HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

EXPIRES 05-31-2019

Provider CCN: 15-0051
From 01/01/2017
To 12/31/2017
Provider CCN: 15-0051
From 01/01/2017
To 12/31/2017
Provider CCN: 15-0051
From 01/01/2017
To 12/31/2017
Provider CCN: 15-0051
From 01/01/2017
From 01/01/2

			5/2	29/2018 2:	U5 pm
PART I - COST	REPORT STATUS				
Provi der use only	<ol> <li>[ X ] Electronically filed cost report</li> <li>[ ] Manually submitted cost report</li> <li>[ 0 ] If this is an amended report enter the number of the filed care Utilization. Enter "F" for full or "L"</li> </ol>		Date: 5/29/2018 esubmitted this cost		2:05 pr
Contractor use only	5. [ 1 ]Cost Report Status 6. Date Received:     (1) As Submitted 7. Contractor No.     (2) Settled without Audit 8. [ N ] Initial Report for (3) Settled with Audit 9. [ N ] Final Report for (4) Reopened (5) Amended	11.0 this Provider CCN 12.	NPR Date: Contractor's Vendor C [ O ]If line 5, colum number of times	n 1 is 4:	

## 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLOOMINGTON HOSPITAL (15-0051) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)
Officer or Administrator of Provider(s)
Ti tl e
Data

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	92, 027	3, 119	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	-11, 436	1		0	3. 00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	0	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
200.00	Total	0	80, 591	3, 120	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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		BLOOMI NGTO		TAL er CCN: 1	5-0051	Period: From 01/01/ To 12/31/	′2017 ′2017	of For Workshe Part I Date/Ti 5/27/20	et S-2 me Pre	pared:
	1.00	2	. 00	;	3. 00			4. 00	0, 2,, 20	71 1	
	Hospital and Hospital Health Care Co										
1.00	Street: 601 WEST SECOND STREET	PO Box:	•		47400	0	MONDOE				1.00
2.00	City: BLOOMINGTON	State: Component N		CCN CODE	CBSA	Provi der	y: MONROE Date	Daymor	nt Syst	om (D	2. 00
		Component		umber	Number	Type	Certified		0, or		
			""		TTGIIIDCT	1,700	oci ti i cu	V .,	XVIII	XIX	
		1.00	2	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
	Hospital and Hospital-Based Componen	t Identification									
3.00	Hospi tal	IU HEALTH BLOOMI	NGTON 15	50051	14020	1	07/01/1966	N	Р	Р	3. 00
		HOSPI TAL									
4.00	Subprovider - IPF					_			_	_	4.00
5. 00	Subprovi der - IRF	IU HEALTH BLOOMI	NGTON 15	5T051	14020	5	10/01/2002	N	P	P	5. 00
6. 00	  Subprovider - (Other)	HOSPI TAL									6. 00
7.00	Swing Beds - SNF			1							7.00
8. 00	Swing Beds - NF			i				İ			8. 00
9. 00	Hospi tal -Based SNF			i							9. 00
10.00	Hospi tal -Based NF										10.00
11.00	Hospi tal -Based OLTC										11. 00
12.00	Hospital-Based HHA										12. 00
	Separately Certified ASC										13. 00
	Hospi tal -Based Hospi ce										14.00
	Hospital-Based Health Clinic - RHC										15.00
	Hospital Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC)   Renal Dialysis										17. 00 18. 00
19. 00											19.00
17.00	other						From:		То		19.00
							1. 00		2. 0		
20. 00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/		20. 00
21.00	Type of Control (see instructions)						2				21.00
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it						Y		N		22. 00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil				2. 106(C)	(2) (PI CKI	9				
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim un				cost r	enorti na	Y		Υ		22. 01
22.01	period? Enter in column 1, "Y" for y										22.01
	reporting period occurring prior to										
	for no for the portion of the cost r	eporting period o	occurring o	n or af	ter Oct	ober 1.					
	(see instructions)										
22. 02	Is this a newly merged hospital that						N		N		22. 02
	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, roi the porti	ron or the	COST TE	epor tring	period o	1				
22 03	Did this hospital receive a geograph	ic reclassificati	ion from ur	ban to	rural a	s a resul	t N		N		22. 03
	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 42 CFR 412.105)? Enter in column 3,	it more than 499 i	beds (as co	unted i	n accor	dance wit	n				
23. 00	Which method is used to determine Me			/or 25	hel ow?	In column		3	N		23. 00
20.00	1, enter 1 if date of admission, 2 i							٦			20.00
	method of identifying the days in th										
	used in the prior cost reporting per	iod? In column :	·	" for y	es or "	N" for no					
			In-State	In-St		out-of		ledi cai		ther	
			Medicai d	Medi c		State		IMO day		li cai d	
			paid days	el i gi unpa			Medicaid   eligible		l a	lays	
				day		a days .	unpai d				
			1.00	2.0		3. 00	4. 00	5. 00	6	. 00	
24. 00	If this provider is an IPPS hospital	, enter the	1, 219		542	55	32	12, 0			24. 00
	in-state Medicaid paid days in colum		,								
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
25 00	column 5, and other Medicaid days in If this provider is an IRF, enter th		14		21	0	o	_	290		25. 00
≥0. UU	Medicaid paid days in column 1, the				21	U	۷	2	. 70		25.00
	Medicaid eligible unpaid days in col								1		
	out-of-state Medicaid days in column								1		
	Medicaid eligible unpaid days in col	umn 4, Medicaid									
	HMO paid and eligible but unpaid day	s in column 5.	I						1		

61.03

instructions)

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

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT			NGTON HOSPITAL Provider CO		Period:	wof Form CMS-2 Worksheet S-2	
HOSFITAL AND HOSFITAL HEALTH CARE COMPLEX TOLINT	TITCATION DA	IIA	Frovider Co	JN. 13-0031	From 01/01/2017 To 12/31/2017		pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5. 00	
Enter the number of unweighted primary ca surgery allopathic and/or osteopathic FTE current cost reporting period. (see instru- Enter the difference between the baseline and/or general surgery FTEs and the curre	s in the actions). primary ent year's						61. 0
primary care and/or general surgery FTE of 61.04 minus line 61.03). (see instruction 1.06 Enter the amount of ACA §5503 award that used for cap relief and/or FTEs that are care or general surgery. (see instruction	is) is being nonprimary						61. 0
		Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4. 00	
51.10 Of the FTEs in line 61.05, specify each r specialty, if any, and the number of FTE for each new program. (see instructions) column 1, the program name. Enter in coluprogram code. Enter in column 3, the IME unweighted count. Enter in column 4, the FTE unweighted count.	residents Enter in mn 2, the FTE				0. 00	0.00	61. 10
1. 20 Of the FTEs in line 61.05, specify each of program specialty, if any, and the number residents for each expanded program. (see instructions) Enter in column 1, the progenter in column 2, the program code. Enter 3, the IME FTE unweighted count. Enter in the direct GME FTE unweighted count.	of FTE ram name.				0.00	0.00	61. 2
						1.00	
ACA Provisions Affecting the Health Resou							
<ol> <li>Enter the number of FTE residents that your hospital received HRSA PCRE funding</li> </ol>			lin this cost	reporting pe	riod for which	0.00	62.0
2.01 Enter the number of FTE residents that roduring in this cost reporting period of FTE reaching Hospitals that Claim Residents i	tated from a RSA THC prog	a Teachi gram. (s	<u>see instructio</u>		o your hospital	0.00	62. C
3.00 Has your facility trained residents in no "Y" for yes or "N" for no in column 1. If	nprovi der se	ettings	during this co			N	63.0
			<u> </u>	Unwei ghted	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Resperiod that begins on or after July 1, 20				inis base yea	ar is your cost i	eporting	
4.00 Enter in column 1, if line 63 is yes, or in the base year period, the number of ur resident FTEs attributable to rotations c settings. Enter in column 2 the number c resident FTEs that trained in your hospit of (column 1 divided by (column 1 + column 2).	your facilit weighted nor ccurring in of unweighted al. Enter ir	ty train n-primar all non d non-pr n column	ned residents ry care aprovider rimary care a 3 the ratio	0.	0. 00	0. 000000	64.0
	am Name		ogram Code	Unwei ghted		Ratio (col. 3/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1 00		2 00	3 00	4 00	5.00	1

2.00

3. 00

4. 00

5.00

1.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/27/2018 9:18 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

108.00 Is this a rural hospital qualifying for an exception to the	N		108. 00		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3. 00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are					109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1.00	
110.00 Did this hospital participate in the Rural Community Hospita	al Demonstratio	on project (§41	OA	N	110. 00
Demonstration) for the current cost reporting period? Enter "	'Y" for yes or	"N" for no. If	yes,		

complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as

appl i cabl e.

reimbursed. If yes complete Wkst. D-2, Pt. II.

are claimed, enter in column 2 the home office chain number. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number

Name: INDIANA UNIVERSITY HEALTH INC | Contractor's Name: WPS 141. 00 Name: I NDI ANA UNI VERSI TY HEALTH I NC Contractor's Number: 08101 141 00 142.00 Street: 340 W. 10TH STREET PO Box: 142.00 143.00 City: INDIANAPOLIS 46202-3082 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 04/01/2017 06/30/2017 170. 00 period respectively (mm/dd/yyyy) 1.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 1, 072 171. 00 section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

Υ

Ν

N

04/04/2018

Ν

Ν

04/04/2018

17.00

18.00

19.00

instructions)

17.00

18.00

date of the PS&R Report used in columns 2 and 4 . (see

Was the cost report prepared using the PS&R Report for

If line 16 or 17 is yes, were adjustments made to PS&R

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date

in columns 2 and 4. (see instructions)

cost report? If yes, see instructions.

information? If yes, see instructions.

Trom 01/01/2017   Part III   Pa		Financial Systems I		- CN: 15-0051	In Lie	wof Form CN Worksheet S	
Computation	11031 1 17	AL AND HOSTITAL HEALTH CARE RETWINDINGEMENT QUESTIONNALINE	Trovider c	CN. 13-0031	From 01/01/2017		Prepared:
Report data for Other? Describe the other adjustments and to PSARR   N   N   N   Report data for Other? Describe the other adjustments:   Y/N   Date   Y/N   Date   Description   Desc						Y/N	
Report data for Other? Describe the other adjustments:   1.00	00.00	16.11 4/ 47.1		0		3. 00	20.00
21.00 Was the cost report prepared only using the provider's N N N 1.00							20. 00
21.00 Was the cost report prepared only using the provider's N N N N records? If yes, see instructions.    COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) (Capital Related Cost lawe assets been relifed for Medicare purposes? If yes, see instructions and variety of the work of the provider of the month of the provider for school are an arrangement with the provider-based physicians?  17.00 Was the cost report prepared only using the provider render services to the home office? If yes, see instructions.  18.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  28.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  29.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit concerns the provider's capitalization policy changed during the cost reporting period? If yes, submit concerns the provider's capitalization policy changed during the cost reporting period? If yes, submit concerns the provider's capitalization policy changed during the cost reporting period? If yes, submit concerns the provider's passed and 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.  29.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  30.00 Has existing debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see instructions.  30.00 Has expert experting period? If yes, see instructions.  30.00 Has expert prepared by seed the provider facility under an arrangement with p						Date	
records? If yes, see instructions.    COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)   Capital Related Cost   Capital Relate	04.00		_	2.00		4. 00	04.00
COMPLETED BY COST RELIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost  22. 0.0 Have assets been relifed for Medicare purposes? If yes, see instructions 3.0 01 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.  24. 0.0 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.  25. 0.0 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  26. 0.0 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.  27. 0.0 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit toopy.  28. 0.0 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29. 0.0 Id the provider have a funded depreciation account? If yes, see instructions  30. 0.0 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  31. 0.0 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.  32. 0.0 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  32. 0.0 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  32. 0.0 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  33. 0.0 If I in 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  34. 0.0 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, se			IN IN		N		21. 00
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preparer.  43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.  RUTTER@I UHEALTH. ORG	43. 00	Enter the telephone number and email address of the cost	317-962-1093		RUTTER@I UHEALT	H. ORG	43. 00

Heal th	Financial Systems IU HEAL	TH BLOOMI	NGTON HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN	NAI RE	Provi der CCN:	Peri od:	Worksheet S-2	
				From 01/01/2017 Fo 12/31/2017	Date/Time Pre	
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	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/posi	ti on	DI RECTOR			41.00
	held by the cost report preparer in columns 1, 2,	and 3.				
	respectively.					
42.00	Enter the employer/company name of the cost report	:				42. 00
	preparer.					
43.00	Enter the telephone number and email address of th	ne cost				43.00
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Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 15-0051

S/27/2018 9:18 am   S/27/2018 9:18 am   I/P Days / O/P   Visits / Trips   Title V
Component   Worksheet A   Li ne Number   No. of Beds   Bed Days   Available   Available   Title V
Li ne Number
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) 2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 198 72,270 0.00 0 1.00 0 1.00 0 1.00 0 1.00 0 0 0.00 0 0 0.00 0 0 0.00 0 0 0.00
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Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)  2.00 HMO and other (see instructions)  3.00 HMO IPF Subprovider  4.00 HMO IRF Subprovider  5.00 Hospital Adults & Peds. Swing Bed SNF  6.00 Hospital Adults & Peds. Swing Bed NF  7.00 Total Adults and Peds. (exclude observation beds) (see instructions)
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11. 00   SURGI CAL   INTENSI VE CARE UNI T   11. 00 12. 00   NEONATAL   INTENSI VE CARE UNI T   35. 00   18   6, 570   0. 00   0   12. 00
13. 00   NURSERY   43. 00   0, 370   0. 00   0   12. 00
14. 00   Total (see instructions)   246   89, 790   0. 00   0   14. 00
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16. 00   SUBPROVIDER - I PF   16. 00
17. 00 SUBPROVIDER - I RF 41. 00 16 5, 840 0 17. 00
18. 00   SUBPROVI DER
19. 00   SKILLED NURSING FACILITY   19. 00
20. 00   NURSING FACILITY   20. 00
21. 00 OTHER LONG TERM CARE
22. 00 HOME HEALTH AGENCY 101. 00 0 22. 00
23. 00   AMBULATORY SURGI CAL CENTER (D. P. ) 115. 00   23. 00
24. 00 HOSPI CE 116. 00 0 0 24. 00 12. 00
24. 10 HOSPICE (non-distinct part) 30. 00 24. 10
25.00   CMHC - CMHC   25.00
26. 00 RURAL HEALTH CLINIC 26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 26. 25
27.00 Total (sum of lines 14-26) 262 27.00
28.00 Observation Bed Days 0 28.00
29.00 Ambul ance Tri ps 29.00
30.00 Employee discount days (see instruction) 30.00
31.00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions) 12 4,380 32.00
32.01 Total ancillary labor & delivery room 32.01
outpatient days (see instructions)
33.00 LTCH non-covered days 33.00
33.01 LTCH site neutral days and discharges 33.01

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO | Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: | Provider CCN: 15-0051

				'	0 12/31/2017	5/27/2018 9:1	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	16, 711	589	39, 237			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	4, 810	10, 936				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4. 00	HMO IRF Subprovider	173	311				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	16, 711	589	39, 237			7. 00
	beds) (see instructions)	4 0/5	0.47				
8. 00	INTENSIVE CARE UNIT	1, 965	367	3, 800			8. 00
9.00	CORONARY CARE UNIT	1, 593	0	3, 296			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT		0.4.0	0.704			11.00
12.00	NEONATAL INTENSIVE CARE UNIT	0	218	2, 791			12.00
13.00	NURSERY	00.040	1, 808	3, 616		4 705 00	13.00
14. 00	Total (see instructions)	20, 269	2, 982	52, 740	0.00	1, 705. 20	14.00
15.00	CAH visits	0	0	0			15.00
16. 00 17. 00	SUBPROVIDER - I PF	1 (27	1.4	2 7/1	0.00	0.00	16. 00 17. 00
18. 00	SUBPROVI DER - I RF SUBPROVI DER	1, 627	14	2, 761	0.00	l e	•
19. 00	SKILLED NURSING FACILITY		٩	Ü	0.00	0.00	19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	1
23. 00	AMBULATORY SURGICAL CENTER (D. P. )		ď	Ü	0.00		23. 00
24. 00	HOSPI CE	0	0	0			24.00
24. 10	HOSPICE (non-distinct part)	20	0	40	0.00	0.00	24. 10
25. 00	CMHC - CMHC	20	ĭ	40			25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)	J	Ĭ	O	0.00		27. 00
28. 00	Observation Bed Days		109	5, 219		1,700.20	28. 00
29. 00	Ambul ance Trips	7, 758		3/2.7			29. 00
30. 00	Employee discount days (see instruction)	,,,,,,,		0			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	0	29	744			32.00
32. 01	Total ancillary labor & delivery room	l ~	- '	0			32. 01
	outpatient days (see instructions)			O			
33.00	LTCH non-covered days	0	İ				33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

 Heal th Financial
 Systems
 I U HEALTH

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provi der CCN: 15-0051

Peri od: Worksheet S-3 From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/27/2018 9: 18 am

							5/27/2018 9:1	8 am
		Full Time Equivalents			Di sch	arges		
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
		Workers	12.00	-	12.00	14.00	Pati ents 15.00	
1 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12. 00	0	13. 00 4, 367	14. 00 175		1. 00
1. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			U	4, 367	175	13, 475	1.00
2.00	HMO and other (see instructions)				1, 051	2, 476		2.00
3.00	HMO I PF Subprovi der					0		3. 00
4.00	HMO I RF Subprovi der					28		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	NEONATAL INTENSIVE CARE UNIT							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)	0.00		0	4, 367	175	13, 475	14.00
15.00	CAH visits							15.00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF	0.00		0	156	1	258	17.00
18.00	SUBPROVI DER	0.00		0		0	0	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	0.00						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00						23. 00
24.00	HOSPI CE	0.00						24. 00
24. 10	HOSPICE (non-distinct part)							24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00						26. 25
27.00	Total (sum of lines 14-26)	0. 00						27.00
28.00	Observation Bed Days							28. 00
29.00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)							32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days				0			33.00
33. 01	LTCH site neutral days and discharges				0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | P

