	3, 467, 283	0. 00000	0 2, 212, 151	0	93.00

Health Financial Systems IU HEALTH PAOLI				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1306	Period: From 01/01/2016	Worksheet D-3	5
			To 12/31/2016		nared.
			10 12/01/2010	5/23/2017 12:	
	Titl€	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1	1(0.001		30.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T			162, 201		30.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS		1			43.00
50. 00 05000 OPERATI NG ROOM		0. 3719	51 22, 563	8, 392	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3296			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2592			
60. 00 06000 LABORATORY		0. 25372			
64. 00 06400 I NTRAVENOUS THERAPY		0. 1699			
65. 00 06500 RESPI RATORY THERAPY		0. 72403		12,056	
66. 00 06600 PHYSI CAL THERAPY		0. 7948			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1742			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1706			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4166		38, 408	
73. 01 07301 DRUGS CHARGED TO PATIENTS		0.0000		0	
74.00 07400 RENAL DI ALYSI S		0.0000	0 00	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)		0.0000	0 00	0	75.00
75. 01 07501 CARDI AC REHAB		0.0000	0 00	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON		0.8541	45 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		1.5376	97 0	0	90.00
91. 00 09100 EMERGENCY		0. 2672	47 4, 396	1, 175	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4801	43 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		1			
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			192, 692		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			192, 692		202.00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider (Peri od:	Worksheet D-3	
	Composite the second		From 01/01/2016		
	Component	CCN: 15-Z306	To 12/31/2016	Date/Time Pre 5/23/2017 12:	
	Titl	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
				(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		-			
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1	-	-	
50.00 05000 OPERATING ROOM		0. 37195		, s	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 32966		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25923		0	
60. 00 06000 LABORATORY		0. 25379			1
64.00 06400 I NTRAVENOUS THERAPY		0. 16995		-	
65. 00 06500 RESPI RATORY THERAPY		0. 72403		54	
66.00 06600 PHYSI CAL THERAPY		0. 79482			1
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 17426		0	
		0. 17065		0 2, 738	
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07301 DRUGS CHARGED TO PATIENTS		0. 41669			1
74. 00 07400 RENAL DIALYSIS		0.00000		0	1
75. 00 07500 ASC (NON-DI STINCT PART)		0.00000			1
75. 01 07501 CARDI AC REHAB		0.00000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 85414		-	
OUTPATIENT SERVICE COST CENTERS		0.00414	5 0	0	/0. //
88. 00 08800 RURAL HEALTH CLINIC		0.00000	0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLINIC		1. 53769		0	
91. 00 09100 EMERGENCY		0. 26724		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 48014		0	
OTHER REIMBURSABLE COST CENTERS		1 0. 15011	<u> </u>		1
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			18, 816	11, 309	200.00
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			18, 816		202.00
· - · · ·					

31.00 03100 INTENSI VE CARE UNI T 0 3 43.00 04300 NURSERY 4,885 4 ANCILLARY SERVICE COST CENTERS 0 0.371951 0 0 50.00 05200 DELI VERY ROOM & LABOR ROOM 0.329662 7,349 2,423 54.00 05400 RADI LLORY SERVICE 0.259232 0 0 5 64.00 06400 INTRAVENOUS THERAPY 0.2593799 2,423 615 6 64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 6 64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 6 65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07301 DRUGS CHARGED TO PATI ENTS 0.170654 0 0 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 7 0 0.000000 0	Health Financial Systems	IU HEALTH PAOLI HOSPITAL		In Lie	eu of Form CMS-	2552-10
Image: Tote 12/31/2016 Date:/Time Preparation Title XIX Hospital PPS Cost Center Description Title XIX Hospital PPS Tote Cost Center Description Inpatient Program Charges Inpatient Program Charges Program Charges Inpatient Program Charges Program Charges 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03000 ADULTS & PEDIATRICS 2,046 3.00 31.00 03000 NETENS 4,885 4 ANCILLARY SERVICE COST CENTERS 4,885 4 0.00 05000 OPERATING ROOM 0.371951 0 0 5 0.00 05000 OPERATING ROOM 0.329662 7,349 2,423 5 0.00 05000 LABORATORY 0.253799 2,423 5 6 0 6 0.00 05000 LABORATORY 0.259322 0 0 0 0 6 0.00 05000 LABORATORY 0.259379 2,423 5 6 0 0	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1306			}
INPATI ENT ROUTI NE SERVICE COST CENTERS Inpati ent Program Charges Inpati ent Program Charges Inpati ent Program Charges Inpati ent Program Charges Inpati ent Program Charges Inpati ent Program Charges Inpati ent Charges Inpati en						nored
Title XIX Hospital PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 1 x col. 2) 1.00 2.00 3.00 0.00 03000 ADULTS & PEDIATRICS 2,046 3 31.00 03100 INTENSIVE CARE UNIT 0 2 0 3 ANCILLARY SERVICE COST CENTERS 0,0175 4,885 4 3 50.00 05000 PERATING ROOM 0,31951 0 0 2 0 5 50.00 05400 RADIOLOGY-DI AGNOSTIC 0,259232 0 0 5 0 5 0 0 5 0 0 6 6 0 6 0 6 0 6 0 6 0 6 0 6 0 6 0 6 0 6 0 6 0 6 6 0 6 0 6 0 0 6 0 6 0 0 6				10 12/31/2016		
Cost Center Description Ratio of Cost To Charges Inpatient Program Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICE COST CENTERS 2.00 3.00 31.00 03100 INTENSIVE CARE UNIT 0 2.046 2.046 43.00 04300 NURSERY 4.885 4 ANCILLARY SERVICE COST CENTERS 4.885 4 50.00 05000 OPERATING ROOM 0.371951 0 0 50.00 05000 OPERATING ROOM 0.371951 0 0 5 50.00 05000 OPERATING ROOM 0.253799 2,423 615 6 60.00 06000 LABORATORY 0.253799 2,423 615 6 61.00 065000 RESPI RATORY THERAPY 0.1253799 2,423 615 6 62.00 065000 RESPI RATORY THERAPY 0.724031 0 0 6 63.00 065000 RESPI RATORY THERAPY 0.174262 341 59 7 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.174262 341 59 7 73.		Titl	e XIX	Hospi tal		<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS (col . 1 x col . 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 2,046 2 31.00 03100 INTENSIVE CARE UNIT 2,046 2 43.00 04300 NURSERY 4,885 4 ANCILLARY SERVICE COST CENTERS 4,885 4 50.00 05000 OPERATING ROM 0.371951 0 0 51.00 05000 OPERATING ROM 0.371951 0 0 5 52.00 05200 DELIVERY ROM & LABOR ROM 0.329662 7,349 2,423 5 54.00 06400 RADIOLOGY-DIAGNOSTIC 0.259322 0 0 0 6 60.00 065000 RESPI RATORY THERAPY 0.169955 0 0 6 61.00 06400 PHYSI CAL THERAPY 0.744031 0 0 6 62.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.174654 0 0 7 73.00 07300 DRUGS CHARGED TO PATIENTS 0.174654 0 0 7 <	Cost Center Description		Ratio of Cos		Inpatient	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 2,046 3 3 3 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 0 3 3 0 0 3 3 0 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 0 3 3 0 3 3<			To Charges	Program	Program Costs	