					To	12/31/2017	Date/Time Prep 5/27/2018 9:18	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Salaries (col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	103, 123, 638	-645, 365	102, 478, 273	3, 670, 253. 00	27. 92	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0.00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4.00	B Physician-Part A -		306, 278	0	306, 278	5, 584. 00	54. 85	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	· -	0.00		
5. 00	Physician and Non Physician-Part B		1, 103, 262		1, 122, 232	10, 273. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0.00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	0	О	0.00	0. 00	7. 01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 10, 798, 890	-111, 690	0 10, 687, 200	0. 00 421, 250. 00		
	instructions) OTHER WAGES & RELATED COSTS			,				
11. 00	Contract labor: Direct Patient Care		6, 766, 310	0	6, 766, 310	77, 183. 88	87. 66	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0.00	0. 00	12. 00
	management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		1, 598, 968	0	1, 598, 968	14, 533. 00	110. 02	13. 00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	О	0	0.00	0. 00	14. 00
14. 01 14. 02	Home office salaries Related organization salaries		24, 137, 776	0	24, 137, 776	779, 943. 00 0. 00	1	14. 01 14. 02
15. 00	Home office: Physician Part A		0	0	0	0.00		15. 00
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		30, 772, 771	0	30, 772, 771			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		3, 802, 408	0	3, 802, 408			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20. 00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		81, 703	0	81, 703			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 225, 329	0	0 225, 329			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization wage-related (core)		0					25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0					25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core)	-c						
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	2, 029, 910					26. 00
27. 00	Administrative & General	5. 00	8, 818, 203	211, 990	9, 030, 193	215, 393. 00	41. 92	27. 00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0051

Peri od: Worksheet S-3 From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/27/2018 9:18 am Wkst. A Line Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Number Reported on of Salaries Sal ari es Related to Wage (col. 4 col . 5) (from Wkst.  $(col.2 \pm col.$ Salaries in A-6)3) col. 4 1.00 2.00 6.00 3.00 4.00 5.00 28.00 Administrative & General under 885, 262 885, 262 4, 525. 24 195. 63 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 29.00 0.00 Operation of Plant 30.00 7.00 2, 322, 865 2, 325, 402 89, 390. 00 26. 01 30.00 2,537 31.00 Laundry & Linen Service 8.00 0.00 0. 00 31.00 32.00 Housekeepi ng 9.00 1, 797, 092 -12, 033 1, 785, 059 130, 736. 00 13. 65 32.00 33.00 Housekeeping under contract 185, 138 185, 138 9, 583. 75 19. 32 33.00 (see instructions) 50, 775. 00 793, 885 34.00 10.00 2, 132, 510 -1, 338, 625 15. 64 34.00 Di etary 35.00 Di etary under contract (see 582 582 33.70 17. 27 35.00 instructions) Cafeteri a 11.00 83, 399. 00 15. 87 36.00 1, 323, 862 1, 323, 862 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 38.00 Nursing Administration 13.00 4, 443, 519 -8, 946 4, 434, 573 132, 637. 00 33. 43 38.00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 Pharmacy 36. 45 40.00 15.00 4, 763, 686 -217, 030 124, 750.00 40.00 4, 546, 656 Medical Records & Medical 41.00 16.00 0.00 0.00 41.00 Records Library 42.00 Social Service 17.00 0.00 0.00 42.00 43.00 Other General Service 18.00 424, 846 -8, 490 416, 356 23, 821.00 17. 48 43. 00 Provider CCN: 15-0051

						o 12/31/2017	Date/Time Prep 5/27/2018 9:18	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4	·	
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		103, 091, 358	-645, 365	102, 445, 993	3, 674, 122. 69	27. 88	1.00
	instructions)							
2.00	Excluded area salaries (see		10, 798, 890	-111, 690	10, 687, 200	421, 250. 00	25. 37	2.00
	instructions)							
3.00	Subtotal salaries (line 1		92, 292, 468	-533, 675	91, 758, 793	3, 252, 872. 69	28. 21	3.00
	minus line 2)							
4.00	Subtotal other wages & related		32, 503, 054	0	32, 503, 054	871, 659. 88	37. 29	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		30, 854, 474	0	30, 854, 474	0.00	33. 63	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		155, 649, 996	-533, 675	155, 116, 321	4, 124, 532. 57	37. 61	6.00
7.00	Total overhead cost (see		27, 803, 613	-57, 340	27, 746, 273	887, 903. 69	31. 25	7.00
	instructions)							

	To 12/31/2017	Date/Time Prep 5/27/2018 9:18	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	4, 715, 823	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	7, 417, 427	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	13, 557, 314	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	-22, 155	9. 00
10.00	Dental, Hearing and Vision Plan	458, 088	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	59, 554	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	774, 096	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	565, 522	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	7, 324, 591	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	16, 364	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	15, 587	23. 00
24. 00		34, 882, 211	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0051	Period: Worksheet S-3 From 01/01/2017 Part V
		To 12/31/2017 Date/Time Prepared

		T	o 12/31/2017	Date/Time Prep 5/27/2018 9:18	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		6, 766, 310	28, 723, 878	1. 00
2.00	Hospi tal		6, 766, 310	28, 723, 878	2. 00
3.00	Subprovi der - IPF				3. 00
4.00	Subprovi der - I RF		0	0	4. 00
5.00	Subprovi der - (0ther)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15. 00
16.00	Hospi tal -Based-CMHC				16. 00
17. 00	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

	AL UNCOMPENSATED AND INDIGENT CARE DATA Prov	/ider CCN: 15-0051	Peri od:	.04 .001=	Worksheet S-10	0
			From 01/ To 12/	/01/2017 /31/2017	Date/Time Pre	naro
			10 12/	31/201/	5/27/2018 9: 1	
				-	1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	d by line 202 col	umn 8)		0. 199339	1.
00	Medicaid (see instructions for each line)			-	20, 007, 410	,
00 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				28, 086, 419 N	3
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	navments from Med	i cai d?		IN	4
00	If line 4 is no, then enter DSH and/or supplemental payments from I				0	
00	Medi cai d charges				247, 154, 568	
00	Medicaid cost (line 1 times line 6)				49, 267, 544	7
00	Difference between net revenue and costs for Medicaid program (line	e 7 minus sum of	lines 2 and	l 5; if	21, 181, 125	8
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (ass instructions for a)</pre>	ach line)				
00	Children's Health Insurance Program (CHIP) (see instructions for earlier Net revenue from stand-alone CHIP	acii i i ile)			0	9
. 00	Stand-alone CHIP charges				0	
. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11
. 00	Difference between net revenue and costs for stand-alone CHIP (line	e 11 minus line 9	; if < zero	then	0	12
	enter zero)					
00	Other state or local government indigent care program (see instruc-					1 40
. 00	Net revenue from state or local indigent care program (Not included Charges for patients covered under state or local indigent care pro			. 4 or	0	13 14
00	10)	ogram (Not frictuu	eu ili illes	0 01	U	14
. 00	State or local indigent care program cost (line 1 times line 14)				0	15
. 00	Difference between net revenue and costs for state or local indige			أمعنا مبي	0	16
	principle between het revende did costs for state or rocal indige	nt care program (	line 15 min	ius iine į	U	10
. 00	13; if < zero then enter zero)	, ,				''
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an	, ,				10
	13; if < zero then enter zero)	nd state/local in			ns (see	
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi	nd state/local in	digent care	program	0 0	17 18
7. 00 3. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local income.	nd state/local in	digent care	program	ns (see	17. 18.
7. 00 3. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi	nd state/local in	digent care	program	0 0	17. 18.
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. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local integration (See Instructions for each line)	nd state/local in ng charity care ital operations digent care progr  Uninsure patient 1.00	ams (sum of	r program	0 0 21, 181, 125 Total (col. 1 + col. 2) 3.00	17 18 19
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. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local integration (See Instructions for each line)	nd state/local in ng charity care ital operations digent care progr  Uninsure patient 1.00  ty 20,891	ams (sum of lns pati 2.	r program  Flines  ured ents  00	0 0 21, 181, 125 Total (col. 1 + col. 2) 3.00 22, 243, 244	17 18 19
7. 00 3. 00 9. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities (see instructions)	nd state/local in ng charity care ital operations digent care progr  Uninsure patient 1.00  ty 20,891	ams (sum of lns pati 2.	Program Flines F	0 0 21, 181, 125 Total (col. 1 + col. 2) 3.00 22, 243, 244	17. 18. 19.
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	nd state/local in ng charity care ital operations digent care progr  Uninsure patient 1.00  ty 20,891  (see 4,164	ams (sum of lns pati 2.	Program Flines F	0 0 21, 181, 125 Total (col. 1 + col. 2) 3.00 22, 243, 244	17 18 19 20 21
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. 00 . 00 . 00 . 00 . 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosping Total unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilia (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient disposed on patients covered by Medicaid or other indigent care proposed in the charges for patient days beyond the interpretations.	nd state/local in ng charity care ital operations digent care progr  Uninsure patient 1.00  ty 20,891  (see 4,164 as 304 3,859  ays beyond a leng gram?	ams (sum of ed Ins pati 2. , 208 1, , 433 1, , 435 , 998 1,	Flines ured ents 00 352,036 0 352,036	0 0 21, 181, 125  Total (col. 1 + col. 2) 3.00  22, 243, 244 5, 516, 469 304, 435 5, 212, 034	20 21 22 23
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7. 00 3. 00 9. 00 . 00 . 00 . 00 4. 00 6. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient discounts in timposed on patients covered by Medicaid or other indigent care proving line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions)	nd state/local in ng charity care ital operations digent care progr  Uninsure patient 1.00  ty 20,891  (see 4,164 as 304 3,859  ays beyond a leng gram? ndigent care prog ctions) ee instructions)	ams (sum of ed Ins pati 2. , 208 1, , 433 1, , 435 , 998 1,	Flines ured ents 00 352,036 0 352,036	0 0 21, 181, 125  Total (col. 1 + col. 2) 3. 00  22, 243, 244  5, 516, 469  304, 435  5, 212, 034  1. 00  0  21, 998, 564	20. 21. 22. 23. 24. 25. 26. 27.
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7. 00 3. 00 2. 00 4. 00 4. 00 5. 00 7. 00 3. 00 7. 00 7. 00 7. 00 7. 00 7. 00 7. 00 7. 00 7. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local intelligence in the support of hospital unreimbursed cost for Medicaid, CHIP and state and local intelligence in the support of hospital unreimbursed cost for Medicaid, CHIP and state and local intelligence in the support of hospital unreimbursed cost for Medicaid, CHIP and state and local intelligence in the support of hospital counts in the support of hospital complex (see instructions)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire hospital complex (see instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care proposed in the supposed of the entire hospital complex (see instructions)  Does the amount on line 20 column 2, include charges for patient days beyond the installight in the supposed of the entire hospital complex (see instructions)  Does the amount on line 20 column 2, include charges for patient days beyond the installight in the supposed of the entire hospital complex (see instructions)	nd state/local in ng charity care ital operations digent care progr  Uninsure patient 1.00  ty 20,891  (see 4,164 as 304 3,859  ays beyond a leng gram? ndigent care prog ctions) ee instructions) ee (see instructions)	ams (sum of ed Ins pati 2. , 208 1, , 433 1, , 435 , 998 1, th of stay ram's lengt	Flines ured ents 00 352,036 0 352,036	0 0 21, 181, 125  Total (col. 1 + col. 2) 3.00  22, 243, 244 5, 516, 469 304, 435 5, 212, 034  1.00  0  21, 998, 564 532, 628 819, 427 21, 179, 137	20 21 22 23 24 25 26 27 27 27 28 29 30

	U HEALTH BLOOMIN				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	UF EXPENSES	Provider Co		eriod: rom 01/01/2017	Worksheet A	
				o 12/31/2017	Date/Time Pre	pared:
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	5/27/2018 9: 1 Recl assi fi ed	8 am
oost center bescriptron	Sararres	Other	+ col . 2)	ons (See A-6)	Trial Balance	
			,	, , (, , , , ,	(col. 3 +-	
					col . 4)	
OFNEDAL CEDIU OF COCT OFNEDO	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS  1. 00   00100   CAP REL COSTS-BLDG & FLXT		0	0	12, 734, 177	12, 734, 177	1.00
2. 00   00200   CAP   REL   COSTS-MVBLE   EQUI   P		0		, , , , ,	6, 728, 191	2.00
3.00 00300 OTHER CAP REL COSTS		0	0		0	3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 029, 910	2, 312, 966			22, 813, 802	4. 00
5. 00   00500   ADMINI STRATI VE & GENERAL	8, 818, 203	88, 643, 407			94, 375, 637	5. 00
7. 00 00700 OPERATION OF PLANT	2, 322, 865	17, 074, 541	19, 397, 406		9, 716, 031	7.00
8.00   00800   LAUNDRY & LINEN SERVICE 9.00   00900   HOUSEKEEPING	0 1, 797, 092	264, 659 1, 731, 900			241, 606 2, 795, 156	8. 00 9. 00
10. 00   01000 DI ETARY	2, 132, 510	2, 425, 967			1, 497, 374	1
11. 00   01100   CAFETERI A	0	0	0		2, 451, 395	11. 00
13.00 01300 NURSING ADMINISTRATION	4, 443, 519	1, 640, 084			5, 257, 363	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	182, 416			10, 110, 308	14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL   RECORDS & LI BRARY	4, 763, 686	20, 837, 229 266, 327			5, 668, 098 263, 807	15. 00 16. 00
18. 00   01850   SOCIAL SERVICES	0	200, 327	200, 327		203, 807	18.00
18. 01   01851   CENTRAL STERI LI ZATI ON	424, 846	541, 662	-		537, 350	18. 01
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY	96, 147	44, 183	140, 330	172, 162	312, 492	23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00   03000   ADULTS & PEDI ATRI CS	20, 196, 181	12, 089, 557				30.00
31. 00   03100   I NTENSI VE CARE UNI T 32. 00   03200   CORONARY CARE UNI T	2, 812, 694 2, 372, 294	1, 822, 911 926, 656	4, 635, 605 3, 298, 950		3, 619, 333 2, 601, 760	31. 00 32. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	1, 754, 691	1, 588, 185			2, 764, 026	35. 00
41. 00   04100   SUBPROVI DER -	859, 437	436, 499			1, 086, 423	41. 00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	375	13, 457	13, 832	885, 508	899, 340	43. 00
ANCI LLARY SERVI CE COST CENTERS	5 457 504	04 007 444	1 20 0/4 005	00.040.050	0.045.77/	
50. 00   05000   0PERATI NG ROOM 50. 01   05001   CV   SURGERY	5, 156, 591	24, 907, 444	30, 064, 035 0		8, 015, 776 0	50. 00 50. 01
51. 00   05100   RECOVERY ROOM	2, 868, 819	802, 059	1		3, 136, 949	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 760, 825	1, 381, 125			3, 112, 569	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	3, 212, 289	3, 581, 869			4, 033, 119	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	2, 213, 603	3, 314, 246	5, 527, 849		4, 039, 447 0	55.00
56. 00   05600   RADI 01 SOTOPE 57. 00   05700   CT   SCAN	643, 228	1, 285, 171	1, 928, 399	١	1, 022, 099	56. 00 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	413, 023	783, 268			627, 552	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 131, 458	8, 383, 112	9, 514, 570	-7, 751, 625	1, 762, 945	59. 00
60. 00   06000   LABORATORY	0	12, 842, 355	12, 842, 355	-88, 143	12, 754, 212	60.00
64. 00   06400   I NTRAVENOUS THERAPY	1 007 ((0	1 100 272	2 004 022	024 025	0	64.00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	1, 987, 660 6, 653, 358	1, 108, 362 2, 454, 876			2, 161, 097 7, 413, 855	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0, 033, 330	2, 434, 676	9, 100, 234		7, 413, 633	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	881, 865	740, 179			1, 035, 772	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	167, 086	1, 011, 366			1, 016, 058	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8, 644, 552 16, 094, 549	8, 644, 552 16, 094, 549	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	105, 415	-68, 877	36, 538		20, 503, 587	73.00
73. 01   07302   OP   PHARMACY	0	00,077	00,000	0	0	73. 01
74. 00 07400 RENAL DIALYSIS	0	1, 186, 110	1, 186, 110	-21, 229	1, 164, 881	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	057.247	140, 201	707.045	75. 01
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	644, 639	211, 707	856, 346	-148, 381	707, 965	76. 97
90. 00   09000   CLI NI C	1, 198, 786	359, 575	1, 558, 361	-249, 448	1, 308, 913	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	1, 199, 638	959, 812			1, 337, 161	90. 01
90.02 09002 WOUND CARE CENTER	792, 482	649, 023	1, 441, 505	-353, 380	1, 088, 125	90. 02
90. 03   09003   PAIN CLINIC	227, 800	190, 373			273, 121	90. 03
90. 05   09005   0P PSYCH CLINIC 91. 00   09100   EMERGENCY	1, 416, 966	387, 702			1, 756, 357	90. 05 91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	4, 780, 351	3, 649, 959	8, 430, 310	-2, 255, 654	6, 174, 656	92.00
OTHER REIMBURSABLE COST CENTERS			1			, , , , , , , , , , , , , , , ,
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	5, 074, 224	3, 153, 544	8, 227, 768	-2, 096, 747	6, 131, 021	
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	1 0	ı O	0	101. 00
113. 00 11300 I NTEREST EXPENSE		1, 238, 202	1, 238, 202	-1, 238, 202	0	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	0	0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	o		115. 00
116. 00 11600 H0SPI CE	0	0	0	0	0	116. 00

Health Financial Systems	HEALTH BLOOMIN	GTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 01/01/2017 o 12/31/2017	Date/Time Pre	nanad.
			'	0 12/31/2017	5/27/2018 9:1	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
· ·			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	98, 354, 556	227, 355, 168	325, 709, 724	1, 469, 847	327, 179, 571	118. 00
NONREI MBURSABLE COST CENTERS	10.074	70 (40	400 500	4, 4,0	10/ 101	400 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	43, 974	78, 619				
190. 01 19001 PROMPTCARE	1, 252, 101	1, 072, 327			1, 703, 953	ł
190. 02 19002 RENTAL PROPERTI ES	271 007	91, 270	' '		10, 961	ł
190. 03 19003 OLCOTT 190. 04 19004 PHYSI CI AN RECRUI TMENT	271, 007	120, 376	391, 383	-75, 533	•	190. 03
190. 04 19004 PHYSICIAN RECRUITMENT	F 4 7 103	204 505	072 (00	-169, 889		
190. 06 19006 MARKETI NG	567, 103	306, 585	873, 688	- 169, 889 124, 621	124, 621	1
190. 00 19000 MARKETTING 190. 07 19007 HME STORE	265, 515	32, 626	298, 141			
190. 08 19008 UNUSED SPACE	203, 313	32, 020	270, 141	-22, 440		190. 07
190. 09 19009 CLINI CAL TRI ALS	281, 445	70, 210	351, 655	-56, 700		
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	201, 443	70, 210	331,030	30, 700	•	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	2, 087, 937	1, 567, 205	3, 655, 142	-552, 652	3, 102, 490	
191. 00 19100 RESEARCH	2,007,707	0	0,000,112	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	0	d	0		192.00
193. 00 19300 NONPALD WORKERS	o	0	ď	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	C	0		194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	C	0	0	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	O	0	C	0	0	194. 02
194. 03 07953 IU HEALTH SIP	0	0	C	0	0	194. 03
194. 04 07954 HOME CARE	0	0	C	0	0	194. 04
194. 05 07955 HOSPI CE	O	o	C	0	0	194. 05
200.00   TOTAL (SUM OF LINES 118 through 199)	103, 123, 638	230, 694, 386	333, 818, 024	o	333, 818, 024	200. 00

Health Financial Systems IU HEALTH BLORGE RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0051

| Period: | Worksheet A | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/27/2018 9:18 am

			5/27/2018 9: 18	
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS	F22 104	12 2// 201		1 00
1.00   00100   CAP REL COSTS-BLDG & FIXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP	532, 104	13, 266, 281		1. 00 2. 00
2. 00   00200   CAP REL COSTS-MVBLE EQUIP 3. 00   00300   OTHER CAP REL COSTS	526, 794 0	7, 254, 985 0		3. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	3, 879, 515	26, 693, 317		4. 00
5.00   00500   ADMINISTRATIVE & GENERAL	-42, 679, 823	51, 695, 814		5. 00
7.00   00700   OPERATION OF PLANT	1	9, 040, 894	·	7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	-675, 137 -52, 654	9, 040, 894 188, 952		8. 00
9. 00   00900   HOUSEKEEPI NG	-52, 654	2, 794, 597		9. 00
10. 00   01000   DI ETARY	-337, 242	1, 160, 132		10.00
11. 00   01100   CAFETERI A	-1, 134, 997	1, 100, 132		11. 00
13. 00   01300   NURSI NG ADMINI STRATI ON	91, 320	5, 348, 683	·	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	91, 320	10, 110, 308	l l	14. 00
15. 00   01500   PHARMACY	-702, 262	4, 965, 836	l l	15. 00
16. 00 01600 MEDICAL RECORDS & LI BRARY	2, 472, 024	2, 735, 831		16. 00
18. 00   01850   SOCIAL SERVICES	2,472,024	2, 733, 631		18. 00
18. 01   01851 CENTRAL STERI LI ZATI ON		537, 350		18. 00
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY		312, 492	l .	23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	312, 472		23.00
30. 00 03000 ADULTS & PEDI ATRI CS	-1, 205, 744	24, 183, 820		30. 00
31. 00   03100   NTENSI VE CARE UNI T	-1, 203, 744	3, 619, 333	·	31. 00
32. 00 03200 CORONARY CARE UNIT		2, 601, 760	·	32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	-282, 138	2, 481, 888	l	35. 00
41. 00   04100   SUBPROVI DER -   I RF	-67, 770	1, 018, 653		41. 00
42. 00   04200   SUBPROVI DER	-07,770	1,010,033	I I	42. 00
43. 00   04300 NURSERY		899, 340	I .	43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	077, 340		43.00
50. 00   05000   OPERATING   ROOM	-20, 066	7, 995, 710		50. 00
50. 01   05001 CV SURGERY	20,000	0,,,,,,	l	50. 01
51. 00   05100   RECOVERY   ROOM	Ö	3, 136, 949		51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 112, 569	·	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0, 112, 007		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-531	4, 032, 588		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	-611, 141	3, 428, 306	·	55. 00
56. 00   05600   RADI OI SOTOPE	0	0, 120, 000		56. 00
57. 00   05700   CT   SCAN	Ö	1, 022, 099		57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	o	627, 552	·	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	Ö	1, 762, 945	l l	59. 00
60. 00   06000   LABORATORY	-353, 728	12, 400, 484	l l	60. 00
64. 00 06400 I NTRAVENOUS THERAPY	0 333, 720	12, 400, 404	l	64. 00
65. 00 06500 RESPIRATORY THERAPY	-1, 350	2, 159, 747	1	65. 00
66. 00 06600 PHYSI CAL THERAPY	-28, 924	7, 384, 931		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0,,001,,701		67. 00
68. 00 06800 SPEECH PATHOLOGY	o o	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	-80, 763	955, 009		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	-15, 433	1, 000, 625		70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 644, 552		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	16, 094, 549	·	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	20, 503, 587	·	73. 00
73. 01 07302 OP PHARMACY	o	0	I I	73. 01
74. 00 07400 RENAL DIALYSIS	o	1, 164, 881		74. 00
75. 00   07500   ASC (NON-DISTINCT PART)	0	0, 101, 001		75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	-132	707, 833		76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	-87, 447	1, 221, 466		90. 00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0,,11,	1, 337, 161		90. 01
90. 02   09002   WOUND CARE CENTER	-270, 179	817, 946		90. 02
90. 03   09003   PAIN CLINIC	0	273, 121		90. 03
90. 05   09005   OP PSYCH CLINIC	-484, 790	1, 271, 567		90. 05
91. 00   09100   EMERGENCY	153, 423	6, 328, 079		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		.,, .		92.00
OTHER REIMBURSABLE COST CENTERS				,2,00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	-318, 605	5, 812, 416		95. 00
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0.5,500	0, 0.2, .10		100. 00
101. 00 10100 HOME HEALTH AGENCY	Ö	0		101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			
113. 00 11300   NTEREST EXPENSE	n	0		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0	I .	114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	Ö	n		115. 00
116. 00 11600 HOSPI CE		n		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-41, 756, 235	285, 423, 336		118. 00
, , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,		ı	

Health FinancialSystemsIUHEALTH BLOWRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0051

Peri od: Worksheet A From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

			5/27/2018 9:18 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7. 00	
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	106, 131	190. 00
190. 01 19001 PROMPTCARE	-87, 780	1, 616, 173	190. 01
190. 02 19002 RENTAL PROPERTIES	0	10, 961	190. 02
190. 03 19003 OLCOTT	0	315, 850	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	190. 04
190. 05 19005 FOUNDATI ON	0	703, 799	190. 05
190. 06 19006 MARKETI NG	0	124, 621	190. 06
190.07 19007 HME STORE	0	275, 693	190. 07
190. 08 19008 UNUSED SPACE	0	0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	294, 955	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	O	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	-77, 508	3, 024, 982	190. 11
191. 00 19100 RESEARCH	0	O	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	O	192. 00
193. 00 19300 NONPALD WORKERS	0	o	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	o	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	o	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	o	194. 02
194.03 07953 IU HEALTH SIP	0	o	194. 03
194.04 07954 HOME CARE	0	o	194. 04
194. 05 07955 HOSPI CE	0	o	194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	-41, 921, 523	291, 896, 501	200. 00

IU HEALTH BLOOMINGTON HOSPITAL

Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am

		1			5/27/2018 9:1	18 am
	Cost Center	Increases Line #	Calassi	O+b o n		
	2. 00	3.00	Sal ary 4. 00	0ther 5.00		
	A - BENEFITS	3.00	4.00	5.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	18, 659, 210		1.00
2. 00	LWI LOTEL BENEFITTS DELAKTIMENT	0.00	o			2. 00
3. 00		0.00	o	0		3. 00
4. 00		0.00	o	0		4. 00
5. 00		0.00	o	0		5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	ol	Ö		7. 00
8.00		0.00	o	Ō		8. 00
9. 00		0.00	o	Ō		9. 00
10.00		0.00	o	Ō		10.00
11. 00		0.00	o	Ō		11. 00
12. 00		0.00	Ö	Ō		12. 00
13.00		0.00	o	0		13. 00
14.00		0.00	o	0		14. 00
15.00		0.00	o	0		15. 00
16.00		0.00	o	0		16. 00
17.00		0.00	o	0		17. 00
18.00		0.00	o	0		18. 00
19.00		0.00	o	0		19. 00
20.00		0.00	0	0		20. 00
21.00		0.00	0	0		21. 00
22.00		0.00	o	0		22. 00
23.00		0.00	o	0		23. 00
25.00		0.00	o	0		25. 00
26.00		0.00	0	0		26. 00
27.00		0.00	0	0		27. 00
28.00		0.00	0	0		28. 00
29.00		0.00	0	0		29. 00
30.00		0.00	0	0		30. 00
31.00		0.00	0	0		31. 00
32.00		0.00	0	0		32. 00
33.00		0.00	0	0		33. 00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35. 00
36.00		0.00	0	0		36. 00
37.00		0.00	0	0		37. 00
38.00		0.00	0	0		38. 00
39. 00		0.00	0	0		39. 00
40.00		0.00	0	0		40. 00
41. 00		0.00	0	0		41. 00
42.00		0.00	0	0		42. 00
43.00		0.00	0	0		43. 00
44.00		0.00	0	0		44. 00
	0		0	18, 659, 210		
	B - CAPITAL RELATED	4 00	al	10.010.107		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0			2.00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0			5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0.00				8. 00
		0. 00 0. 00	0	0		9.00
10. 00 11. 00		0.00	o	0		10. 00 11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0			14. 00
15. 00		0.00	o	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	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
24. 00		0.00	0			24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	o	o		26. 00
27. 00		0.00	o	0		27. 00
28. 00		0.00	o			28. 00
29. 00		0.00	o	0		29. 00
	1		<u> </u>	0		55

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/27/2018 9:18 am Provider CCN: 15-0051

						 5/27/2018 9:	18 am
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4. 00	5.00			
30.00		0. 00	C				30. 00
31. 00		0. 00	C				31. 00
32.00		0. 00	C				32. 00
33.00		0.00	C				33. 00
34.00		0.00	C	0			34. 00
35.00		0.00	C	0			35. 00
36.00		0.00	C	0			36. 00
37.00		0.00	C				37. 00
38. 00		0.00	C	1			38. 00
39. 00		0.00	C				39. 00
40. 00		0.00	C	1			40. 00
41. 00		0.00	C				41. 00
42.00		0.00	C	1			42. 00
43.00		0.00	C				43. 00
44. 00		0.00	C				44. 00
45. 00		0.00					45. 00
	0		C	16, 644, 151			_
	C - BILLABLE MEDICAL SUPPLIES						
1. 00	CORONARY CARE UNIT	32. 00	C				1. 00
2.00	NEONATAL INTENSIVE CARE UNIT	35. 00	C				2. 00
3.00	SUBPROVI DER - I RF	41. 00	C				3. 00
4.00	RECOVERY ROOM	51.00	C	2, 792			4. 00
5.00	MEDICAL SUPPLIES CHARGED TO	71. 00	C	8, 644, 552			5. 00
	PATI ENTS						1
6.00	EMERGENCY	91.00	C	30, 427			6. 00
7. 00	OLCOTT	190. 03	C				7. 00
8.00		0.00	C	i e			8. 00
9. 00		0. 00	C				9. 00
10. 00		0.00	C				10. 00
11. 00		0.00	C	i e			11. 00
		0.00	C				
12.00							12.00
13.00		0.00	C				13. 00
14. 00		0. 00	C				14. 00
15. 00		0. 00	C				15. 00
16. 00		0. 00	C				16. 00
17. 00		0. 00	C				17. 00
18.00		0.00	C	0			18. 00
19.00		0.00	C	0			19. 00
20.00		0.00	C	0			20.00
21.00		0.00	C				21. 00
22. 00		0.00	C	1			22. 00
23. 00		0.00	C	1			23. 00
24. 00		0.00	C	1			24. 00
25. 00		0.00	C	1			25. 00
26. 00		0.00					26. 00
20.00			C				20.00
	D - BILLABLE DRUGS			0,000,917			-
1 00		14 00		141			1 00
1.00	CENTRAL SERVICES & SUPPLY	14.00	C				1.00
2.00	RENAL DIALYSIS	74.00	C				2.00
3.00	DRUGS CHARGED TO PATIENTS	73. 00	C				3. 00
4.00		0.00	C				4. 00
5. 00		0.00	C				5. 00
6.00		0.00	C				6. 00
7.00		0.00	C	0			7. 00
8.00		0.00	C	0			8. 00
9.00		0.00	C	0			9. 00
10.00		0.00	C	0			10.00
11. 00		0.00	C				11.00
12.00		0.00	C	l .			12. 00
13. 00		0.00	C				13. 00
14. 00		0.00	C				14. 00
15. 00		0.00	C				15. 00
16.00		0.00	C				16.00
17. 00		0.00	C				17. 00
18. 00		0.00	C				18. 00
19. 00		0.00	C				19. 00
20.00		0.00	C				20. 00
21.00		0.00	C	0			21. 00
22.00		0.00	C	0			22. 00
23. 00		0.00	C	1			23. 00
24. 00		0.00	C	1			24. 00
25. 00		0.00	C				25. 00
26. 00		0.00	C	i e			26. 00
20.00		— — <del> </del>	— — — č				
	I-			20, 101, 070	I		

Health Financial Systems RECLASSIFICATIONS IU HEALTH BLOOMINGTON HOSPITAL Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/27/2018 9:18 am Provider CCN: 15-0051

					5/27/2018 9:18	am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
1 00	E - IMPLANTS SUPPLIES IMPL. DEV. CHARGED TO	72.00	ما	14 004 E40		1 00
1. 00	PATIENTS	72.00	0	16, 094, 549		1. 00
2.00	I ATTENTS	0.00	0	0		2. 00
3. 00		0.00	Ö	o	1	3. 00
4. 00		0.00	Ö	0		4. 00
5. 00		0.00	O	Ö		5. 00
6.00		0.00	o	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	0	0		10.00
11. 00		0.00	0	0	1	11. 00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	0	0	l l	15. 00
16. 00		0.00	0	0	l l	16. 00
17. 00		0.00	Ö	Ö		17. 00
18.00		0.00	О	0		18.00
19.00	L	0.00	o	0		19.00
	0		0	16, 094, 549		
	F - LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 152, 478		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	211, 480		2.00
3. 00 4. 00		0. 00 0. 00	0	0	1	3. 00 4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	Ö	Ö		7. 00
8.00		0.00	О	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0	1	12.00
13.00		0.00	0	0	l l	13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	Ö	0		17. 00
				1, 363, 958		
	G - NON-BILLABLE DRUGS					
1.00	PHARMACY	15. 00	0	681, 154		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 828		2. 00
3.00		0.00	0	0	1	3.00
4.00		0.00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	0	0	l l	7. 00
8. 00		0.00	0	o	l l	8. 00
9. 00		0.00	Ö	Ö		9. 00
10.00		0.00	O	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		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 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20. 00
21. 00		0.00	0	o		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	Ö	Ö		23. 00
24. 00		0.00	0	Ō	l l	24. 00
25.00		0.00	0	0		25.00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00		0.00	0	<u>0</u> 683, 982		30. 00
	0	ı I	۰Į	003, 702	I I	

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/27/2018 9: 18 am Provider CCN: 15-0051

					5/27/2018 9:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
4 00	H - NON-BILLABLE MEDICAL SUPF			2 222		1.00
1.00	LAUNDRY & LINEN SERVICE	8.00	0	3, 222		1.00
2.00	LABORATORY	60.00	0	4, 168		2. 00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	10, 077, 082		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0. 00 0. 00	0	0		6.00
7. 00 8. 00		0.00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	0	Ö		11. 00
12. 00		0.00	o	Ö		12. 00
13. 00		0.00	o	o		13. 00
14. 00		0.00	o	Ö		14. 00
15. 00		0.00	O	0		15. 00
16. 00		0.00	O	0		16. 00
17.00		0.00	0	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0.00	O	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
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31. 00 32. 00		0. 00 0. 00	0	0		31. 00 32. 00
33. 00		0.00	0	0		33. 00
34. 00		0.00	0	0		34. 00
35. 00		0.00	o	Ö		35. 00
36. 00		0.00	0	Ö		36. 00
37. 00		0.00	o	o		37. 00
38. 00		0.00	o	0		38. 00
				10, 084, 472		
	J - INTEREST EXPENSE	•				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 238, 202		1. 00
	0		0	1, 238, 202		_
	K - PHARMACY RESIDENCY					
1. 00	PARAMED ED PRGM-PHARMACY	23. 00	180, 951	13, 843		1. 00
	RESI DENCY					
	U DEVOLUADMINI		180, 951	13, 843		-
1.00	L - PSYCH ADMIN OP PSYCH CLINIC	90. 05	201, 119	5, 744		1.00
1.00	0	90.03	201, 119	5, 744		1.00
	M - SOFTWARE LICENSE		201, 117	5, 744		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	216, 057		1. 00
2.00		0.00	Ö	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	— — <u></u>	0		11. 00
	N CAEETEDIA		0	216, 057		
1. 00	N - CAFETERI A CAFETERI A	11.00	1, 323, 862	1, 127, 533		1.00
1.00	0	<u> </u>	1, 323, 862	1, 127, 533		1.00
	O - SHORT TERM DISABILITY/FLM	MA	1, 020, 002	1, 121, 000		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10, 605		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	Ö	30, 203		2. 00
3.00	OPERATION OF PLANT	7. 00	2, 537	0		3. 00
4.00	HOUSEKEEPI NG	9.00	0	12, 033		4. 00
5.00	DI ETARY	10.00	0	14, 763		5. 00
6.00	NURSING ADMINISTRATION	13.00	0	8, 946		6. 00
7.00	PHARMACY	15. 00	0	36, 079		7. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/27/2018 9:18 am Provider CCN: 15-0051