INPATI ENT ROUTINE SERVICE COST CENTERS INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 43.00 04300 NURSERY ANCILLLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.025200 DELI VERY ROOM & LABOR ROOM 0.025200 DELI VERY ROOM & LABOR ROOM 0.025200 DELI VERY ROOM & LABOR ROOM 0.0000 LABORATORY 0.0000 LABORATORY 0.0000 OC4000 LABORATORY 0.00000 LABORATORY 0.00000 LABORATORY 0.00000 LABORATORY 0.00000 LABORATORY 0.000000 LABORATORY				Charges		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 2,046 3 31. 00 03100 INTENSI VE CARE UNI T 0 3 43. 00 04300 INTENSI VE CARE UNI T 0 3 50. 00 05000 OPERATI NG ROOM 0.371951 0 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.329662 7,349 2,423 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.259232 0 0 60. 00 06000 LABORATORY 0.269532 0 0 64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 65.00 06500 RESPI RATORY THERAPY 0.74826 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.174622 341 59 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.170654 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 74.00						
30. 00 03000 ADULTS & PEDIATRICS 2,046 3 31. 00 03100 INTENSIVE CARE UNIT 0 3 43. 00 04300 NURSERY 4,885 4 ANCILLARY SERVICE COST CENTERS 0 0 3 0 50. 00 05000 OPERATING ROOM 0.371951 0 0 5 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.329662 7,349 2,423 5 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.259232 0 0 5 60. 00 06000 LABORATORY 0.253799 2,423 615 6 64. 00 06400 INTRAVENOUS THERAPY 0.724031 0 0 6 65. 00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.174262 341 59 7 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.174654 0 0 7 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.0000000 0 7 <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td></td>			1.00	2.00	3.00	
31.00 03100 INTENSIVE CARE UNIT 0 3 43.00 04300 NURSERY 4,885 4 ANCILLARY SERVICE COST CENTERS 50.00 OSC00 DELIVERY ROOM 0.371951 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.329662 7,349 2,423 54.00 05400 RADIOLOGY-DI AGNOSTIC 0.259232 0 0 64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 64.00 06400 INTRAVENOUS THERAPY 0.724031 0 0 65.00 06500 RESPI RATORY THERAPY 0.174262 341 59 72.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.174262 341 59 73.01 07301 DRUGS CHARGED TO PATIENTS 0.174654 0 0 74 74.00 07400 RENAL DI ALYSIS 0.000000 0 0 77 75.01 07501 CARDI AC REHAB 0.000000 0 0 77 75.01 07501 CARDI AC REHABILL			1		I	-
43.00 04300 NURSERY 4,885 4 ANCILLARY SERVICE COST CENTERS						30.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.371951 0 0 5 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.329662 7,349 2,423 6 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0.259232 0 0 5 60.00 06400 LABORATORY 0.253799 2,423 615 6 64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 6 65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 66.00 06600 PHYSI CAL THERAPY 0.74826 0 0 6 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.170654 0 0 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 7 7 0 0 7 75.01 07501 CARDIA C REHABI LI TATI ON 0.000000 0 0 7				Ũ		31.00
50.00 05000 0PERATI NG ROOM 0.371951 0 0 5 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.329662 7,349 2,423 5 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.259232 0 0 6 60.00 06000 LABORATORY 0.253799 2,423 615 6 64.00 06400 I INTRAVENOUS THERAPY 0.169955 0 0 6 65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 66.00 06600 PHYSI CAL THERAPY 0.174262 341 59 7 71.00 07100 MEL DEV. CHARGED TO PATI ENTS 0.174262 341 59 7 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.416699 1,794 748 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 7 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 <t< td=""><td></td><td></td><td></td><td>4, 885</td><td></td><td>43.00</td></t<>				4, 885		43.00
52.00 05200 DELI VERY ROM & LABOR ROM 0.329662 7,349 2,423 5 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.259232 0 0 5 60.00 06000 LABORATORY 0.253799 2,423 615 6 64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 6 65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 66.00 06600 PHYSI CAL THERAPY 0.74826 0 0 6 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.170654 0 0 7 73.01 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 7 75.01 07501 CARDI AC REHAB 0.000000 0 0 7 7 76.97 O7697 CARDI AC REHABI LI T			0.0710	1 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.259232 0 0 5 60.00 06000 LABORATORY 0.253799 2,423 615 6 64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 6 65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 66.00 06600 PHYSI CAL THERAPY 0.794826 0 0 6 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.170654 0 0 7 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.170654 0 0 7 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 7 75.01 07501 ASC (NON-DI STI INCT PART) 0.000000 0 0 7 75.01 07501 CARDI AC REHABI LI TATI ON 0.854145 0 0 7 76.97 07697 CARDI AC REHABI LI TATI O					-	
60.00 06000 LABORATORY 0.253799 2,423 615 6 64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 6 65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 66.00 06600 PHYSI CAL THERAPY 0.794826 0 0 6 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.170654 0 0 7 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 7 75.01 07501 CARDI AC REHAB ILI TATI ON 0.000000 0 0 7 76.70 07697 CARDI AC REH						