						5/27/2018 9:	<u>18 am</u>
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3. 00	4. 00	5. 00			
8. 00	CENTRAL STERILIZATION	18. 01	0	8, 490	·		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	137, 170			9. 00
10.00	INTENSIVE CARE UNIT	31.00	0				10.00
11. 00	CORONARY CARE UNIT	32. 00	0				11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	,			12. 00
13. 00	SUBPROVI DER - I RF	41. 00	0	,			13. 00
14. 00	NURSERY	43.00	0	-,			14. 00
15. 00	OPERATING ROOM	50.00	0				15. 00
16. 00	RECOVERY ROOM	51.00	0	21, 368			16. 00
			0				1
17. 00	DELIVERY ROOM & LABOR ROOM	52.00	-	,			17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 620			18. 00
19. 00	RADI OLOGY-THERAPEUTI C	55. 00	0				19. 00
20. 00	CT SCAN	57. 00	0				20. 00
21. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	4, 298			21. 00
	(MRI)						
22.00	CARDIAC CATHETERIZATION	59. 00	0	3, 890			22. 00
23.00	RESPIRATORY THERAPY	65. 00	0	12, 958			23. 00
24.00	PHYSI CAL THERAPY	66.00	0	35, 683			24. 00
25.00	ELECTROCARDI OLOGY	69. 00	0				25. 00
26. 00	CARDIAC REHABILITATION	76. 97	0	956			26. 00
27. 00	CLINIC	90.00	0				27. 00
28. 00	OP ONCOLOGY INFUSION CENTER	90.01	0				28. 00
			-				1
29. 00	WOUND CARE CENTER	90. 02	0	- '			29. 00
30. 00	PAIN CLINIC	90. 03	0				30. 00
31. 00	OP PSYCH CLINIC	90. 05	0	763			31. 00
32. 00	EMERGENCY	91. 00	0	32, 415			32. 00
33.00	AMBULANCE SERVICES	95. 00	0	22, 491			33. 00
34.00	PROMPTCARE	190. 01	0	3, 272			34. 00
35.00	OLCOTT	190. 03	0	1, 672			35. 00
36.00	FOUNDATI ON	190. 05	0	6, 164			36. 00
37.00	HME STORE	190. 07	0	568			37. 00
38. 00	COMMUNITY HEALTH SERVICES	190. 11	0	10, 055			38. 00
00.00	0	— — <del>170.</del> 1 <del>1</del>	${2,537}$	647, 902			00.00
	P - UTILITIES EXPENSE		2,007	017,702			
1.00	OPERATION OF PLANT	7. 00	0	285, 255			1. 00
2. 00	I ENTRY OF TEXAS	0.00	0	0			2. 00
3.00		0.00	0				3. 00
							1
4.00		0.00	0				4. 00
5.00		0.00	0				5. 00
6.00		0. 00	0				6. 00
7.00		0.00	0				7. 00
8.00		0. 00	0				8. 00
9.00		0. 00	0	0			9. 00
10.00		0.00	0	0			10.00
11. 00		0.00	0	0			11. 00
12.00		0.00	0	0			12.00
13.00		0.00	0				13. 00
14. 00		0.00	0	Ō			14. 00
		— — <del></del>					1
	Q - MARKETING EXPENSE						
1.00	MARKETI NG	190. 06	0	124, 621			1. 00
2. 00		0.00	0				2. 00
3.00		0.00	0	_			3. 00
		0.00	0	0			1
4.00			0	-			4. 00
5.00		0.00	0	0			5. 00
6.00		0.00	0	0			6. 00
7. 00		0.00	0	0			7. 00
8.00		0. 00	0	0			8. 00
9.00		0.00	0	0			9. 00
10.00		0.00	0	0			10. 00
11.00		0.00	0	0			11. 00
	0			124, 621			
	R - OCCUPATIONAL HEALTH ADMIN						
1.00	ADMI NI STRATI VE & GENERAL		242, 193				1. 00
	0		242, 193				]
	S - NURSERY						
1.00	NURSERY	43. 00	818, 638	80, 222			1. 00
2.00	L	0.00	0	0			2. 00
	TOTALS		818, 638				
500.00	Grand Total: Increases		2, 769, 300	96, 432, 494			500.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provider CCN: 15-0051 

						o 12/31/2017   Date/lime Pro   5/27/2018 9:1	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
1. 00	A - BENEFITS ADMINISTRATIVE & GENERAL	5. 00	0	1, 369, 505	0		1.00
2. 00	OPERATION OF PLANT	7. 00	0	,			2. 00
3. 00	HOUSEKEEPI NG	9. 00	0	648, 870			3. 00
4.00	DI ETARY	10.00	0	549, 769			4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	652, 893	0		5. 00
6.00	PHARMACY	15. 00	0	746, 581			6. 00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	34			7. 00
8.00	CENTRAL STERILIZATION	18. 01	0	121, 901	0		8.00
9. 00	PARAMED ED PRGM-PHARMACY RESIDENCY	23. 00	0	22, 482	. 0		9. 00
10.00	ADULTS & PEDIATRICS	30.00	0	3, 751, 673	0		10.00
11. 00	INTENSIVE CARE UNIT	31.00	0	496, 416			11. 00
12.00	CORONARY CARE UNIT	32.00	0	420, 422	. 0		12. 00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	294, 002	0		13. 00
14.00	SUBPROVI DER - I RF	41. 00	0	155, 596			14. 00
15. 00	NURSERY	43. 00	0				15. 00
16.00	OPERATING ROOM	50. 00 51. 00	0	921, 491	0		16.00
17. 00 18. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00 52.00	0	459, 248 432, 936			17. 00 18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	690, 209			19. 00
20. 00	RADI OLOGY-THERAPEUTI C	55.00	0	381, 727			20. 00
21.00	CT SCAN	57. 00	0	124, 023			21.00
22.00	MAGNETIC RESONANCE IMAGING	58. 00	0	90, 013	0		22. 00
	(MRI)						
23. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	,			23. 00
25. 00	RESPIRATORY THERAPY	65. 00	0	352, 803			25. 00
26. 00	PHYSICAL THERAPY	66. 00 69. 00	0	1, 120, 136			26. 00
27. 00 28. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	70.00	0	159, 157 30, 397			27. 00 28. 00
29. 00	DRUGS CHARGED TO PATIENTS	73.00	0	1			29. 00
30. 00	CARDI AC REHABI LI TATI ON	76. 97	0	1			30.00
31.00	CLINIC	90.00	0				31.00
32.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	218, 026	0		32.00
33.00	WOUND CARE CENTER	90. 02	0	173, 557			33. 00
34. 00	PAIN CLINIC	90. 03	0	54, 525			34. 00
35. 00	OP PSYCH CLINIC	90.05	0	251, 422			35. 00
36. 00 37. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	747, 051			36. 00 37. 00
38.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	., ,			38.00
00.00	CANTEEN	170.00	9	10, 102			00.00
39.00	PROMPTCARE	190. 01	0	206, 248	0		39. 00
40.00	OLCOTT	190. 03	0	56, 559	0		40. 00
41.00	FOUNDATI ON	190. 05	0	89, 900			41. 00
42.00	HME STORE	190. 07	0	20, 394			42. 00
43. 00 44. 00	CLINICAL TRIALS	190.09	0	56, 590			43. 00 44. 00
44.00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 1 <u>1</u>		47 <u>2, 6</u> 79 18, 659, 210			44.00
	B - CAPITAL RELATED		0	10, 037, 210	1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	12, 890	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 674, 982	9		2. 00
3.00	OPERATION OF PLANT	7. 00	0	9, 165, 754			3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	26, 275			4. 00
5.00	HOUSEKEEPI NG	9.00	0				5. 00
6. 00 7. 00	DIETARY NURSING ADMINISTRATION	10. 00 13. 00	0	1,			6. 00 7. 00
8.00	PHARMACY	15. 00	0	143, 853			8. 00
9. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	2, 486			9. 00
10.00	CENTRAL STERILIZATION	18. 01	0	44, 208			10.00
11.00	ADULTS & PEDIATRICS	30.00	0	194, 113			11. 00
12.00	INTENSIVE CARE UNIT	31. 00	0	35, 230			12.00
13.00	CORONARY CARE UNIT	32.00	0	34, 993			13. 00
14.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	,			14. 00
15. 00 16. 00	SUBPROVI DER - I RF NURSERY	41. 00 43. 00	0	_,			15. 00 16. 00
17. 00	OPERATING ROOM	50. 00	0	1			17. 00
19. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	76, 515			19.00
20. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	584, 462			20. 00
21. 00	RADI OLOGY-THERAPEUTI C	55.00	0	511, 124			21. 00
22. 00	CT SCAN	57. 00	0	498, 133			22. 00
23. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	401, 965	0		23. 00
24 00	(MRI)	59. 00	0	505, 880	0		24. 00
24. 00 25. 00	CARDI AC CATHETERI ZATI ON LABORATORY	60.00					25. 00
	I BOWN OK	00.00	0	1 10,112	.1	<u> </u>	

IU HEALTH BLOOMINGTON HOSPITAL

Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am

						5/27/2018 9:	<u>18 am</u>
		Decreases				ı	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
26. 00	RESPI RATORY THERAPY	65. 00	0		0	l e e e e e e e e e e e e e e e e e e e	26. 00
27. 00	PHYSI CAL THERAPY	66. 00	0	69, 759	0		27. 00
28. 00	ELECTROCARDI OLOGY	69. 00	0	137, 977	0		28. 00
29. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	58, 909	0		29. 00
30.00	DRUGS CHARGED TO PATIENTS	73.00	0	9, 346	0		30.00
31.00	RENAL DIALYSIS	74.00	0	196	0		31. 00
32.00	CARDIAC REHABILITATION	76. 97	0	5, 806	0		32. 00
33.00	CLINIC	90.00	0	11, 877	0		33.00
34.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	195, 585	0		34.00
35.00	WOUND CARE CENTER	90. 02	0	1	0		35. 00
36.00	PAIN CLINIC	90. 03	0	1	0		36. 00
37.00	OP PSYCH CLINIC	90. 05	0	1	0	l l	37. 00
38. 00	EMERGENCY	91.00	0	1	0		38. 00
39. 00	AMBULANCE SERVICES	95. 00	0	420, 656	0	l I	39. 00
40. 00	PROMPTCARE	190. 01	0	1	0		40. 00
41. 00	RENTAL PROPERTIES	190. 02	0	50, 978	0		41. 00
42. 00	OLCOTT	190. 03	0	114	0		42. 00
43. 00	FOUNDATI ON	190.05	0	393	0		43. 00
44. 00	HME STORE	190.03	0		0		44. 00
45. 00		190. 07	0	1, 070	0		45. 00
45.00	COMMUNITY HEALTH SERVICES			<del></del>			45.00
	C DILLABLE MEDICAL SUBDILLES			16, 644, 151			
1 00	C - BILLABLE MEDICAL SUPPLIES				0		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0		0		1. 00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0		0		2. 00
3.00	NURSING ADMINISTRATION	13.00	0	1,	0		3. 00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	0	1	0	l e e e e e e e e e e e e e e e e e e e	4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	1,	0	l I	5. 00
6.00	INTENSIVE CARE UNIT	31. 00	0	1	0		6. 00
7.00	OPERATING ROOM	50. 00	0	4, 886, 994	0		7. 00
8.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	164, 105	0		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	815, 799	0		9. 00
10.00	RADI OLOGY-THERAPEUTI C	55. 00	0	1, 341	0		10. 00
11.00	CT SCAN	57.00	0	9, 623	0		11. 00
12.00	MAGNETIC RESONANCE IMAGING	58. 00	0	628	0		12. 00
	(MRI)						
13.00	CARDIAC CATHETERIZATION	59. 00	0	2, 481, 268	0		13. 00
14.00	RESPIRATORY THERAPY	65. 00	0	8, 172	0		14. 00
15.00	PHYSI CAL THERAPY	66.00	0	28, 523	0		15. 00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	12, 320	0		16. 00
17.00	RENAL DIALYSIS	74. 00	0	1, 483	0		17. 00
18.00	CARDIAC REHABILITATION	76. 97	0	135	0		18. 00
19.00	CLINIC	90.00	0	1, 462	0		19. 00
20.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	1	0		20. 00
21. 00	WOUND CARE CENTER	90. 02	0	1	0		21. 00
22. 00	PAIN CLINIC	90. 03	0	1	0	l l	22. 00
23. 00	OP PSYCH CLINIC	90. 05	0	73	0		23. 00
24. 00	AMBULANCE SERVICES	95.00	0	1	0		24. 00
25. 00	PROMPTCARE	190. 01	Ö	1	0	l l	25. 00
26. 00	COMMUNITY HEALTH SERVICES	190. 11	0	888	0		26. 00
20.00	O DELL'I SERVICES	170.11	— — <u> </u>				20.00
	D - BILLABLE DRUGS			0,000,717		<u> </u>	-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	82, 073	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0		0		2. 00
3. 00	OPERATION OF PLANT	7. 00	0		0		3. 00
4. 00	HOUSEKEEPI NG	9. 00	0	1	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	0		0		5. 00
6. 00	PHARMACY	15. 00	0		0		6. 00
	ADULTS & PEDIATRICS				0	l e	1
7.00	1	30.00	0		0		7. 00
8.00	INTENSIVE CARE UNIT	31.00	0	186		l .	8. 00
9.00	CORONARY CARE UNIT	32.00	0		0		9. 00
10.00	OPERATING ROOM	50.00	0		0	l .	10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0		0		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1,	0		12.00
13.00	RADI OLOGY-THERAPEUTI C	55.00	0	1,	0		13. 00
14. 00	CT SCAN	57. 00	0		0	l e e e e e e e e e e e e e e e e e e e	14. 00
15. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	61, 687	0		15. 00
	(MRI)						
16. 00	CARDI AC CATHETERI ZATI ON	59. 00	0		0	l l	16. 00
17. 00	PHYSI CAL THERAPY	66.00	0		0		17. 00
18. 00	ELECTROCARDI OLOGY	69. 00	0	,	0	l e	18. 00
19. 00	CARDIAC REHABILITATION	76. 97	0	114	0	l .	19. 00
20.00	CLINIC	90. 00	0		0	l e	20. 00
21. 00	WOUND CARE CENTER	90. 02	0		0	l e	21. 00
22. 00	PAIN CLINIC	90. 03	0	31, 528	0		22. 00

	Financial Systems	1	U HEALTH BLOOM				u of Form CMS-2	
RECLAS	SIFICATIONS			Provi der (		Period: From 01/01/2017	Worksheet A-6	
					-	Γο 12/31/2017	Date/Time Pre 5/27/2018 9:1	
		Decreases					072772010 7. 1	o am
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00			
23. 00	EMERGENCY	91.00	0.00	1, 365				23. 00
24. 00	AMBULANCE SERVICES	95.00	0	76, 696				24. 00
25. 00 26. 00	PROMPTCARE	190. 01	0	94, 633				25. 00 26. 00
20.00	COMMUNITY HEALTH SERVICES	19011	— — <u> </u>	<u>3, 0</u> 03 20, 481, 876				20.00
	E - IMPLANTS SUPPLIES							
1.00	ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION	5.00		318		ł .		1.00
2. 00 3. 00	CENTRAL STERILIZATION	13. 00 18. 01		6, 139 456				2. 00 3. 00
4. 00	ADULTS & PEDIATRICS	30.00		2, 827	_			4. 00
5. 00	INTENSIVE CARE UNIT	31.00		4, 029				5. 00
6. 00 7. 00	CORONARY CARE UNIT SUBPROVIDER - IRF	32. 00 41. 00		409 50				6. 00 7. 00
8. 00	OPERATING ROOM	50.00		11, 436, 943	_			8. 00
9. 00	RECOVERY ROOM	51.00		177				9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00		428, 587				10.00
11. 00 12. 00	CT SCAN CARDIAC CATHETERIZATION	57. 00 59. 00		1, 374 4, 207, 220				11. 00 12. 00
13. 00	PHYSI CAL THERAPY	66.00		4, 207, 220	1			13. 00
14.00	ELECTROENCEPHALOGRAPHY	70.00		110	0			14.00
15. 00	CARDI AC REHABI LI TATI ON	76. 97		4 520	0			15.00
16. 00 17. 00	OP ONCOLOGY INFUSION CENTER WOUND CARE CENTER	90. 01 90. 02		4, 530	5 0			16. 00 17. 00
18. 00	EMERGENCY	91.00		1, 255	1			18. 00
19. 00	PROMPTCARE	1 <u>90.</u> 01		38				19. 00
	O F - LEASE EXPENSE		0	16, 094, 549	)			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 893	10			1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	23, 795	10			2. 00
3.00	OPERATION OF PLANT	7.00	0	265, 676				3. 00
4. 00 5. 00	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	14. 00 30. 00	0	143, 233 1, 674				4. 00 5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 596				6. 00
7. 00	LABORATORY	60.00	0	21, 528				7. 00
8. 00 9. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00	0	27, 649 420, 275			-	8. 00 9. 00
10. 00	ELECTROENCEPHALOGRAPHY	70.00	0	420, 273 9, 771				10. 00
11. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	55, 797	0			11. 00
12.00	WOUND CARE CENTER	90. 02	0	65, 886				12.00
13. 00 14. 00	PAIN CLINIC AMBULANCE SERVICES	90. 03 95. 00	0	18, 291 156, 316				13. 00 14. 00
15. 00	PROMPTCARE	190. 01	0	32, 179				15. 00
16.00	FOUNDATION	190.05	0	63, 045				16.00
17. 00	COMMUNITY HEALTH SERVICES	190.11		4 <u>2, 3</u> 54 1, 363, 958				17. 00
	G - NON-BILLABLE DRUGS		<u> </u>	1, 303, 730	4			
1.00	NURSING ADMINISTRATION	13. 00	0			•		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 701		l e e e e e e e e e e e e e e e e e e e		2.00
3. 00 4. 00	CENTRAL STERILIZATION ADULTS & PEDIATRICS	18. 01 30. 00	0	15 175, 704		l e		3. 00 4. 00
5. 00	INTENSIVE CARE UNIT	31.00	0	73, 764				5. 00
6.00	CORONARY CARE UNIT	32.00	0	26, 752				6. 00
7. 00 8. 00	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	35. 00 41. 00	0	15, 999 1, 383				7. 00 8. 00
9. 00	RECOVERY ROOM	51.00	0	11, 349				9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	13, 684	0	ł .		10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	2, 418				11.00
12. 00 13. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	0	10, 567 11				12. 00 13. 00
14. 00	RESPIRATORY THERAPY	65.00	0	9, 590				14.00
15.00	ELECTROCARDI OLOGY	69.00	0	2, 896	1			15.00
16. 00 17. 00	ELECTROENCEPHALOGRAPHY RENAL DI ALYSI S	70. 00 74. 00	0	66 5, 659				16. 00 17. 00
18. 00	CARDI AC REHABI LI TATI ON	76. 97	0	518		l e e e e e e e e e e e e e e e e e e e		18. 00
19. 00	CLINIC	90.00	0	1, 952				19. 00
20. 00 21. 00	OP ONCOLOGY INFUSION CENTER	90. 01 90. 02	0	15, 125				20.00
21.00	WOUND CARE CENTER PAIN CLINIC	90.02	0	68 394				21. 00 22. 00
23. 00	EMERGENCY	91.00	0	171, 980	0			23. 00
24. 00	AMBULANCE SERVICES	95.00	0	22, 294				24. 00
25. 00 26. 00	PROMPTCARE COMMUNITY HEALTH SERVICES	190. 01 190. 11	0	972 156				25. 00 26. 00
27. 00	OPERATING ROOM	50.00	0	83, 622		•		27. 00
28. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	24, 748	0			28. 00

Provider CCN: 15-0051

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/27/2018 9:18 am

						5/27/2018 9:	18 am
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
20.00	6. 00	7.00	8. 00	9. 00	10. 00		20.00
29. 00	CT SCAN	57.00	0	7, 120	0		29. 00
30. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	1, 156	0		30. 00
	(MRI )	+	+		+		1
	H - NON-BILLABLE MEDICAL SUPF	DITES	<u> </u>	003, 702			-
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	70, 786	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5.00	o	70, 760 967	0		2. 00
3. 00	OPERATION OF PLANT	7.00	0	4, 850	0		3. 00
4. 00	HOUSEKEEPI NG	9.00	o	83, 146	0		4. 00
5. 00	DI ETARY	10.00	o	23, 734	0		5. 00
6. 00	NURSING ADMINISTRATION	13.00	o	51, 571	0		6. 00
7. 00	PHARMACY	15. 00	o	84, 115	0		7. 00
8. 00	CENTRAL STERILIZATION	18. 01	o	262, 578	0		8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0	1, 625, 678	0		9. 00
10. 00	INTENSIVE CARE UNIT	31.00	0	388, 270	0		10.00
11. 00	CORONARY CARE UNIT	32.00	o	215, 129	0		11.00
12. 00	NEONATAL INTENSIVE CARE UNIT	35.00	o	205, 211	0		12. 00
13. 00	SUBPROVI DER - I RF	41.00	o	51, 231	0		13. 00
14. 00	OPERATING ROOM	50.00	o	3, 568, 620	0		14. 00
15. 00	RECOVERY ROOM	51.00	o	65, 947	0		15. 00
16. 00	DELIVERY ROOM & LABOR ROOM	52.00	o	313, 731	0		16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	172, 110	o		17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55.00	Ö	426, 996	o		18. 00
19. 00	CT SCAN	57.00	Ö	133, 728	o		19. 00
20. 00	MAGNETIC RESONANCE I MAGING	58.00	Ö	13, 290	o		20.00
20.00	(MRI)	30.00	٦	15, 270			20.00
21. 00	CARDIAC CATHETERIZATION	59.00	o	198, 618	0		21. 00
22. 00	RESPIRATORY THERAPY	65. 00	o	418, 421	0		22. 00
23. 00	PHYSI CAL THERAPY	66.00	o	25, 414	0		23. 00
24. 00	ELECTROCARDI OLOGY	69. 00	o	29, 902	O		24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	o	50, 821	0		25. 00
26. 00	RENAL DIALYSIS	74.00	o	14, 452	0		26. 00
27. 00	CARDI AC REHABI LI TATI ON	76. 97	o	9, 003	0		27. 00
28. 00	CLINIC	90.00	o	19, 743	0		28. 00
29. 00	OP ONCOLOGY INFUSION CENTER	90. 01	ol	196, 614	o		29. 00
30. 00	WOUND CARE CENTER	90. 02	ol	81, 850	o		30.00
31. 00	PAIN CLINIC	90. 03	o	20, 745	o		31. 00
32. 00	OP PSYCH CLINIC	90. 05	o	720	0		32. 00
33. 00	EMERGENCY	91.00	o	1, 053, 102	0		33. 00
34.00	AMBULANCE SERVICES	95.00	o	162, 112	0		34.00
35. 00	PROMPTCARE	190. 01	ol	28, 917	o		35. 00
36. 00	OLCOTT	190. 03	ol	158	- 1		36. 00
37. 00	CLINICAL TRIALS	190. 09	o	5	0		37. 00
38. 00	COMMUNITY HEALTH SERVICES	190. 11	o	12, 187	0		38. 00
				10, 084, 472			1
	J - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1, 238, 202	11		1.00
				1, 238, 202			
	K - PHARMACY RESIDENCY				,		
1.00	PHARMACY	15. 00	180, 951	13, 843	0		1.00
			180, 951	13, 843			1
	L - PSYCH ADMIN	<u> </u>					
1.00	ADULTS & PEDIATRICS	30.00	201, 119	5, 744	0		1. 00
	0 — — — — — —		201, 119				1
	M - SOFTWARE LICENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10, 780	14		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	O	155, 851	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	o	13, 158	0		3. 00
4.00	OPERATING ROOM	50.00	o	8, 225	0		4. 00
5.00	RADI OLOGY-THERAPEUTI C	55.00	0	1, 350	0		5. 00
6.00	PHYSI CAL THERAPY	66.00	0	355	0		6. 00
7.00	OP ONCOLOGY INFUSION CENTER	90. 01	o	285			7. 00
8.00	OP PSYCH CLINIC	90. 05	o	2, 193	O		8. 00
9.00	AMBULANCE SERVICES	95.00	o	2, 553			9. 00
10.00	PROMPTCARE	190. 01	o	2, 193	0		10.00
11.00	OLCOTT	190. 03	0	19, 114	0		11. 00
	0			216, 057			
	N - CAFETERIA						
1.00	DI ETARY	10.00	1, 323, 862	1, 127, 533	0		1.00
	0	$\Box$	1, 323, 862	1, 127, 533			
	O - SHORT TERM DISABILITY/FLM						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	10, 605	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	30, 203	0	0		2. 00
3.00	OPERATION OF PLANT	7.00	O	2, 537	0		3. 00
				_			

Health Financial Systems RECLASSIFICATIONS

Peri od: From 01/01/2017 To 12/31/2017

Date/Time Prepared: 5/27/2018 9:18 am

						5/27/2018 9:	18 am
		Decreases	6.1	011			
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10.00		1 00
4.00	HOUSEKEEPI NG	9. 00	12, 033	0	0		4. 00
5. 00	DI ETARY	10. 00	14, 763	0	0		5. 00
6. 00	NURSING ADMINISTRATION	13. 00	8, 946	0	0		6. 00
7. 00	PHARMACY	15. 00	36, 079	0	0		7. 00
8. 00	CENTRAL STERILIZATION	18. 01	8, 490	0	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	137, 170	0	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	53, 020	0	0		10.00
11.00	CORONARY CARE UNIT	32.00	38, 271	0	0		11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	22, 366	0	o		12.00
13.00	SUBPROVI DER - I RF	41.00	6, 226	0	O		13.00
14.00	NURSERY	43.00	6, 901	0	o		14. 00
15. 00	OPERATING ROOM	50.00	34, 868	0	0		15. 00
16. 00	RECOVERY ROOM	51.00	21, 368	0	o		16. 00
17. 00	DELIVERY ROOM & LABOR ROOM	52. 00	17, 110	0	o		17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54.00	7, 620	0	o		18. 00
19. 00	RADI OLOGY-THERAPEUTI C	55.00	8, 773	0	o		19. 00
20. 00	CT SCAN	57. 00	15, 198	0	0		20.00
21. 00	MAGNETIC RESONANCE I MAGING	58. 00		0	0		21.00
21.00		36.00	4, 298	U	۷		21.00
22.00	(MRI)	FO 00	2 000	0			22.00
22. 00	CARDI AC CATHETERI ZATI ON	59.00	3, 890	0	0		22. 00
23. 00	RESPIRATORY THERAPY	65.00	12, 958	0	0		23. 00
24. 00	PHYSI CAL THERAPY	66.00	35, 683	0	0		24. 00
25. 00	ELECTROCARDI OLOGY	69. 00	1, 670	0	0		25. 00
26. 00	CARDIAC REHABILITATION	76. 97	956	0	0		26. 00
27. 00	CLINIC	90.00	254	0	0		27. 00
28. 00	OP ONCOLOGY INFUSION CENTER	90. 01	2, 594	0	0		28. 00
29. 00	WOUND CARE CENTER	90. 02	13, 412	0	0		29. 00
30.00	PAIN CLINIC	90. 03	4, 777	0	0		30. 00
31.00	OP PSYCH CLINIC	90. 05	763	0	0		31. 00
32.00	EMERGENCY	91.00	32, 415	0	O		32. 00
33.00	AMBULANCE SERVICES	95.00	22, 491	0	O		33. 00
34.00	PROMPTCARE	190. 01	3, 272	0	0		34.00
35. 00	OLCOTT	190. 03	1, 672	0	o		35. 00
36. 00	FOUNDATI ON	190. 05	6, 164	0	o		36. 00
37. 00	HME STORE	190.07	568	0	o		37. 00
38. 00	COMMUNITY HEALTH SERVICES	190. 11	10, 055	0	o o		38.00
30.00	O DELL'I SERVICES		647, 902	$\frac{1}{2,537}$	— — — 4		30.00
	P - UTILITIES EXPENSE		047, 702	2, 337			-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 796	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5.00	0	4, 066	0		2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	11, 503	0		3.00
	RADI OLOGY-THERAPEUTI C				-		1
4.00		55.00	0	147, 799	0		4. 00
5.00	PHYSICAL THERAPY	66.00	0	27, 879	0		5. 00
6. 00	CARDIAC REHABILITATION	76. 97	0	70	0		6. 00
7. 00	CLINIC	90.00	0	980	0		7. 00
8. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	4, 304	0		8. 00
9. 00	PAIN CLINIC	90. 03	0	5, 621	0		9. 00
10. 00	AMBULANCE SERVICES	95. 00	0	27, 145	0		10.00
11. 00	RENTAL PROPERTIES	190. 02	0	29, 331	0		11. 00
12.00	FOUNDATI ON	190. 05	0	8, 343	0		12. 00
13.00	CLINICAL TRIALS	190. 09	0	105	0		13. 00
14.00	COMMUNITY HEALTH SERVICES	190. 11	0	15, 313	0		14.00
	0		0	285, 255			
	Q - MARKETING EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		33	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00		98, 585	0		2. 00
3.00	NURSING ADMINISTRATION	13. 00		25	O		3. 00
4.00	PARAMED ED PRGM-PHARMACY	23.00		150	O		4. 00
	RESI DENCY						
5.00	NEONATAL INTENSIVE CARE UNIT	35. 00		2, 045	o		5. 00
6. 00	OPERATING ROOM	50.00		8, 190	o		6. 00
7. 00	PHYSI CAL THERAPY	66.00		1, 672	n		7. 00
8. 00	AMBULANCE SERVICES	95.00		683	o		8. 00
9. 00	OLCOTT	190. 03		28	o		9. 00
10. 00	FOUNDATI ON	190.03		8, 208	0		10.00
11. 00	COMMUNITY HEALTH SERVICES	190. 03		5, 002	0		11.00
11.00	O SERVICES	— — <sup>190.</sup> 1 1	— — — <sub>o</sub>	<u>5,002</u> 124, 621	— — — Ч		11.00
	R - OCCUPATIONAL HEALTH ADMIN	<u> </u>	U <sub>I</sub>	124, 021			1
1. 00	PROMPTCARE	190. 01	242, 193	0	0		1.00
1.00	0	— 1 <del>90.</del> 01			— — — Ч		1.00
	S - NURSERY		242, 193	U			1
1. 00	ADULTS & PEDIATRICS	30.00	795, 624	77, 072	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	23, 014	3, 150			2.00
2.00			818, 638	80, 222	— — — 4		2.00
	TOTALS		010, 038	00, 222			<u> </u>

Health Financial Systems RECLASSIFICATIONS IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0051

						 3/2//2010 7. 1	i o aiii
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
500.00	Grand Total: Decreases		3, 414, 665	95, 787, 129			500.00

Provider CCN: 15-0051

				7	To 12/31/2017	Date/Time Pre 5/27/2018 9:1	pared: 8 am
	·			Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES			_		
1.00	Land	19, 741, 447	0	(	0	0	1. 00
2.00	Land Improvements	2, 058, 207	0	(	0	0	2. 00
3.00	Buildings and Fixtures	150, 797, 533	0	(	0	63, 862	3. 00
4.00	Building Improvements	11, 202, 889	135, 226	(	135, 226	0	4. 00
5.00	Fi xed Equipment	0	0	(	0	0	5. 00
6.00	Movable Equipment	188, 676, 895	0	(	0	12, 054, 659	6. 00
7.00	HIT designated Assets	0	0	(	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	372, 476, 971	135, 226	(	135, 226	12, 118, 521	8. 00
9.00	Reconciling Items	0	0	(	0	0	9. 00
10.00	Total (line 8 minus line 9)	372, 476, 971	135, 226	(	135, 226	12, 118, 521	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	19, 741, 447	0				1. 00
2.00	Land Improvements	2, 058, 207	0				2. 00
3.00	Buildings and Fixtures	150, 733, 671	0				3. 00
4.00	Building Improvements	11, 338, 115	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	176, 622, 236	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	360, 493, 676	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	360, 493, 676	0				10. 00

Heal th	Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0051	Period: From 01/01/2017	Worksheet A-7 Part II	
					To 12/31/2017		
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see instructions)	
		9.00	10. 00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMI	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY OF	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMI	N 2, LINES 1 a	ind 2			
1. 00	CAP REL COSTS-BLDG & FLXT	0	0	1			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1			2. 00
3. 00	Total (sum of lines 1-2)		0	1			3.00

Heal th	Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	F	Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part III Date/Time Prep	
						5/27/2018 9: 18	3 am
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	183, 871, 440	0	183, 871, 440	0. 510055	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	176, 622, 236	0	176, 622, 236	0. 489945	0	2.00
3.00	Total (sum of lines 1-2)	360, 493, 676	0	360, 493, 676	1. 000000	0	3.00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	col s. 5			
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(	12, 118, 113	1, 152, 478	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(	6, 827, 448	211, 480	2.00
3.00	Total (sum of lines 1-2)	0	0	1	18, 945, 561	1, 363, 958	3.00
	,		SL	JMMARY OF CAPIT	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	cost center bescription	Tillerest	,	,	Capi tal -Rel ate		
			instructions)	instructions)	d Costs (see	through 14)	
					instructions)	tili ougii 14)	
		11.00	12.00	13. 00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00	
1. 00	CAP REL COSTS-BLDG & FIXT	-4, 310	0			13, 266, 281	1. 00
2.00	CAD DEL COSTS MADLE ENLLD	-4,310		_	1		

0 -4, 310

0 216, 057 216, 057

13, 266, 281 7, 254, 985 20, 521, 266

2. 00

0 0 0

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

				To	rom 01/01/2017 o 12/31/2017	Date/Time Prep 5/27/2018 9:18	pared:
				Expense Classification on		5/2//2018 9: 18	8 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	A		CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		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		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-15, 523, 022			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	15, 329, 293			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0. 00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	
	and others		0				
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	patients		0				
18. 00	Sale of medical records and abstracts		U		0. 00	0	
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	О	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
211.00	therapy costs in excess of	7. 0 0	C	THE THE THE THE THE THE THE THE THE THE	00.00		21100
25. 00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00	0	29. 00 30. 00
30. 00	therapy costs in excess of	A-0-3	U	DOGOLATIONAL HIERAPT	67. 00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of		0	5. 22011 1711102001	00.00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest MISCELLANEOUS INCOME	В	-364, 270	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
		- 1		,	30	· <u> </u>	

Provi der CCN: 15-0051 Worksheet A-8 From 01/01/2017 | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