64.00 06400 INTRAVENOUS THERAPY 0.169955 0 0 6 65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 66.00 06600 PHYSI CAL THERAPY 0.794826 0 0 6 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.170654 0 0 7 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.100000 0 0 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 7 75.00 07501 CARDI AC REHAB 1.TATI ON 0.000000 0 0 7 76.70 07671 CARDI AC REHAB LI TATI ON 0.000000 0 0 7 76.70 07697 CARDI AC REHAB LI TATI ON 0.000000 0 0 7 77.00 08800 RURAL HEALTH CL					-	
65.00 06500 RESPI RATORY THERAPY 0.724031 0 0 6 66.00 06600 PHYSI CAL THERAPY 0.794826 0 0 6 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.170654 0 0 7 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.416699 1,794 748 7 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 7 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 7 75.01 07501 CARDI AC REHAB 0.000000 0 0 7 76.97 07697 CARDI AC REHABI LI TATI ON 0.854145 0 0 7 78.00 08800 RURAL HEALTH CLINI C 0.000000 0 0 7 88.00 08800 08000 00000 0 0 0 6 90.00 090000 CLINI C 1.537697						
66.00 06600 PHYSI CAL THERAPY 0.794826 0 0 6 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.170654 0 0 7 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.416699 1,794 748 7 73.01 07400 RENAL DI ALYSI S 0.000000 0 0 7 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 7 75.01 07501 CARDI AC REHAB 0.000000 0 0 7 75.01 07501 CARDI AC REHAB 0.000000 0 0 7 76.97 07697 CARDI AC REHABI LI TATI ON 0.854145 0 0 7 76.97 08800 RURAL HEALTH CLINIC 0.000000 0 0 7 7 88.00 08900 OB800 RURAL HEALTH CLINIC 0.000000 0 0 8 90.00 090000 CLINIC<						
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.174262 341 59 7 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.170654 0 0 7 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.416699 1,794 748 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 7 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 7 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 7 75.01 07501 CARDI AC REHAB 0.114 C REHAB 0.000000 0 0 7 76.97 07697 CARDI AC REHAB LI TATI ON 0.000000 0 7 7 77.90 08800 RURAL HEALTH CLINIC 0.000000 0 0 7 88.00 08900					-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.170654 0 7 73.00 07300 DRUGS CHARGED TO PATIENTS 0.416699 1,794 748 7 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 7 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 7 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 7 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 7 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 7 75.01 07501 CARDIAC REHAB 0.000000 0 0 7 76.70 07697 CARDIAC REHAB LITATION 0.854145 0 0 7 76.97 07697 CARDIAC REHABILITATION 0.000000 0 7 7 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 8 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000					-	
73.00 07300 DRUGS CHARGED TO PATIENTS 0.416699 1,794 748 7 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 7 73.01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 0 7 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 7 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 7 75.01 07501 CARDI AC REHAB 0.000000 0 0 7 76.97 07697 CARDI AC REHABILI TATION 0.854145 0 0 7 00TPATIENT SERVICE COST CENTERS 0.000000 0 0 0 8 8 0.000000 0 0 8 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 9 9 0 9000 0 0 0 9						
73. 01 07301 DRUGS CHARGED TO PATIENTS 0.000000 0 7 74. 00 07400 RENAL DI ALYSI S 0.000000 0 0 7 75. 00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 7 75. 01 07501 CARDI AC REHAB 0.000000 0 0 7 76. 97 07697 CARDI AC REHABILI TATI ON 0.000000 0 0 7 000000 000000 0 0 0 0 7 7 88. 00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 9 90. 00 09000 CLINIC 1.537697 0 0 9 9 0 0 0 9					Ŭ	
74.00 07400 RENAL DI ALYSI S 0.000000 0 7 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 7 75.01 07501 CARDI AC REHAB 0.000000 0 0 7 76.97 07697 CARDI AC REHABI LI TATI ON 0.854145 0 0 7 00TPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 7 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 99.00 09000 CLINIC 1.537697 0 0 9						
75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 7 75.01 07501 CARDIAC REHAB 0.000000 0 7 76.97 07697 CARDIAC REHABILITATION 0.854145 0 0 7 0UTPATI ENT SERVICE COST CENTERS 0 0 0 7 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 8 99.00 09000 CLINIC 1.537697 0 0 9						
76.97 O7697 CARDI AC REHABI LI TATI ON 0.854145 0 0 7 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 8 0 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 8 8 0 08900 FEDERALLY QUALI FIED HEALTH CENTER 0.000000 0 <t< td=""><td>75.00 07500 ASC (NON-DISTINCT PART)</td><td></td><td></td><td></td><td>0</td><td>75.00</td></t<>	75.00 07500 ASC (NON-DISTINCT PART)				0	75.00
76.97 O7697 CARDI AC REHABI LI TATI ON 0.854145 0 0 7 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 8 0 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 8 8 0 08900 FEDERALLY QUALI FIED HEALTH CENTER 0.000000 0 <t< td=""><td></td><td></td><td></td><td></td><td>0</td><td></td></t<>					0	
88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 8 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 8 90.00 09000 CLINIC 1.537697 0 0 0 9			0.85414	15 0	0	76.97
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0	OUTPATIENT SERVICE COST CENTERS		•			
90. 00 09000 CLINIC 1.537697 0 0 9	88.00 08800 RURAL HEALTH CLINIC		0.0000	0 0	0	88.00
	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0 0	0	89.00
91.00 09100 EMERGENCY 0.267247 0 0 9 9					0	90.00
	91. 00 09100 EMERGENCY		0. 26724	17 0	0	91.00
			0. 48014	13 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1			
						95.00
200.00 Total (sum of lines 50-94 and 96-98) 11,907 3,845 20				11, 907	3, 845	
		ogram only charges (line 61)		°,		201.00
202.00 Net Charges (line 200 minus line 201) 11,907 20	202.00 Net Charges (line 200 minus line 201)		1	11, 907		202.00

	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-1306 Period: From 01/01/2016		
	To 12/31/2016	5/23/2017 12:	
	Title XVIII Hospital	Cost	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	6, 107, 879	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instructions) PPS payments	0	2.00 3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6	0.00	6.00 7.00
8.00	Transitional corridor payment (see instructions)	0.00	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acqui si ti ons	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	6, 107, 879	11.00