					12/31/201/	5/27/2018 9:18	
				Expense Classification on	Worksheet A	0,27,2010 7.11	<u> </u>
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 01	MI SCELLANEOUS I NCOME	В	-5, 501, 386	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	MI SCELLANEOUS I NCOME	В	-675, 137	OPERATION OF PLANT	7. 00	0	33. 02
33. 03	MI SCELLANEOUS I NCOME	В	-52, 654	LAUNDRY & LINEN SERVICE	8. 00	0	33. 03
33.04	MI SCELLANEOUS I NCOME	В	-87, 446	PROMPTCARE	190. 01	0	33. 04
33. 05	MI SCELLANEOUS I NCOME	В	-337, 149		10.00	0	33. 05
33.06	MI SCELLANEOUS I NCOME	В	-348, 922	NURSING ADMINISTRATION	13.00	0	33. 06
33. 07	MI SCELLANEOUS I NCOME	В	-702, 262	PHARMACY	15. 00	0	33. 07
33. 08	MI SCELLANEOUS I NCOME	В	-36, 680	ADULTS & PEDIATRICS	30.00	0	33. 08
33. 09	MI SCELLANEOUS I NCOME	В	-531	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 09
33. 10	MI SCELLANEOUS I NCOME	В	-64, 143	RADI OLOGY-THERAPEUTI C	55.00	0	33. 10
33. 11	MI SCELLANEOUS I NCOME	В	-353, 728	LABORATORY	60.00	0	33. 11
33. 12	MI SCELLANEOUS I NCOME	В	-1, 350	RESPI RATORY THERAPY	65.00	0	33. 12
33. 13	MI SCELLANEOUS I NCOME	В	-28, 924	PHYSI CAL THERAPY	66.00	0	33. 13
33. 14	MI SCELLANEOUS I NCOME	В	-15, 433	ELECTROENCEPHALOGRAPHY	70.00	0	33. 14
33. 15	MI SCELLANEOUS I NCOME	В	-132	CARDIAC REHABILITATION	76. 97	0	33. 15
33. 16	MI SCELLANEOUS I NCOME	В	-87, 447	CLINIC	90.00	0	33. 16
33. 17	MI SCELLANEOUS I NCOME	В	-102, 461	WOUND CARE CENTER	90. 02	0	33. 17
33. 18	MI SCELLANEOUS I NCOME	В	-2, 693	OP PSYCH CLINIC	90.05	0	33. 18
33. 19	MI SCELLANEOUS I NCOME	В	-318, 605	AMBULANCE SERVICES	95.00	0	33. 19
33. 20	ACCELERATED DEPRECIATION	A	208, 936	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 20
33. 21	ACCRUED PTO	A	-972, 166	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 21
33. 22	UNNECESSARY BORROWING	A	-801, 240	CAP REL COSTS-BLDG & FIXT	1.00	11	33. 22
33. 23	BENEFIT EXPENSE	A	-18, 930, 986	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 23
33. 24	CONTRI BUTI ON EXPENSE	A	-25, 500	ADMINISTRATIVE & GENERAL	5. 00	0	33. 24
33. 25	PHYSICIAN RECRUITMENT	A	-169, 273	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26	PHYSICIAN RECRUITMENT	A	-47, 147	ADULTS & PEDIATRICS	30.00	0	33. 26
33. 27	PHYSICIAN RECRUITMENT	A	-20, 066	OPERATING ROOM	50.00	0	33. 27
33. 28	PHYSICIAN RECRUITMENT	A	-3, 919	RADI OLOGY-THERAPEUTI C	55.00	0	33. 28
33. 29	HAF FEES	A	-16, 657, 654	ADMINISTRATIVE & GENERAL	5.00	0	33. 29
33. 30	CAFETERIA REVENUE	В	-1, 134, 997	CAFETERI A	11.00	0	33. 30
33. 31	WEGMILLER CAPITALIZED INTEREST	A	-343	CAP REL COSTS-BLDG & FIXT	1.00	11	33. 31
33. 32	1983 CAPITALIZED INTEREST	A	-3, 968	CAP REL COSTS-BLDG & FIXT	1.00	11	33. 32
33. 33	OTHER CARRYFORWARD ADJUSTMENTS	A	153, 996	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 33
33. 34	START UP COSTS	A	-1, 877, 979	ADMINISTRATIVE & GENERAL	5. 00	0	33. 34
33. 35	PENSION CASH CONTRIBUTION	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 35
	ADJUSTMENT	'	.,, 310		00	]	
33. 36	TELEPHONE	A	-326	ADULTS & PEDIATRICS	30.00	0	33. 36
33. 37	TELEPHONE	A		PROMPTCARE	190. 01	0	33. 37
33. 38	TELEPHONE	A		DI ETARY	10.00	0	33. 38
33. 39	TELEPHONE	A		HOUSEKEEPI NG	9. 00	0	33. 39
33. 40	D MISCELLANEOUS INCOME B -77, 508		COMMUNITY HEALTH SERVICES	190. 11	O	33. 40	
50.00	· · · · · · · · · · · · · · · · · · ·		-41, 921, 523	1			50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> 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.

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

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

Provider CCN: 15-0051

Worksheet A-8-1

From 01/01/2017 12/31/2017 Date/Time Prepared:

					5/27/2018 9:1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1. 00			HO ALLOCATION	2, 649, 886	1, 238, 202	1. 00
2.00	I	CAP REL COSTS-MVBLE EQUIP	HO ALLOCATION	526, 794	0	2. 00
3.00			HO ALLOCATION	15, 995, 291	0	3.00
4.00	1	ADMINISTRATIVE & GENERAL	HO ALLOCATION	41, 333, 428	51, 085, 416	4. 00
4. 01		NURSING ADMINISTRATION	HO ALLOCATION	440, 242	0	4. 01
4.02	1	MEDICAL RECORDS & LIBRARY	HO ALLOCATION	2, 472, 024	0	4. 02
4.03		EMERGENCY	SIP ER	6, 252, 181	2, 016, 935	4. 03
4.04	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	37, 117	37, 117	4. 04
4.05	5. 00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	3, 793, 053	3, 793, 053	4. 05
4.06	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	540, 484	540, 484	4.06
4.07	35. 00	NEONATAL INTENSIVE CARE UNIT	SHARED EMPLOYEES	816, 300	816, 300	4. 07
4.08	41.00	SUBPROVI DER - I RF	SHARED EMPLOYEES	117, 907	117, 907	4. 08
4.09	50.00	OPERATING ROOM	SHARED EMPLOYEES	394, 137	394, 137	4. 09
4. 10	55. 00	RADI OLOGY-THERAPEUTI C	SHARED EMPLOYEES	631, 650	631, 650	4. 10
4. 11	60.00	LABORATORY	SHARED EMPLOYEES	11, 576, 772	11, 576, 772	4. 11
4. 12	66.00	PHYSI CAL THERAPY	SHARED EMPLOYEES	55, 130	55, 130	4. 12
4. 13	70.00	ELECTROENCEPHALOGRAPHY	SHARED EMPLOYEES	804, 249	804, 249	4. 13
4.14	90. 02	WOUND CARE CENTER	SHARED EMPLOYEES	167, 718	167, 718	4. 14
4. 15	90. 05	OP PSYCH CLINIC	SHARED EMPLOYEES	19, 321	19, 321	4. 15
4. 16	95.00	AMBULANCE SERVICES	SHARED EMPLOYEES	126, 316	126, 316	4. 16
4. 17	190. 01	PROMPTCARE	SHARED EMPLOYEES	588, 564	588, 564	4. 17
4. 18	190. 09	CLINICAL TRIALS	SHARED EMPLOYEES	32	32	4. 18
5.00	0		0	89, 338, 596	74, 009, 303	5. 00

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

				Related Organization(s) and/	or Home Office		
	Symbol (1)	Name	Percentage of	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

i Ci ilibui	Schicit ander title Aviii.					
6.00	С		0. 00	IU HEALTH SIP	0. 00	6. 00
7.00	С		0.00	IU HEALTH PAOLI	0. 00	7. 00
8.00	В	IU HEALTH	0.00		0. 00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

002	300.0				To 12/31/2017	Date/Time Pr 5/27/2018 9:	repared: 18 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO						
1.00	1, 411, 684						1.00
2.00	526, 794						2.00
3.00	15, 995, 291						3.00
4.00	-9, 751, 988	0					4.00
4.01	440, 242	0					4. 01
4.02	2, 472, 024						4. 02
4.03	4, 235, 246	0					4. 03
4.04	0	0					4. 04
4.05	0	0					4. 05
4.06	0	0					4. 06
4.07	0	0					4. 07
4.08	0	0					4. 08
4.09	0	0					4. 09
4. 10	0	0					4. 10
4. 11	0	0					4. 11
4. 12	0	0					4. 12
4. 13	0	0					4. 13
4. 14	0	0					4. 14
4. 15	0	0					4. 15
4. 16	0	0					4. 16
4. 17	0	0					4. 17
4. 18	0	0					4. 18
5.00	15, 329, 293	:[					5.00

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

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

i ei iiibui	Termodi Sement under titte XVIII.							
6. 00	PHYSICIAN GROUP	6.00						
7.00	HOSPI TAL	7.00						
8.00		8.00						
9. 00 10. 00		9.00						
10.00		10.00						
100.00		100.00						

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0051

						lo 12/31/2017	Date/lime Pre 5/27/2018 9:1	
	Wkst. A Line #	3	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	Hours 7.00	
1.00		ADMINISTRATIVE & GENERAL	542, 949	542, 949	0.00		7.00	1. 00
2.00		ADMINISTRATIVE & GENERAL	529, 189	529, 189	0		0	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	1, 097, 383	1, 097, 383	0		0	3. 00
4.00		ADMINISTRATIVE & GENERAL	3, 266, 442	3, 266, 442	0	,	0	4. 00
5. 00		ADMINISTRATIVE & GENERAL	817, 008	817, 008	0		0	5. 00
6.00		ADMINISTRATIVE & GENERAL	87, 514	87, 514	0	,	0	6. 00
7.00		ADMINISTRATIVE & GENERAL	500, 000	500, 000	0		0	7. 00 8. 00
8. 00 9. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	81, 236 63, 294	81, 236 63, 294	0	211, 500 271, 900	0	9. 00
10. 00		ADMINISTRATIVE & GENERAL	308, 568	03, 274	308, 568		1, 661	10. 00
11. 00		ADULTS & PEDIATRICS	566, 578	546, 671	19, 907		128	11. 00
12.00	90. 05	OP PSYCH CLINIC	19, 321	19, 321	0	181, 300	0	12.00
13.00		OP PSYCH CLINIC	378, 260	365, 249	13, 011		91	13.00
14. 00		ADMINISTRATIVE & GENERAL	-3, 915	-3, 915	0	,	0	14. 00
15. 00	•	NEONATAL INTENSIVE CARE UNIT	741, 300	282, 138	459, 162		5, 705	15. 00
16. 00 17. 00		RADI OLOGY-THERAPEUTI C ADMI NI STRATI VE & GENERAL	543, 079 834, 947	543, 079 834, 947	0		0	16. 00 17. 00
18. 00		SUBPROVIDER - IRF	67, 770	67, 770	0	211, 500	0	18. 00
19. 00		ADULTS & PEDIATRICS	508, 699	508, 699	0	211, 500	0	19. 00
20. 00		OP PSYCH CLINIC	240, 965	92, 448	148, 517		2, 945	20. 00
21.00		ADULTS & PEDIATRICS	142, 325	57, 471	84, 854		1, 729	21. 00
22. 00		ADMINISTRATIVE & GENERAL	779, 293	779, 293	0	,	0	22. 00
23. 00		ELECTROCARDI OLOGY	120, 752	80, 763	39, 989		691	23. 00
24. 00		WOUND CARE CENTER	167, 718	167, 718	0	,	0	24. 00
25. 00 200. 00	91.00	EMERGENCY	4, 081, 823	4, 081, 823 15, 408, 490	1 074 009	211, 500	12, 950	25. 00
	Wkst. A Line #	Cost Center/Physician	16, 482, 498 Unadj usted RCE		1, 074, 008 Cost of		Physician Cost	200. 00
	WK3t. A LITTE #	I denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
		1 40	2	Li mi t	Continuing	Share of col.	Insurance	
					Educati on	12		
4.00	1.00	2.00	8. 00	9. 00	12. 00	13.00	14. 00	4 00
1. 00 2. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	0	0	0		0	1. 00 2. 00
3.00		ADMINISTRATIVE & GENERAL	0	0	0		0	3. 00
4. 00		ADMINISTRATIVE & GENERAL	Ö	0	0	-	0	4. 00
5.00		ADMINISTRATIVE & GENERAL	0	0	0	0	0	5. 00
6.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0		0	6. 00
7. 00		ADMINISTRATIVE & GENERAL	0	0	0	_	0	7. 00
8.00		ADMINISTRATIVE & GENERAL	0	0	0		0	8. 00
9. 00 10. 00	•	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	207, 865	0 10, 393	0	-	0	9. 00 10. 00
11. 00		ADULTS & PEDIATRICS	11, 157	558	0		0	11. 00
12. 00		OP PSYCH CLINIC	0	0	0		0	12. 00
13.00		OP PSYCH CLINIC	7, 932	397	0	0	0	13.00
14.00		ADMINISTRATIVE & GENERAL	0	0	0	0	0	14.00
15. 00		NEONATAL INTENSIVE CARE UNIT	650, 315	32, 516	0		0	15. 00
16. 00		RADI OLOGY-THERAPEUTI C	0	0	0	,	0	16.00
17. 00 18. 00		ADMINISTRATIVE & GENERAL SUBPROVIDER - IRF	0	0	0		0	17. 00
19. 00		ADULTS & PEDIATRICS	0	0	0		0	18. 00 19. 00
20. 00		OP PSYCH CLINIC	256, 696	12, 835	0		0	20. 00
21. 00		ADULTS & PEDIATRICS	150, 706	7, 535	0		0	21. 00
22.00		ADMINISTRATIVE & GENERAL	0	0	0	0	0	22. 00
23. 00		ELECTROCARDI OLOGY	70, 263	3, 513	0	0	0	23. 00
24. 00		WOUND CARE CENTER	0	0	0	0	0	24. 00
25. 00	91.00	EMERGENCY	1 254 024	(7.747	0	0	0	25. 00
200. 00	Wkst. A Line #	Cost Center/Physician	1, 354, 934 Provi der	67,747 Adjusted RCE	RCE	Adjustment	0	200. 00
	WKSt. A LITTE #	I denti fi er	Component	Li mi t	Di sal I owance	Adj d3 tillerit		
			Share of col.					
	1.00	2. 00	14 15. 00	16. 00	17. 00	18. 00		
1.00		ADMI NI STRATI VE & GENERAL	15.00	16.00	17.00			1. 00
2. 00		ADMINISTRATIVE & GENERAL	Ö	Ö	0			2. 00
3.00		ADMINISTRATIVE & GENERAL	0	0	0			3. 00
4.00		ADMINISTRATIVE & GENERAL	0	0	0	3, 266, 442		4. 00
5.00		ADMINISTRATIVE & GENERAL	0	0	0	,		5. 00
6.00		ADMINISTRATIVE & GENERAL	0	0	0	87, 514		6. 00
7.00		ADMINISTRATIVE & GENERAL	0	0	0	500, 000		7. 00
8. 00 9. 00	J 5.00	ADMINISTRATIVE & GENERAL	l O	O	0	81, 236		8. 00
7. 00	5 00	IADMINISTRATIVE & CENEDAL	Λ.	$\cap$	^	Y3 301		Q /1/1
10.00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	0	0 207 865	0 100 703	63, 294 100, 703		9. 00 10. 00
10. 00 11. 00	5. 00	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0 0 0	0 207, 865 11, 157	0 100, 703 8, 750	100, 703		9. 00 10. 00 11. 00

Peri od: Worksheet A-8-2 From 01/01/2017 Date/Time Prepared: 5/27/2018 9: 18 am

							5/27/2018 9:18 am
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	
		l 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	
12.00	90. 05	OP PSYCH CLINIC	0	0	C	19, 321	12. 00
13.00	90. 05	OP PSYCH CLINIC	0	7, 932	5, 079	370, 328	13. 00
14.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	C	-3, 915	14. 00
15.00	35. 00	NEONATAL INTENSIVE CARE UNIT	0	650, 315	C	282, 138	15. 00
16.00	55. 00	RADI OLOGY-THERAPEUTI C	0	0	C	543, 079	16. 00
17.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	C	834, 947	17. 00
18.00	41.00	SUBPROVIDER - IRF	0	0	C	67, 770	18. 00
19.00	30.00	ADULTS & PEDIATRICS	0	0	C	508, 699	19. 00
20.00	90. 05	OP PSYCH CLINIC	0	256, 696	C	92, 448	20. 00
21.00	30.00	ADULTS & PEDIATRICS	0	150, 706	C	57, 471	21. 00
22.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	C	779, 293	22. 00
23.00	69. 00	ELECTROCARDI OLOGY	0	70, 263	C	80, 763	23. 00
24.00	90. 02	WOUND CARE CENTER	0	0	C	167, 718	24. 00
25.00	91.00	EMERGENCY	0	0	(	4, 081, 823	25. 00
200.00			0	1, 354, 934	114, 532	15, 523, 022	200. 00