	Reasonabl e charges		
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	12.00 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	
	Customary charges	-	
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
20100	instructions)	, i i i i i i i i i i i i i i i i i i i	20100
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6, 168, 958	
22.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	22.00 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions)	47, 389 3, 180, 693	
28.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	2, 940, 876	
	instructions)	_, ,	
28.00	Direct graduate medical education payments (from Wkst, E-4, line 50)	0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)	0 2, 940, 876	29.00 30.00
	Primary payer payments	3, 128	
32.00	Subtotal (line 30 minus line 31)	2, 937, 748	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	0	22.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)	0 1, 233, 607	
	Adjusted reimbursable bad debts (see instructions)	801, 845	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 227, 414	
37.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	3, 739, 593	
38.00 39.00		0	38.00 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	2 720 502	39.99 40.00
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)	3, 739, 593 74, 792	
41.00	Interim payments	3, 757, 134	
	Tentative settlement (for contractors use only)	0	42.00
43.00 44.00	Balance due provider/program (see instructions)	-92, 333 41, 792	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	41, 792	44.00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0	
91.00 92.00	The rate used to calculate the Time Value of Money		91.00
93.00	Time Value of Money (see instructions)	0	93.00
94 00	Total (sum of lines 91 and 93)	0	94.00

Title XVIII Hospital Cost Inpatient Part A Part B mm/dd/yyy Amount mm/dd/yyy Amount 1.00 Total interim payments paid to provider 3.664,134 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, write *10NE* or enter a zero. 3.664,134 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the Interin rate for the cost reporting period. Also show date of each for the cost reporting period. Also show date of each of the top the *000° or enter a zero. 07/21/2016 27,000 07/21/2016 93,000 3.01 ADJUSINENTS TO PROVIDER 07/21/2016 27,000 07/21/2016 93,000 3.03 ADJUSINENTS TO PROGRAM 0 0 0 0 3.03 ADJUSINENTS TO PROGRAM 0 0 0 0 0 3.04 O 0 0 0 0 0 0 3.05 ADJUSINENTS TO PROGRAM 0 0 0 0 0 0 0 0 0 <th>ANALY</th> <th>SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED</th> <th>Provider CC</th> <th>CN: 15-1306</th> <th>Period: From 01/01/2016 To 12/31/2016</th> <th></th> <th>pared:</th>	ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1306	Period: From 01/01/2016 To 12/31/2016		pared:
Interference mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 2.00 Interim payments payable on individual bills, either 3.00 4.00 0 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write NONE" or enter a zero. (1) none 0 0 payments 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) 07/21/2016 27,000 07/21/2016 93,000 3.01 Adultiments Top PROVIDER 07/21/2016 0 0 0 0 3.03 Adultiments 1.1 frome, write "NONE" or enter a zero. (1) program 0 <td< th=""><th></th><th></th><th>Title</th><th>XVIII</th><th>Hospi tal</th><th></th><th></th></td<>			Title	XVIII	Hospi tal		
Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for 3.664,134 3.00 List separately each retroactive lump sum adjustment anont based on subsequent revision of the interim rate for the cost reporting period. Also show date of each 93,000 payments T frome, write "NORE" or enter a zero. (1) Pregram to Provider 07/21/2016 27,000 07/21/2016 93,000 3.03 3.04 0 0 0 0 0 0 3.05 Provider to Program 0			I npati en	t Part A	Par	t B	
1.00 Total interim payments paid to provider 329,762 3,664,134 2.00 Interim payments payable on individual bills, either submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3 3 664,134 0 3.00 Usts 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) 9 9 0 <t< th=""><th></th><th></th><th>mm/dd/yyyy</th><th>Amount</th><th>mm/dd/yyyy</th><th>Amount</th><th></th></t<>			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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, write "NONE" or enter a zero. 0 0 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. 0 07/21/2016 07/21/2016 93.000 3.01 AJUSTMENTS TO PROVIDER 07/21/2016 27,000 07/21/2016 93.000 3.03			1.00	2.00	3.00	4.00	
Program to Provider DJUSTMENTS TO PROVIDER 07/21/2016 27,000 07/21/2016 93,000 3.03 0 0 0 0 0 0 3.03 0	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, 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		329, 7			1.00 2.00 3.00
3.01 ADJUSTMENTS TO PROVIDER 07/21/2016 27,000 07/21/2016 93,000 3.02 3.03 0							
3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.51 0 0 0 0 0 3.52 0 0 0 0 0 0 3.53 0	3. 01 3. 02 3. 03 3. 04 3. 05		07/21/2016	27, 0	0 0 0	0 0 0	3.0 3.0 3.0 3.0 3.0 3.0
3.51 0 0 3.52 0 0 3.53 0 0 3.54 0 0 3.54 0 0 3.54 0 0 3.54 0 0 3.57 0 0 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 27,000 93,000 3.50-3.98) 356,762 3,757,134 0 0 (transfer to Wkst. E or Wkst. E -3, line and column as appropriate) 356,762 3,757,134 0 TO BE COMPLETED BY CONTRACTOR 0 0 0 0 5.00 Lis separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 0 Program to Provider 0 0 0 0 0 5.01 TENTATIVE TO PROVIDER 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) interminant appropriate TO BE COMPLETED BY CONTRACTOR ist separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) ist separately each tentative settlement payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 0 5.01 TENTATI VE TO PROVIDER 0 5.02 0 0 5.03 0 0 Provider to Program 0 0 5.50 TENTATI VE TO PROGRAM 0 5.51 0 0 0 5.52 0 0 0 5.52 0 0 0 5.54 0 0 0 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 6.01 SETTLEMENT TO PROGRAM 0 0 0 6.02 SETTLEMENT TO PROGRAM 24,480 92,333 7.00 Total Medicare program liability (see instructions) 332,282 3,6	3.50 3.51 3.52 3.53 3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		27, 0	0 0 0 0	0 0 0	3.5(3.5 [°] 3.5 [°] 3.5 [°] 3.5 [°] 3.9 [°]
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 5.01 TENTATIVE TO PROVIDER 5.02 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 5.51 5.52 5.52 5.54 5.55 5.55 5.52 5.54 5.55 5.55 5.50 Determined net settlement amount (balance due) based on the cost report. (1) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROGRAM 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)	4.00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		356, 7	62	3, 757, 134	4.00
5.01 TENTATI VE TO PROVIDER 0 0 5.02 0 0 0 5.03 Provider to Program 0 0 7.50 TENTATI VE TO PROGRAM 0 0 5.51 0 0 0 5.52 0 0 0 5.54 0 0 0 5.55 0 0 0 0 5.52 0 0 0 0 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 5.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 0 6.01 SETTLEMENT TO PROVIDER 0 0 0 6.02 SETTLEMENT TO PROGRAM 24, 480 92, 333 7.00 Total Medicare program liability (see instructions) 332, 282 3, 664, 801	5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5.03000Provider to Program5.50TENTATI VE TO PROGRAM005.510005.520005.99Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)006.00Determined net settlement amount (balance due) based on the cost report. (1)006.01SETTLEMENT TO PROVIDER 6.02006.02SETTLEMENT TO PROGRAM To PROGRAM24,48092,3337.00Total Medicare program liability (see instructions)332,2823,664,801	5.01				0	0	5. 0 ²
Provider to Program5.50TENTATIVE TO PROGRAM005.510005.520005.99Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)006.00Determined net settlement amount (balance due) based on the cost report. (1)006.01SETTLEMENT TO PROVIDER 0006.02SETTLEMENT TO PROGRAM 7.0024,48092,3337.00Total Medicare program liability (see instructions)332,2823,664,801							5.02
5.50TENTATIVE TO PROGRAM005.510005.520005.99Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)006.00Determined net settlement amount (balance due) based on the cost report. (1)006.01SETTLEMENT TO PROVIDER 0006.02SETTLEMENT TO PROGRAM 7.0024,48092,3337.00Total Medicare program liability (see instructions)332,2823,664,801	5.03				0	0	5.03
6.00Determined net settlement amount (balance due) based on the cost report. (1)006.01SETTLEMENT TO PROVIDER006.02SETTLEMENT TO PROGRAM24, 48092, 3337.00Total Medicare program liability (see instructions)332, 2823, 664, 801	5. 51 5. 52	TENTATIVE TO PROGRAM Subtotal (sum of lines 5.01-5.49 minus sum of lines			0 0	0	5.50 5.5 5.52 5.90
6.02 SETTLEMENT TO PROGRAM 24, 480 92, 333 7.00 Total Medicare program liability (see instructions) 332, 282 3, 664, 801	6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
	6. 02	SETTLEMENT TO PROGRAM			80	92, 333	6.0 [°] 6.02 7.00
0 1.00 2.00)	Number	(Mo/Day/Yr)	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 01/01/201		
		Component	CCN: 15-Z306	To 12/31/201	6 Date/Time Pre 5/23/2017 12:	
		Title	XVIII	Swing Beds - SN		
		I npati en	t Part A	Pa	art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	-
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		48, 22	28	0	
00	Interim payments payable on individual bills, either			0	0) 2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	
)2				0	0	
)3				0	0	
)4				0	0	
)5	Dan dalar ta Dan mara			0	0) 3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	
50 51	ADJUSIMENTS TU PRUGRAM			0		-
52				0		-
53				0	0	-
54				0	0	-
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		48, 22	28	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate)					
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					1.
00	desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	
)3				0	0) 5
	Provider to Program		1	-	-	
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		
/ /	5. 50-5. 98)			0		/
00	Determined net settlement amount (balance due) based on					6
-	the cost report. (1)					
)1	SETTLEMENT TO PROVIDER		7, 39	99	0	6
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		55, 62		0) 7
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	-
	Name of Contractor	()	1.00	2.00	8

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1306 Period: From 01/01/2016 To 12/31/2016 Worksheet E-1 Part II To 12/31/2016 TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS Title XVIII Hospital Cost 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 200 1.00 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6. Line 2 47 3.00 4.00 Total hospital charges from Wkst. S-3, Pt. I, col. 8 line 20 484 4.00 5.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 59, 016,515 5.00 7.00 CALculation of the HIT incentive payment (see instructions) 0 9, 00 9, 00 9.00 Sequestration adjustment amount (see instructions) 0 9, 00 9, 00 9, 00 9.00 Initial/interim HIT payment adjustment (see instructions) 0 9, 00 00 030, 00 031, 00 9.00 Other Adjustment (specify) 0 30, 00 0 030, 00 0 30, 00 9.00 Sequestration adjustment (see instructions) 0 0 0 0 0 0 0	Heal th	Financial Systems IU HE	ALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
To 12/31/2016 Date/Time Prepared: 5/23/2017 12:41 pm Title XVIII Hospital Cost 1.00 To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 200 1.00 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6. Line 2 47 3.00 4.00 Total inpatient days from S-3, Pt. I, col. 8 sum of lines 1, 8-12 484 4.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 59,016,515 5.00 6.00 Total hospital charges from Wkst. S-10, col. 3 line 20 59,016,515 5.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 7.00 Calculation of the HIT incentive payment after sequestration (see instructions) 0 9.00 9.00 0.00 Initial/interim HIT payment adjust	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1306					
5/23/2017 12: 41 pm Title XVIII Hospital Title XVIII Hospital To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 1.00 Contractor for Nonstandard Calculation HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Contractor for Nonstandard Sq102 from Wkst. S-3, Pt. I col. 15 line 14 200 00 Medicare days from Wkst. S-3, Pt. I, col. 6 line 2 1.00 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 8 line 20 1.00 5.00 Total hospital charges from Wkst. S-10, col. 3 line 20 5.00 5.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 0 0 Non Calculation of the HIT incentive payment (see instructions) 0 <td <="" colspan="2" td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>pared.</td></td>	<td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>pared.</td>								pared.