CAPITAL RELATED COSTS   BAME   SUBTOR		ALLOCATION - GENERAL SERVICE COSTS	O HEALTH BLOOM	Provi der Co	CN: 15-0051 F	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part   Date/Time Pre	
Control   Cont				CAPLTAL REI		12, 31, 231,	5/27/2018 9:1	8 am
SERREAL SERVICE COST CRITTERS   0   1 00   2 00   4.00   4.4		Cost Center Description	for Cost Allocation (from Wkst A			BENEFI TS	Subtotal	
1.00				1.00	2. 00	4. 00	4A	
DOZDO CAP NIL COSTS - MINIL FOUR   7, 724, 988   7, 734,	1 00		12 2// 201	12 2// 201				1 00
0.00   OD-000   EMPLOYEE BEREFITS DEPARTWENT   26, 093, 317   98, 756   55, 259   26, 987, 331   4.00   4.00   7.00   60   7.00   60   7.00   60   7.00   60   7.00   60   7.00   60   7.00   60   7.00   60   7.00   60   7.00		l l						
7.00   000000   000001   00   PLANT   1, 17, 093   7, 200   224, 182, 290   1, 200   2, 400   1, 200   1, 200   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   1, 200   2, 40   2,				l				4. 00
8.00   0.0000   JAJINDRY & LI NEN SERVICE   188. 952   22. 500   12. 640   0   224, 182   8. 00   10. 00   0.0000   DIETARY   1. 160, 132   156, 753   87, 712   212, 163   1. 161, 760   10. 00   10.000   DIETARY   1. 160, 132   156, 753   87, 712   212, 163   1. 161, 760   10. 00   10. 00   DIETARY   1. 160, 132   156, 753   87, 712   212, 163   1. 161, 760   10. 00   14.00   CENTRAL SERVICES & SUPPLY   10. 110, 308   24, 900   122, 161   1. 185, 126   6. 00, 120, 103   10. 00   10. 00   DIETARY   4. 965, 836   76, 292   42, 689   1. 185, 126   6. 00, 122, 289   14. 00   10. 00   DIETARY   1. 180, 120, 120   10. 00   DIETARY   4. 965, 836   76, 292   42, 689   1. 180, 120   10. 00   DIETARY   1. 180, 120   10. 00   DIETARY   2. 735, 831   85, 762   48, 000   2. 25, 806   6. 204, 421   15. 00   DIETARY   1. 180, 120   10. 00   DIETARY   1. 180, 120   DIETARY   1. 18								
9.00   0.0990    0.0990    0.0950								
10.00   01000   IETARY								
13.00   01300   MURSHIG AMIN IN STRATION   5, 348, 643   236, 190   132, 161   1, 185, 126   6, 902, 160   13.00   16.00   1		01000 DI ETARY						
14.00 01400 CENTRAL SERVICES & SUPPLY 10.110.308								
15.00 0 10500 [PARABIACY   4, 966, 826   72, 922   40, 80, 00   0   2, 80, 613   16.00		1 1		l				
18.00   01850   SOCIAL SERVICES   0	15. 00	01500 PHARMACY		72, 922	40, 804	1, 215, 080	6, 294, 642	15. 00
18.0 10   0851 [CENTRAL STERILI ZATION   537, 350   44, 663   24, 432   111, 270   716, 715   18.0 10   19.						1		
23.00			_	1				
30.00   3000   ADULTS & PEDIATRICS   24, 183, 820   1, 623, 254   908, 301   31, 809, 685   30.00   3010   3100   3310   MITNESINY CARE UNIT   2, 601, 760   189, 030   105, 773   623, 761   3, 520, 324   32, 000   3000   0000   COROMARY CARE UNIT   2, 601, 760   189, 030   105, 773   623, 761   3, 520, 324   32, 001   3000   00000   00000   00000   00000								
31-00   03100   NTENSI VE CARE UNIT   3, 619, 333   144, 772   80, 773   737, 515   4, 581, 848   31, 200   20300   CRROMARY CARE UNIT   2, 681, 760   189, 303   105, 773   623, 761   3, 520, 324   32, 200   20300   CRROMARY CARE UNIT   2, 481, 888   98, 821   53, 617   462, 999   3, 094, 285   35, 004   285   35, 004, 285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   285   35, 004   325   35, 004			1 04 400 000				24 222 425	
32.00   03200   CORDMARY CARE UNIT   2, 601, 760   189, 030   105, 773   623, 761   3, 520, 324   32.00   300, 000   000   00   00   00   00								•
35.00		I I		l				
42.00   04200   NURSERY   B99, 340   68, 584   38, 376   277, 241   12, 233, 324   34, 300   04200   NURSERY   B99, 340   68, 584   38, 376   277, 243   12, 233, 324   34, 300   04200   OFERATING ROWN   7, 995, 710   689, 559   385, 847   1, 368, 765   10, 439, 881   50, 00   500   0   0   0   0   0   0   0							3, 094, 285	35. 00
43.00   04300 NURSERY   A   30.00   04300 NURSERY   A   30.00   0500			1, 018, 653	170, 737				
MACILLARY SERVICE COST CENTERS   50.00   GROOD OPERATING ROOM   7, 995, 710   689, 559   385, 847   1, 368, 765   10, 439, 881   50.00   50.01   50.00   50.			899, 340	68, 584		1		
50.00   05001   05001   05001   05001   05001   05001   05001   05001   05001   05000   0500	F0 00		7 005 740					
51.00   OSTOO   OSTO		l l	1	1				•
53.00   05300   ABISTHESI DLOGY   0   0   0   0   53.00   0.55			-	1	_			
54.00   OS400   RADI OLOGY-DI AGNOSTIC   4, 032, 588   292, 559   163, 703   856, 438   5, 345, 288   54.00   550   OS500   RADI OLOGY-THERAPEUTIC   0   0   0   0   0   0   0   0   0				469, 529				
55. 00   05500   RADI DLOGY-THERAPEUTIC   3, 428, 306   308, 368   172, 549   589, 234   4, 498, 457   55. 00   56. 00			-	202 550				
56. 00   05600   RADI OI SOTOPE   0   0   0   0   56. 00				l				•
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI )   627, 552   27, 251   15, 248   109, 231   779, 282   58.00   69.00   0500   CADDIAC CATHETERI ZATION   1, 762, 945   90, 949   50, 891   301, 339   331, 339   2, 206, 124   59.00   60.00   06		05600 RADI OI SOTOPE	0	0	C	o		
59.00   05000   CARDIA C CATHETERI ZATI ON   1,762,945   90,949   50,891   301,339   2,266,124   59.00   60.00   6000   LABORATORY   12,400,484   245,329   137,275   0   12,783,088   60.00   64.00   64.00   06400   INTRAVENOUS THERAPY   2,159,747   18,532   10,370   527,733   2,716,382   65.00   66.00   6600   PMSIC LACH THERAPY   7,384,931   140,481   78,607   1,768,554   9,372,573   66.00   66.00   6600   PMSIC LACH THERAPY   0   0   0   0   0   0   0   0   68.00   66.00   6600   PMSIC LACH THERAPY   0   0   0   0   0   0   0   68.00   66.00   6600   SPECERI PATHOLOGY   0   0   0   0   0   0   0   68.00   69.00   69.00   0   0   0   0   0   0   0   0   68.00   69.00   69.00   0   0   0   0   0   0   0   0   0						·		
60.00   06000   LABORATORY   12, 400, 484   245, 329   137, 275   0   12, 783, 088   60.00			1	l				
65.00   06500   RESPI RATORY THERAPY   2,159,747   18,532   10,370   527,733   2,716,382   65.00   66.00   06600   PHYSI CAL THERAPY   7,384,931   140,481   78,607   1,768,554   9,372,573   66.00   67.00   06700   OCCUPATI ONAL THERAPY   0 0 0 0 0 0 0 0 0 67.00   68.00   06800   SPEECH PATHOLOGY   0 0 0 0 0 0 0 0 0 0 68.00   69.00   06900   ELECTROCARDI OLOGY   955,009   34,439   19,271   235,229   1,243,948   89.00   70.00   07000   ELECTROENCEPHALOGRAPHY   1,000,625   60,778   34,009   44,653   1,140,065   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   16,094,549   0 0 0 0   6,094,549   72.00   72.00   07300   DRUGS CHARGED TO PATI ENTS   20,503,587   0 0 0 0   28,172   20,531,759   73.00   73.01   07302   DP PHARMACY   0 0 0 0 0 0 0   73.01   74.00   07400   RENAL DIALYSI S   1,164,881   11,063   6,191   0   1,182,135   74.00   75.01   07550   ASC (NON-DISTINCT PART)   0 0 0 0 0 0 0 0   75.01   76.97   07697   CARDI AC REHABI LITATI ON   707,833   52,775   29,531   172,022   962,161   76.97   07000   07000   ONDOLOGY INFUSION CENTER   1,337,161   47,398   26,522   319,906   1,738,875   90.00   79.00   09000   CLINI C   1,221,466   126,385   70,720   320,304   1,738,875   90.00   79.01   09000   ONDOLOGY INFUSION CENTER   1,337,161   47,398   26,522   319,906   1,730,987   90.01   79.02   09000   ONDOLOGY INFUSION CENTER   1,337,161   47,398   26,522   319,906   1,730,987   90.01   79.00   09000   DISCREVANTION BEDS (NON-DISTINCT PART)   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY		l	137, 275	0		60.00
66.00   06600   PHYSICAL THERAPY   7,384,931   140,481   78,607   1,768,554   9,372,573   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0 0 0 0 0 0 0 0 0 0 68.00   68.00   06800   SPEECH PATHOLOGY   0 0 0 0 0 0 0 0 0 0 0 68.00   69.00   06900   ELECTROCARDI OLOGY   955,009   34,439   19,271   235,229   1,243,948   69.00   71.00   07000   ELECTROCARDI OLOGY   1,000,625   60,778   34,009   44,653   1,140,065   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   8,644,552   0 0 0 0 8,644,552   71.00   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   16,094,549   0 0 0 0 16,094,549   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   20,503,587   0 0 28,172   20,531,759   73.00   73.01   07302   OP PHARMACY   0 0 0 0 0 0 0 0 0 0 0 73.01   74.00   07400   RENAL DI ALYSI S   1,164,881   11,063   6,191   0 1,182,135   74.00   75.00   07500   ASC (NON-DI STI NCT PART)   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·	0	10 522		-		
67. 00   06700   0CCUPATI (ONAL THERAPY   0   0   0   0   0   0   0   0   0								
69.00   0,000			0	0	(	0		1
70. 00   07000   ELECTROENCEPHALOGRAPHY   1,000,625   60,778   34,009   44,653   1,140,065   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   8,644,552   0 0 0 0 0   8,644,552   71.00   72.00   72.00   MPUL. DEV. CHARGED TO PATIENTS   16,094,549   0 0 0 0   16,094,549   72.00   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   20,503,587   0 0 0 0   28,172   20,531,759   73.00   73.01   07302   DRUGS CHARGED TO PATIENTS   20,503,587   0 0 0 0   28,172   20,531,759   73.00   73.01   07302   DRUGS CHARGED TO PATIENTS   1,164,881   11,063   6,191   0 0 1,182,135   74.00   75.00   75.00   07500   ASC (NON-DISTINCT PART)   0 0 0 0 0 0 0 0 0   0 75.00   75.01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0 0 0 0 0 0 0 0 0   0 75.01   76.97   07697   CARDI AC REHABI LITATI ON   707,833   52,775   29,531   172,022   962,161   76.97   0017471 ENT SERVI CE COST CENTERS   1,221,466   126,385   70,720   320,304   1,738,875   90.00   90.00   0 0 0 0   0 0 0 0   0 0 0 0   0 0 0   0 0 0 0   0 0 0 0 0   0 0 0 0 0   0 0 0 0 0 0   0 0 0 0 0 0   0 0 0 0 0 0 0   0 0 0 0 0 0 0   0 0 0 0 0 0 0 0 0   0 0 0 0 0 0 0 0 0 0 0   0 0 0 0 0 0 0 0 0 0 0   0 0 0 0 0 0 0 0 0   0 0 0 0 0 0 0 0   0 0 0 0 0 0 0 0   0 0 0 0 0 0 0 0 0   0 0 0 0 0 0 0 0 0 0   0			0	0	10.071	0		ı
71. 00		1 1						•
73. 00   07300   DRUGS CHARGED TO PATIENTS   20, 503, 587   0   0   0   28, 172   20, 531, 759   73. 00   73. 01   07302   OP PHARMACY   0   0   0   0   0   0   0   0   0		1 1		l				1
73. 01 07302 OP PHARMACY 0 0 0 0 0 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSIS 1, 164,881 11,063 6,191 0 1,182,135 74,00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 75. 01 76. 97 07697 CARDI AC REHABILITATI ON 707,833 52,775 29,531 172,022 962, 161 90. 01 09000 CLI NI C 1,221,466 126,385 70,720 320,304 1,738,875 90. 00 90. 01 09000 DPATI ENT SERVI CE COST CENTERS 1,337,161 47,398 26,522 319,906 1,730,987 90. 01 90. 02 09002 WOUND CARE CENTER 817,946 65,565 36,687 208,204 1,128,402 90. 02 90. 03 09003 PAI N CLI NI C 273,121 42,119 23,568 59,602 398,410 90. 03 90. 05 09005 OP PSYCH CLI NI C 1,271,567 126,357 70,704 432,224 1,900,852 90. 05 91. 00 09100 EMERGENCY 6,328,079 371,743 208,011 1,268,872 8,176,705 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0THE REI MBURSABLE COST CENTERS  94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	C	0		
74. 00   07400   RENAL DIALYSIS   1, 164, 881   11, 063   6, 191   0   1, 182, 135   74. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0		I I	20, 503, 587	0		28, 172		
75. 00   07500   ASC (NON-DISTINCT PART)			1, 164, 881	11, 063	6, 191			
76. 97 O7697 CARDI AC REHABI LI TATI ON 707, 833 52, 775 29, 531 172, 022 962, 161 76. 97 OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 1, 221, 466 126, 385 70, 720 320, 304 1, 738, 875 90. 00 9000 O9001 OP ONCOLOGY I NFUSI ON CENTER 1, 337, 161 47, 398 26, 522 319, 906 1, 730, 987 90. 01 9000 O9002 WOUND CARE CENTER 817, 946 65, 565 36, 687 208, 204 1, 128, 402 90. 02 90. 02 90002 WOUND CARE CENTER 817, 946 65, 565 36, 687 208, 204 1, 128, 402 90. 02 90. 05 09005 OP PSYCH CLI NI C 273, 121 42, 119 23, 568 59, 602 398, 410 90. 03 90. 05 09005 OP PSYCH CLI NI C 1, 271, 567 126, 357 70, 704 432, 224 1, 900, 852 90. 05 91. 00 09100 EMERGENCY 6, 328, 079 371, 743 208, 011 1, 268, 872 8, 176, 705 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 O7500 AMBULANCE SERVI CES 5, 812, 416 198, 704 111, 186 1, 350, 060 7, 472, 366 95. 00 101. 00 10000   Respectively and the service of the service			0	0	C	o	0	75. 00
OUTPATIENT SERVICE COST CENTERS   O		l l	707 922	0	20 521	172 022		1
90. 00	70. 97		101, 633	52,775	29, 551	172, 022	902, 101	70.97
90. 02   09002   WOUND CARE CENTER   817, 946   65, 565   36, 687   208, 204   1, 128, 402   90. 02   90. 03   09003   PAI N CLINIC   273, 121   42, 119   23, 568   59, 602   398, 410   90. 03   90. 05   09005   0P PSYCH CLINIC   1, 271, 567   126, 357   70, 704   432, 224   1, 900, 852   90. 05   91. 00   09100   EMERGENCY   6, 328, 079   371, 743   208, 011   1, 268, 872   8, 176, 705   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   92. 00   000   OBSERVATION BEDS (NON-DISTINCT PART)   0   000		09000 CLI NI C		1				•
90. 03				l				•
90. 05				l				•
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   92. 00				l			1, 900, 852	90. 05
OTHER REIMBURSABLE COST CENTERS           94. 00         09400 HOME PROGRAM DI ALYSI S         0         0         0         0         0         94. 00           95. 00         09500 AMBULANCE SERVI CES         5, 812, 416         198, 704         111, 186         1, 350, 060         7, 472, 366         95. 00           100. 00         1 0000 I &R SERVI CES-NOT APPRVD PRGM         0         0         0         0         0         100. 00           101. 00         10100 HOME HEALTH AGENCY         0         0         0         0         0         0         101. 00           SPECIAL PURPOSE COST CENTERS           113. 00         1 NTEREST EXPENSE         113. 00         101. 00         0 <td< td=""><td></td><td></td><td>6, 328, 079</td><td>371, 743</td><td>208, 011</td><td>1, 268, 872</td><td></td><td></td></td<>			6, 328, 079	371, 743	208, 011	1, 268, 872		
94. 00	92.00						0	92.00
100. 00 10000   1 &R SERVI CES-NOT APPRVD PRGM	94.00		0	0	C	0	0	94.00
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS  113.00 11300 INTEREST EXPENSE 113.00		1 1	5, 812, 416	198, 704	111, 186	1, 350, 060		
SPECIAL PURPOSE COST CENTERS  113.00 11300 INTEREST EXPENSE 113.00			0	0		)   O		
		SPECIAL PURPOSE COST CENTERS						
114. 00 11400 011 LIZATI ON REVIEW-SNF								
	114.00	PITT-OO OTTEL ZATION KEVIEW-SINF	I	l	l .	<u> </u>		1114.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part I Provider CCN: 15-0051

			To	o 12/31/2017	Date/Time Pre 5/27/2018 9:1	
		CAPITAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1. 00	2.00	4. 00	4A	
115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. ) 116. 00   11600   HOSPI CE 118. 00   SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0 0 285, 423, 336	0 0 11, 470, 297	0 0 6, 418, 268	0 0 25, 643, 342		115. 00 116. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	106, 131	13, 239	7, 408	11, 752	138, 530	190 00
190. 01 19001 PROMPTCARE	1, 616, 173	90, 359		269, 020	2, 026, 113	
190. 02 19002 RENTAL PROPERTIES	10, 961	236, 948		0	380, 494	
190. 03 19003 OLCOTT	315, 850	38, 609	21, 604	71, 979	448, 042	190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	703, 799	90, 514	50, 648	149, 909	994, 870	
190. 06 19006 MARKETI NG	124, 621	0	0	0	124, 621	190. 06
190. 07 19007 HME STORE	275, 693	0	0	70, 806	346, 499	
190. 08 19008 UNUSED SPACE	0	480, 606	268, 926	0	749, 532	
190. 09 19009 CLI NI CAL TRI ALS	294, 955	7, 371	4, 124	75, 215	381, 665	
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	3, 024, 982	384, 800	215, 317	555, 308	4, 180, 407	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0		194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL 194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	U		194. 01 194. 02
194.03 07953 IU HEALTH SIP	0	300, 660	0	0	300, 660	
194. 04 07954 HOME CARE		85, 544	47, 867	0	133, 411	
194. 05 07955 HOSPI CE	0	67, 334	37, 677	0	105, 011	
200.00 Cross Foot Adjustments		07, 334	37,077	٩		200. 00
201.00 Negative Cost Centers		n	n	٥		201. 00
202.00 TOTAL (sum lines 118 through 201)	291, 896, 501	13, 266, 281	7, 254, 985	26, 847, 331	291, 896, 501	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0051

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/27/2018 9:18 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 59 051 947 5 00 5 00 7.00 00700 OPERATION OF PLANT 3,080,636 15, 227, 729 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 56, 855 40, 928 321, 965 8.00 9.00 00900 HOUSEKEEPI NG 849, 089 88. 698 4, 285, 792 9.00 01000 DI ETARY 2, 310, 788 10.00 410,028 284, 000 0 10.00 01100 CAFETERI A 456, 992 153, 052 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 1, 750, 464 427, 921 76 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 2, 594, 260 138, 223 14 00 0 0 14.00 15.00 01500 PHARMACY 1, 596, 390 132, 118 575 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 727, 765 155, 418 C 0 0 16.00 01850 SOCIAL SERVICES 0 18.00 18.00 0 C 01851 CENTRAL STERILIZATION 181, 767 0 18.01 79, 108 2.821 0 18.01 23.00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY 99, 171 5, 215 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 2, 940, 960 1, 846, 828 30.00 03000 ADULTS & PEDIATRICS 8.067.297 124, 181 1,646,000 30.00 03100 INTENSIVE CARE UNIT 31.00 1, 162, 007 261, 387 11, 652 2.996 178.860 31 00 03200 CORONARY CARE UNIT 892, 793 342, 479 143, 825 155, 139 32.00 9, 264 32.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 784, 745 173, 605 1, 906 999 35.00 0 04100 SUBPROVI DER - I RF 129, 961 383, 699 41.00 309, 335 6, 229 306, 627 41.00 42.00 04200 SUBPROVI DER 0 42.00 43.00 04300 NURSERY 310, 251 124, 258 4, 831 83, 898 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 647, 669 1, 249, 321 23, 608 175, 786 Λ 50.00 50.01 05001 CV SURGERY 0 50.01 05100 RECOVERY ROOM 1,007,797 28, 755 51.00 88, 138 258, 686 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 159, 490 850.678 17, 257 469, 430 0 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 355, 624 530, 049 22, 580 55, 932 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 1, 140, 858 558, 691 0 0 55.00 0 56 00 05600 RADI OI SOTOPE 0 0 0 56 00 0 57.00 05700 CT SCAN 308, 972 32, 940 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 197, 634 49, 373 0 0 58.00 58.00 C 0 59.00 05900 CARDIAC CATHETERIZATION 559, 497 164, 779 0 59.00 6.864 06000 LABORATORY 60.00 3, 241, 932 444, 480 63 0 60.00 06400 I NTRAVENOUS THERAPY 64.00 0 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 688, 904 33, 576 C 0 0 65.00 66 00 06600 PHYSI CAL THERAPY 2, 376, 988 Ω 254, 519 635 66 00 06700 OCCUPATIONAL THERAPY 67.00 C 0 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 315, 479 62, 396 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 289, 133 0 70 00 70 00 110, 115 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 192, 353 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4.081.755 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 103, 874 73.00 5, 207, 080 0 0 73.00 07302 OP PHARMACY 0 73.01 0 0 73.01 74.00 07400 RENAL DIALYSIS 299, 802 20, 044 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75. 01 0 0 75.01 07697 CARDIAC REHABILITATION 76.97 244, 015 95, 616 5,078 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 440, 998 228, 981 0 0 90.00 09001 OP ONCOLOGY INFUSION CENTER 438, 997 90.01 90.01 85, 874 0 255, 689 0 90.02 09002 WOUND CARE CENTER 286, 175 118, 789 0 0 90.02 09003 PAIN CLINIC 101,041 90.03 90.03 76, 310 0 09005 OP PSYCH CLINIC 90.05 482,077 228, 930 55, 575 134, 836 90.05 91.00 09100 EMERGENCY 2,073,702 673, 512 647, 214 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0 94.00 0 09500 AMBULANCE SERVICES 1, 895, 074 9 95.00 360,005 0 0 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 116. 00 11600 HOSPI CE  $\cap$ 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 56, 437, 255 11, 973, 821 321, 965 4, 285, 792 2, 310, 788 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 35 133 23 987 0 0

| Period: | Worksheet B | From 01/01/2017 | Part | | Date/Time Prepared: | 5/27/2018 9:18 am