1.001.001.001.001.00TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 142002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1211.73.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2474.00Total inpatient days from Wst. S-3, Pt. I, col. 8 sum of lines 1, 8-124844.00Total hospital charges from Wst. C, Pt. I, col. 8 line 20059,016,5155.00Total hospital charity care charges from Wkst. S-10, col. 3 line 2059,016,5156.00Total hospital charity care charges from Wkst. S-10, col. 3 line 202,477,4157.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I08.00Calculation of the HIT incentive payment (see instructions)08.009.00Sequestration adjustment amount (see instructions)08.0010.00InPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH030.0031.00Other Adjustment (specify)031.00					10 12/01/2010				
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 142001.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-121172.003.00Medicare HMO days from S-3, Pt. I, col. 6. line 24773.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124844.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 20059,016,5155.006.00Total hospital charges from Wkst. S-10, col. 3 line 202,477,4156.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.008.00Calculation of the HIT incentive payment (see instructions)08.009.00Sequestration adjustment amount (see instructions)09.0010.00Inital /interim HIT payment adjustment (see instructions)030.0031.00Other Adjustment (specify)031.00				Title XVIII	Hospi tal	Cost			
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 142001.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-121172.003.00Medicare HMO days from S-3, Pt. I, col. 6. line 24773.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124844.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 20059,016,5155.006.00Total hospital charges from Wkst. S-10, col. 3 line 202,477,4156.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.008.00Calculation of the HIT incentive payment (see instructions)08.009.00Sequestration adjustment amount (see instructions)09.0010.00Inital /interim HIT payment adjustment (see instructions)030.0031.00Other Adjustment (specify)031.00									
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 142001.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-121172.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2473.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124844.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 20059,016,5155.006.00Total hospital charjes from Wkst S, S-10, col. 3 line 202,477,4156.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.008.00Calculation of the HIT incentive payment (see instructions)08.009.009.00Calculation of the HIT incentive payment after sequestration (see instructions)09.0010.00Initial/interim HIT payment adjustment (see instructions)030.0030.00Initial/interim HIT payment adjustment (see instructions)030.0031.00Other Adjustment (specify)031.00						1.00			
1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 142001.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-121172.003.00Medicare HM0 days from Wkst. S-3, Pt. I, col. 6. line 2473.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124844.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 20059,016,5155.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 2059,016,5155.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.008.00Calculation of the HIT incentive payment (see instructions)08.009.009.00Calculation of the HIT incentive payment after sequestration (see instructions)09.0010.00Initial/interim HIS payment adjustment (see instructions)030.0030.00J1.000031.0031.00									
2.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-121172.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2473.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124844.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 20059,016,5155.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 2059,016,5155.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.008.00Calculation of the HIT incentive payment (see instructions)08.009.00Sequestrati on adjustment amount (see instructions)09.0010.00Initial/interim HIT payment adjustment (see instructions)09.0030.00Initial/interim HIT payment adjustment (see instructions)030.0031.00Other Adjustment (specify)031.00	1 00						4 00		
3.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2473.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124844.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 20059,016,5155.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 202,477,4156.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.008.00Calculation of the HIT incentive payment (see instructions)08.009.00Sequestration adjustment amount (see instructions)09.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH030.0031.00Other Adjustment (specify)031.00					14				
4.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124844.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 20059,016,5155.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 202,477,4156.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.008.00Calculation of the HIT incentive payment (see instructions)08.009.00Sequestration adjustment amount (see instructions)09.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH030.0031.00Other Adjustment (specify)031.00									
5.00Total hospital charges from Wkst C, Pt. I, col. 8 line 20059,016,5155.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 202,477,4156.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.008.00Cal culation of the HIT incentive payment (see instructions)08.009.00Sequestration adjustment amount (see instructions)09.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH030.0030.00Initial/interim HIT payment adjustment (see instructions)030.0031.00Other Adjustment (specify)031.00	5								
6.00Total hospital charity care charges from Wkst. S-10, col. 3 line 202,477,4156.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I07.001 ine 1688.00Cal culation of the HIT incentive payment (see instructions)08.009.00Sequestration adjustment amount (see instructions)09.0010.00Cal culation of the HIT incentive payment after sequestration (see instructions)09.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH030.0030.00Jintial/interim HIT payment adjustment (see instructions)030.0031.00Other Adjustment (specify)031.00				-12					
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 1 ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 9.00 Sequestration adjustment amount (see instructions) 0 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 0 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 0 30.00 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 0 31.00				ing 20					
I ine 1688.008.00Cal cul ation of the HIT incentive payment (see instructions)9.00Sequestration adjustment amount (see instructions)09.0010.00Cal cul ation of the HIT incentive payment after sequestration (see instructions)010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0031.00Other Adjustment (specify)031.00									
8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 9.00 Sequestration adjustment amount (see instructions) 0 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 0 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 0 31.00	7.00			er till ed hill technology	WKSL 3-2, PL I	U	7.00		
9.00Sequestration adjustment amount (see instructions)09.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)010.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH030.0030.00Initial/interim HIT payment adjustment (see instructions)030.0031.00Other Adjustment (specify)031.00	8 00		uctions)			0	8 00		
10.00Calculation of the HIT incentive payment after sequestration (see instructions)010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0030.0030.0030.0031.00Other Adjustment (specify)031.00		1 3 1				-			
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 0 31.00			estration	(see instructions)		0			
31.00 Other Adjustment (specify) 0 31.00				()		-			
31.00 Other Adjustment (specify) 0 31.00	30.00	Initial/interim HIT payment adjustment (see instruc	tions)			0	30.00		
	31.00		,			0	31.00		
	32.00		e 30 and li	ine 31) (see instruction	s)	0	32.00		

	Financial Systems	IU HEALTH PAOLI			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING	BEDS	Provider CCN: 15-1306	Peri od:	Worksheet E-2	
			Component CCN: 15-Z306	From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
				10 12/31/2010	5/23/2017 12:	
			Title XVIII	Swing Beds - SNF	Cost	
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICE					
1.00	Inpatient routine services - swing bed-SN			45, 340	0	
2.00	Inpatient routine services - swing bed-NF					2.00
3.00	Ancillary services (from Wkst. D-3, col. 3			11, 422	0	3.00
	Part V, cols. 6 and 7, line 202, for Part					
4.00	Per diem cost for interns and residents no	ot in approved teach	ing program (see		0.00	4.00
F 00	instructions)			10	0	F 00
5.00	Program days			18	0	
6.00	Interns and residents not in approved tead				0	
7.00	Utilization review - physician compensation		thod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus li	nes 6 and 7)		56, 762	0	
9.00	Primary payer payments (see instructions)			0	0	
10.00	Subtotal (line 8 minus line 9)			56, 762	0	
11.00	Deductibles billed to program patients (e: professional services)	xclude amounts appli	cable to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)			56, 762	0	12.00
13.00	Coinsurance billed to program patients (fi	rom provider records) (exclude coi nsurance	0	0	
15.00	for physician professional services)	Tom provider Tecolus		0	0	15.00
14.00	80% of Part B costs (line 12 x 80%)				0	14.00
15.00	Subtotal (enter the lesser of line 12 minu	usline 13 orline	14)	56, 762	-	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPE	-	,	0	0	
16.50	Pioneer ACO demonstration payment adjustme		s)	0	0	
16.55	410A RURAL DEMONSTRATION PROJECT			0	0	16.55
17.00	Allowable bad debts (see instructions)			0	0	17.00
17.01	Adjusted reimbursable bad debts (see inst	ructions)		0	0	
18.00	Allowable bad debts for dual eligible ben		ructions)	0	0	
19.00	Total (see instructions)			56, 762	0	
19.01	Sequestration adjustment (see instructions	5)		1, 135	0	19.01
20.00	Interim payments	-,		48, 228	0	20.00
21.00	Tentative settlement (for contractor use of	(v lac		40, 220	0	
22.00	Balance due provider/program (line 19 minu		and 21)	7, 399	0	
23.00	Protested amounts (nonallowable cost report			860	0	23.00
20.00	chapter 1, §115.2		nee with ows rub. 15-2,	800	0	25.00

	Financial Systems IU HEALTH PAOL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1306	Period: From 01/01/2016	Worksheet E-3	
			To 12/31/2016	Part V Date/Time Pre	nared
			10 12/31/2010	5/23/2017 12:	
		Title XVIII	Hospi tal	Cost	
				1.00	
1.00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR Inpatient services	E PART A SERVICES - CUST	REIMBURSEMENT	372, 506	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruct	ti ana)		372,506	2.00
2.00 3.00	Organ acquisition	1015)		0	3.00
4.00	Subtotal (sum of lines 1 through 3)			372, 506	
4.00 5.00	Primary payer payments			372, 300	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			376, 231	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			370, 231	0.00
	Reasonable charges				1
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for			0	11.00
12.00	Amounts that would have been realized from patients liable f		n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13((e)			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
14.00	Total customary charges (see instructions)			0	
15.00	Excess of customary charges over reasonable cost (complete c	only if line 14 exceeds li	ne 6) (see	0	15.00
1/ 00	instructions)	velvifling (avoada lin	. 14) (222	0	1/ 00
16.00	Excess of reasonable cost over customary charges (complete c instructions)	Shi y 11 11he 8 exceeds 11h	le 14) (See	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17.00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	17.00
18.00	Direct graduate medical education payments (from Worksheet E	-4. line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	.,		376, 231	
20.00	Deductibles (exclude professional component)			46, 368	
21.00	Excess reasonable cost (from line 16)			0	
22.00	Subtotal (line 19 minus line 20 and 21)			329, 863	22.00
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			329, 863	24.00
25.00	Allowable bad debts (exclude bad debts for professional serv	/ices) (see instructions)		14, 154	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			9, 200	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		14, 154	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			339, 063	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29.50
29.99	Recovery of Accel erated Depreciation			0	
30.00	Subtotal (see instructions)			339, 063	
30.01	Sequestration adjustment (see instructions)			6, 781	
	Interim payments			356, 762	
32.00	Tentative settlement (for contractor use only)	and 22)		0	32.00
33.00 34.00	Balance due provider/program (line 30 minus lines 30.01, 31, Protested amounts (nonallowable cost report items) in accord		chaptor 1	-24, 480 5, 329	33.00 34.00
34. UU	FIGESTED ANDUITS (NONATIONADIE COST FEDOLE FLENS) IN ACCORD	ance with two Pub. 15-2,	chapter I,	5, 329	J 34. U

MCRI F32 - 10. 5. 160. 2

	E SHEET (If you are nonproprietary and do not maintain	Provider C		eri od:	Worksheet G	
	ype accounting records, complete the General Fund column		Fi	rom 01/01/2016 o 12/31/2016	Date/Time Pre	nar
y)					5/23/2017 12:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS Cash on hand in banks	28, 657, 928	0	0	0	1 1
	Temporary investments	20,037,920	0	0	0	
	Notes receivable	0	0	0	0	
	Accounts receivable	2, 781, 731	0	0	0	
00	Other receivable	-1, 724, 975	0	0	0	5
00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
	Inventory	498, 604	0	0	0	
	Prepai d expenses	149, 433		0	0	
	Other current assets	0	0	0	0	
	Due from other funds	0	0	0	0	
	Total current assets (sum of lines 1-10)	30, 362, 721	0	0	0	1
	FI XED ASSETS Land	148, 000	0	0	0	112
	Land improvements	438, 464	0	0	0	
	Accumulated depreciation	-305, 848	-	0	0	
	Buildings	6, 593, 280		o	0	
	Accumulated depreciation	-2, 976, 274	0	0	0	
	Leasehold improvements	253, 197	0	0	0	
00	Accumulated depreciation	-253, 197	0	0	0	18
. 00	Fixed equipment	0	0	0	0	19
. 00	Accumulated depreciation	0	0	0	0	20
	Automobiles and trucks	0	0	0	0	1 -
	Accumulated depreciation	0	0	0	0	
	Major movable equipment	10, 068, 496		0	0	
	Accumulated depreciation	-6, 322, 192	0	0	0	
	Minor equipment depreciable	0	0	0	0	1
	Accumulated depreciation HIT designated Assets	0	0	0	0	
	Accumul ated depreciation	0	0	0	0	
	Mi nor equi pment-nondepreci abl e	0	0	0	0	
	Total fixed assets (sum of lines 12-29)	7, 643, 926		0	0	
	OTHER ASSETS	7,010,720			0	
	Investments	-1, 778, 603	0	0	0	13
. 00	Deposits on Leases	0	0	0	0	32
. 00	Due from owners/officers	0	0	0	0	33
. 00	Other assets	9, 127, 459	0	0	0	34
. 00	Total other assets (sum of lines 31-34)	7, 348, 856		0	0	35
	Total assets (sum of lines 11, 30, and 35)	45, 355, 503	0	0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	974, 132		0	0	
	Salaries, wages, and fees payable	677, 621	0	0	0	
	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term) Deferred income	0	0	0	0	
	Accel erated payments	0	0	0	U	42
	Due to other funds		0	0	0	
	Other current liabilities	2, 939, 258	-	0	0	
	Total current liabilities (sum of lines 37 thru 44)	4, 591, 011	0			
	LONG TERM LIABILITIES	.,			_	1
. 00	Mortgage payable	0	0	0	0	4
	Notes payable	0	0	0	0	
	Unsecured Loans	0	0	0	0	48
	Other long term liabilities	33, 948	0	0	0	49
	Total long term liabilities (sum of lines 46 thru 49)	33, 948		0	0	
	Total liabilities (sum of lines 45 and 50)	4, 624, 959	0	0	0	5
	CAPITAL ACCOUNTS					Ι.
	General fund balance	40, 730, 544				52
	Specific purpose fund		0		ļ	53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	0	56
	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
					U	1 30
. 00	replacement and expansion					1
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	40, 730, 544	0	n	0	59

Health Financial Syst	ems	IU HEALTH PAOL	LI HOSPITAL			In Lie	u of Form CMS	5-25	52-10
STATEMENT OF CHANGES			Provider CC		Fr To	riod: om 01/01/2016 12/31/2016	Worksheet G Date/Time P 5/23/2017 12	-1 repa <u>2: 4</u> 1	ared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fur	nd	
		1.00	0.00	0.00		1.00	F 00		
1.00 Fund bal ances	at beginning of period	1.00	2.00 36,253,456	3.00		4.00	5.00		1.00
2.00 Net income (Ic	oss) (from Wkst. G-3, line 29)		4, 477, 089						2.00
3.00 Total (sum of 4.00	line 1 and line 2)	0	40, 730, 545		0	0		0	3.00 4.00
5.00		0			0			0	5.00
6.00		0			0			0	6.00 7.00
7.00 8.00		0			0			0	7.00 8.00
9.00	<i>.</i>	0			0			0	9.00
	ns (sum of line 4-9) e 3 plus line 10)		0 40, 730, 545			0			10. 00 11. 00
12. 00 ROUNDI NG		1	40, 730, 343		0	0			12.00
13.00		0			0 0			-	13.00 14.00
14. 00 15. 00		0			0				14.00 15.00
16.00		0			0				16.00
17.00 18.00 Total deductio	ons (sum of lines 12-17)	0	1		0	0			17.00 18.00
19.00 Fund balance a	it end of period per balance		40, 730, 544			0			19.00
sheet (line 11	minus line 18)	Endowment Fund	PI ant	Fund	_			_	
1.00 Fund balances	at beginning of period	6.00	7.00	8.00	0				1.00
	oss) (from Wkst. G-3, line 29)	0			0				2.00
	line 1 and line 2)	0			0				3.00
4.00 5.00			0						4.00 5.00
6.00			0						6.00
7.00 8.00			0						7.00 8.00
9.00			0						9.00
	ns (sum of line 4-9)	0			0				10.00
11.00 Subtotal (line 12.00 ROUNDING	e 3 plus line 10)	0	0		0				11.00 12.00
13.00			0						13.00
14.00 15.00			0						14.00 15.00
16.00			0						16.00
17.00 18.00 Total deductio	p_{r} (sum of lines 12 17)		0		0				17. 00 18. 00
	ns (sum of lines 12-17) It end of period per balance	0			0 0				18.00 19.00
sheet (line 11	minus line 18)								

	Financial Systems IU HEALTH PAOL IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-1306	Peri od:		worksheet G-2	
				From 01/01 To 12/31			
	Cost Center Description		Inpati ent	Outpati		Total	
			1.00	2.00	1	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services						-
1.00	Hospi tal		1, 086, 4	12		1, 086, 412	1.00
2.00	SUBPROVIDER - IPF		1, 000, 4	12		1,000,412	2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		1, 086, 4	12		1, 086, 412	10.00
	Intensive Care Type Inpatient Hospital Services			- 1		-	
11.00	I NTENSI VE CARE UNI T			0		0	
12.00	CORONARY CARE UNIT						12.00
13.00 14.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						14.00
16.00	Total intensive care type inpatient hospital services (sum o	flines		0		0	
10.00	11-15)	n THES		0		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	1, 086, 4	12		1, 086, 412	17.00
18.00	Ancillary services		2, 512, 7		5, 806		
19.00	Outpatient services		108, 8				19.00
20.00	RURAL HEALTH CLINIC			0	0		20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY				0	0	22.00
23.00	AMBULANCE SERVICES			0	0	0	23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	PHYSI CI AN CHARGES		0 700 0		0, 944		
28.00	Total patient revenues (sum of lines 17-27)(transfer column G-3. line 1)	3 to WKST.	3, 708, 0	00 55, 33	9, 382	59, 047, 382	28.00
	PART II - OPERATING EXPENSES						-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			20, 80	1 944		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				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00	Tatal deductions (our of Lines 27 41)			0	~		41.00
42.00 43.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line	12) (transfor		20, 80	0		42.00
43.00	to Wkst. G-3, line 4)	42) (ti alisi el		20,80	1, 944		43.00

Heal th	Financial Systems IU HE	ALTH PAOLI HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES		Prov	ider CCN: 15-1306	Period:	Worksheet G-3	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
				10 12/01/2010	5/23/2017 12:	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				59, 047, 382	1.00
2.00	Less contractual allowances and discounts on patients' accounts				35, 149, 965	2.00
3.00	Net patient revenues (line 1 minus line 2)				23, 897, 417	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)				20, 801, 944	4.00
5.00	Net income from service to patients (line 3 minus line 4)				3, 095, 473	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellaneous communication services				0	8.00
9.00					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					0	
14.00	Revenue from meals sold to employees and guests				0	
	Revenue from rental of living quarters				0	15.00
	J				0	16.00
					0	17.00
18.00					0	18.00
					0	19.00
20.00					0	20.00
21.00					0	21.00
22.00					0	22.00
23.00	Governmental appropriations				0	23.00
	MI SCELLANEOUS I NCOME				1, 381, 616	
	Total other income (sum of lines 6-24)				1, 381, 616	
	Total (line 5 plus line 25)				4, 477, 089	
27.00	OTHER EXPENSES (SPECIFY)	-)			0	27.00
	Total other expenses (sum of line 27 and subscripts				0 4, 477, 089	28.00
29.00	Net income (or loss) for the period (line 26 minus	11110 20)		l	4, 477, 089	29.00