					5/27/2018 9:18 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10. 00
190. 01 19001 PROMPTCARE	513, 845	163, 710	0	0	0 190. 01
190. 02 19002 RENTAL PROPERTIES	96, 497	429, 294	0	0	0 190. 02
190. 03 19003 OLCOTT	113, 628	69, 951	0	0	0 190. 03
190. 04 19004 PHYSICIAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	252, 310	163, 990	0	0	0 190. 05
190. 06 19006 MARKETI NG	31, 605	0	0	0	0 190. 06
190.07 19007 HME STORE	87, 876	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	190, 090	870, 748	0	0	0 190. 08
190. 09 19009 CLI NI CAL TRI ALS	96, 794	13, 354	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	1, 060, 197	697, 168	0	0	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194.03 07953 IU HEALTH SIP	76, 251	544, 726	0	0	0 194. 03
194.04 07954 HOME CARE	33, 834	154, 986	0	0	0 194. 04
194. 05 07955 HOSPI CE	26, 632	121, 994	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	59, 051, 947	15, 227, 729	321, 965	4, 285, 792	2, 310, 788 202. 00

			10	12/31/2017	Date/lime Pre   5/27/2018 9:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS &	
	11. 00	13. 00	14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00   00200   CAP REL COSTS-MVBLE EQUIP						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00   00700   OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000 DI ETARY						10.00
11. 00  01100   CAFETERI A	2, 411, 986					11. 00
13.00 01300 NURSING ADMINISTRATION	103, 947	9, 184, 568				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	12, 961, 772			14. 00
15. 00   01500   PHARMACY	96, 003	0	30, 816	8, 150, 544	0 750 70/	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	0	0	0	3, 752, 796	16.00
18. 00   01850   SOCI AL SERVI CES 18. 01   01851   CENTRAL STERI LI ZATI ON	0 18, 668	0	96, 813	0	0	18. 00 18. 01
23. 00   02301 PARAMED ED PRGM-PHARMACY RESIDENCY	5, 475	0	90, 613	0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3,473	<u> </u>	0	<u> </u>	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	584, 311	3, 928, 204	578, 835	67, 555	300, 116	30.00
31.00 03100 INTENSIVE CARE UNIT	77, 156	527, 855	144, 493	28, 549	44, 172	31. 00
32. 00 03200 CORONARY CARE UNIT	62, 845	447, 030	79, 978	10, 354	34, 473	32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	44, 896	331, 077	76, 202	6, 192	32, 906	35. 00
41. 00   04100   SUBPROVI DER -   I RF	24, 660	183, 150	18, 787	535	12, 681	41.00
42. 00   04200   SUBPROVI DER	0	172 024	0	0	12 140	42.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	21, 440	172, 934	25, 456	499	13, 148	43. 00
50. 00 05000 OPERATING ROOM	128, 757	577, 086	1, 458, 949	32, 364	534, 067	50.00
50. 01   05001   CV   SURGERY	120, 737	0	1, 430, 747	32, 304	0	50. 00
51. 00 05100 RECOVERY ROOM	71, 876	533, 450	24, 173	4, 392	80, 406	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	70, 559	443, 838	115, 858	5, 245	95, 363	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	О	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	86, 782	126, 276	68, 593	9, 578	153, 428	54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	51, 498	58, 719	158, 834	1, 192	229, 886	55. 00
56. 00   05600   RADI OI SOTOPE	1/ 0/0	0	40.707	2 754	74 140	56.00
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	16, 060 10, 446	0	49, 786 4, 870	2, 756 447	74, 149 27, 858	57. 00 58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	29, 941	165, 197	181, 300	4, 090	189, 093	59.00
60. 00 06000 LABORATORY	96, 743	0	0	0	346, 827	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	ō	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	48, 985	0	155, 115	4	33, 668	65. 00
66. 00 06600 PHYSI CAL THERAPY	156, 917	531	9, 310	3, 712	77, 359	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	24, 059	55, 066	10, 953	1, 121	57, 226 36, 916	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 829 0	0	18, 617 3, 166, 361	26	151, 467	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	5, 895, 191	0	281, 475	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	o	0	7, 887, 124	427, 015	
73. 01 07302 OP PHARMACY	0	О	0	0	0	73. 01
74.00   07400   RENAL DIALYSIS	0	0	5, 302	2, 190	10, 289	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	15, 965	27, 896	3, 299	200	9, 277	76. 97
90. 00 09000 CLINIC	24 490	83, 120	7 227	755	7, 425	00 00
90. 01   09001 OP ONCOLOGY INFUSION CENTER	26, 680 31, 741	224, 852	7, 237 72, 432	755 5, 854	43, 329	90. 00 90. 01
90. 02   09002   WOUND CARE CENTER	18, 778	125, 372	29, 980	26	12, 775	90.01
90. 03   09003   PAIN CLINIC	5, 984	22, 871	7, 599	152	5, 790	90. 03
90. 05 09005 OP PSYCH CLINIC	33, 704	81, 761	264	0	7, 930	90. 05
91. 00   09100   EMERGENCY	141, 282	975, 536	391, 854	66, 562	305, 631	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS			1			
94. 00 09400 HOME PROGRAM DI ALYSI S	100 001	0	0	0 (33	114 451	94.00
95. 00   09500   AMBULANCE SERVICES 100. 00   10000   I&R SERVICES-NOT APPRVD PRGM	180, 821	U	59, 391	8, 628	116, 651	95. 00 100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0		100.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	ı	<u> </u>	<u> </u>		, 101.00
113. 00 11300   NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	o	0	o		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)	2, 292, 808	9, 091, 821	12, 946, 648	8, 150, 108	3, 752, 796	118. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Par

				12/01/2017	5/27/2018 9: 18 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
		ADMI NI STRATI ON	SERVICES &		RECORDS &
			SUPPLY		LI BRARY
	11. 00	13.00	14. 00	15. 00	16. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 938		0	0	0 190. 00
190. 01 19001 PROMPTCARE	23, 946	29, 116	10, 600	376	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0 190. 02
190. 03 19003 OLCOTT	6, 921	6, 663	58	0	0 190. 03
190. 04 19004 PHYSI CLAN RECRUI TMENT	0	0	0	0	0 190. 04
190. 05   19005   FOUNDATI ON	11, 211	0	0	0	0   190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	2, 089	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0 190. 08
190. 09 19009 CLI NI CAL TRI ALS	6, 527	13, 148	2	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	65, 546	43, 820	4, 464	60	0   190. 11
191. 00 19100 RESEARCH	0	0	0	0	0   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	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0	0 194. 00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	0	0	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194. 03 07953 IU HEALTH SIP	0	0	0	0	0 194. 03
194. 04 07954 HOME CARE	0	0	0	0	0 194. 04
194. 05 07955 HOSPI CE	0	0	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	2, 411, 986	9, 184, 568	12, 961, 772	8, 150, 544	3, 752, 796 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

					To 12/31/2017	Date/Time Prep 5/27/2018 9:18	
		OTHER GENE	RAL SERVICE			3/2//2010 4.10	o alli
	Cost Center Description	SOCI AL SERVI CES	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		18. 00	18. 01	23. 00	24.00	25.00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	I	I				1. 00
2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 18. 00 18. 01	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01850 SOCIAL SERVICES	C	1, 095, 898				2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 18. 00
23. 00		C	)  0	500, 89	5		23. 00
30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER	C C C C C C C C C C C C C C C C C C C	30, 610 1, 424 0 12, 457 0 0 0 15, 661		51, 924, 582 7, 022, 399 5, 698, 504 0 4, 559, 270 0 2, 888, 609 0 1, 995, 710		30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS		000 021		0 10 257 210		E0 00
50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 01 74. 00 75. 01	05001 CV SURGERY 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 CCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 RENAL DI ALYSI S 07500 ASC (NON-DISTINCT PART)		989, 831 0 0 0 0 0 5, 695 0 0 0 0 8, 186 0 0 0 4, 983 0 0 0 9, 254 5, 339 0 0 0 0 0 0 0 0 0 0 0 0 0	500, 89	0 18, 257, 319 0 6, 071, 464 0 7, 799, 643 0 7, 759, 825 0 6, 698, 135 0 1, 702, 955 1, 069, 910 0 3, 515, 071 0 16, 913, 133 0 3, 676, 634 0 12, 257, 527 0 0 1, 779, 502 0 1, 606, 040 14, 154, 733 0 26, 352, 970 0 34, 657, 747 0 0 1, 519, 762 0 1, 519, 762		50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 59. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 01 74. 00 75. 00 75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	C	0		0 1, 363, 507	0	76. 97
90. 00 90. 01 90. 02 90. 03 90. 05 91. 00 92. 00	09000 CLINIC 09001 OP ONCOLOGY INFUSION CENTER 09002 WOUND CARE CENTER 09003 PAIN CLINIC 09005 OP PSYCH CLINIC 09100 EMERGENCY	C C C C	0 0 0 356 0 5,339		2, 534, 071 0 2, 889, 755 0 1, 720, 297 0 618, 513 0 2, 925, 929 0 13, 457, 337	0 0 0 0	90. 00 90. 01 90. 02 90. 03 90. 05 91. 00 92. 00
95. 00 100. 00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES D10000 I&R SERVICES-NOT APPRVD PRGM D10100 HOME HEALTH AGENCY	000000000000000000000000000000000000000			0 0 0 0 10, 092, 945 0 0	0	94. 00 95. 00 100. 00 101. 00
	SPECIAL PURPOSE COST CENTERS D11300 INTEREST EXPENSE D11400 UTI LI ZATI ON REVIEW-SNF						113. 00 114. 00

| Period: | Worksheet B | From 01/01/2017 | Part | I | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 | Part | To | 13/21/2017 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

			To	o 12/31/2017	Date/Time Prepared:
					5/27/2018 9:18 am
	OTHER GENER	AL SERVICE			
Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &
	SERVI CES	STERTLIZATION	PRGM-PHARMACY		Residents Cost
			RESI DENCY		& Post
					Stepdown
	10.00	40.04	00.00	04.00	Adjustments
145 00 14500 MIDIN 470DV 0UDOLOM 05UTED (D.D.)	18. 00	18. 01	23. 00	24. 00	25. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 089, 135	500, 895	275, 483, 798	0 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		200, 588	
190. 01 19001 PROMPTCARE	0	356	0	2, 768, 062	
190. 02 19002 RENTAL PROPERTIES	0	0	0	906, 285	
190. 03 19003 OLCOTT	0	0	0	645, 263	
190. 04 19004 PHYSICIAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	1, 422, 381	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	156, 226	
190. 07 19007 HME STORE	0	0	0	436, 464	
190. 08 19008 UNUSED SPACE	0	0	0	1, 810, 370	
190. 09 19009 CLINI CAL TRI ALS	0	0	0	511, 490	
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0	0	6, 051, 662	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194.03 07953 IU HEALTH SIP	o	6, 407	0	928, 044	0 194. 03
194. 04 07954 HOME CARE	o	0	0	322, 231	0 194. 04
194. 05 07955 HOSPI CE	o	0	0	253, 637	0 194. 05
200.00 Cross Foot Adjustments			0	0	0 200. 00
201.00 Negative Cost Centers	o	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	o	1, 095, 898	500, 895	291, 896, 501	
	'				•

| Period: | Worksheet B | From 01/01/2017 | Part | | Part | | | Date/Time Prepared: | 5/27/2018 9:18 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

		5/27/2018 9: 18 am
Cost Center Description	Total	0,27,2010 7.10 diii
OFNEDAL CEDIU OF COCT OFNEDO	26. 00	
GENERAL SERVICE COST CENTERS		1.0
1.00   00100   CAP REL COSTS-BLDG & FLXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP		1.0
1 1		2.0
I I		4.0
I I		5.0
7.00   00700   0PERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE		7. 0
1 1		
1 1		9.0
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A		10. 0   11. 0
13. 00 O1300 NURSING ADMINISTRATION		13.0
I I		
I I		14. 0   15. 0
· · · · · · · · · · · · · · · · · · ·		15.0
l i		
18. 00   01850   SOCIAL SERVICES		18.0
18. 01 01851 CENTRAL STERILIZATION		18.0
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY		23. 0
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	E1 004 E00	30.0
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   INTENSI VE CARE UNI T	51, 924, 582	30.0
· · · · · · · · · · · · · · · · · · ·	7, 022, 399	31.0
32. 00 03200 CORONARY CARE UNIT	5, 698, 504	32. 0
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	4, 559, 270	35. 0
41. 00   04100   SUBPROVI DER -   RF	2, 888, 609	41.0
42. 00   04200   SUBPROVI DER	0	42. 0
43. 00 04300 NURSERY	1, 995, 710	43. 0
ANCILLARY SERVICE COST CENTERS	10 257 210	50.0
50. 00   05000   OPERATI NG ROOM	18, 257, 319	50.0
50. 01   05001   CV   SURGERY	0	50.0
51. 00   05100   RECOVERY ROOM	6, 071, 464	51.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM	7, 799, 643	52. 0
53. 00 05300 ANESTHESI OLOGY	0	53. 0
54. 00   05400   RADI OLOGY - DI AGNOSTI C	7, 759, 825	54. 0
55. 00   05500   RADI OLOGY-THERAPEUTI C	6, 698, 135	55. 0
56. 00   05600   RADI OI SOTOPE	0	56. 0
57. 00  05700   CT   SCAN	1, 702, 955	57. 0
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	1, 069, 910	58. 0
59. 00   05900   CARDI AC CATHETERI ZATI ON	3, 515, 071	59. 0
60. 00   06000   LABORATORY	16, 913, 133	60.0
64. 00   06400   I NTRAVENOUS THERAPY	0	64. 0
65. 00   06500   RESPI RATORY THERAPY	3, 676, 634	65. 0
66. 00   06600   PHYSI CAL THERAPY	12, 257, 527	66.0
67. 00   06700   OCCUPATI ONAL THERAPY	0	67.0
68. 00   06800   SPEECH PATHOLOGY	0	68. 0
69. 00   06900   ELECTROCARDI OLOGY	1, 779, 502	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 606, 040	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 154, 733	71. 0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	26, 352, 970	72. 0
73.00 07300 DRUGS CHARGED TO PATIENTS	34, 657, 747	73.0
73. 01   07302   OP   PHARMACY	0	73.0
74.00 07400 RENAL DIALYSIS	1, 519, 762	74.0
75.00 07500 ASC (NON-DISTINCT PART)	0	75. 0
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	75. 0
76. 97 07697 CARDIAC REHABILITATION	1, 363, 507	76. 9
OUTPATIENT SERVICE COST CENTERS		
90. 00   09000   CLI NI C	2, 534, 071	90.0
90. 01 09001 OP ONCOLOGY INFUSION CENTER	2, 889, 755	90.0
90. 02   09002   WOUND CARE CENTER	1, 720, 297	90.0
90. 03   09003   PAIN CLINIC	618, 513	90.0
90.05 09005 OP PSYCH CLINIC	2, 925, 929	90.0
91. 00 09100 EMERGENCY	13, 457, 337	91. 0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		92. 0
OTHER REIMBURSABLE COST CENTERS		
94.00 09400 HOME PROGRAM DIALYSIS	0	94. 0
95. 00 09500 AMBULANCE SERVICES	10, 092, 945	95. 0
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	100. 0
101.00 10100 HOME HEALTH AGENCY	0	101. 0
SPECIAL PURPOSE COST CENTERS		
113. 00 11300 I NTEREST EXPENSE		113. 0
114.00 11400 UTILIZATION REVIEW-SNF		114. 0
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	115. 0
116. 00 11600 HOSPI CE	O	116. 0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	275, 483, 798	118. 0
NONREI MBURSABLE COST CENTERS		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	200, 588	190. 0
190. 01 19001 PROMPTCARE	2, 768, 062	190. 0

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0051	Period: Worksheet B From 01/01/2017 Part I To 12/31/2017 Pate/Time Prepared:

			Γο 12/31/2017	Date/Time Prepared: 5/27/2018 9:18 am
Cost Center Description	Total			072772010 7. 10 dill
	26.00			
190. 02 19002 RENTAL PROPERTIES	906, 285			190. 02
190. 03 19003 OLCOTT	645, 263			190. 03
190. 04 19004 PHYSICIAN RECRUITMENT	0			190. 04
190. 05 19005 FOUNDATI ON	1, 422, 381			190. 05
190. 06 19006 MARKETI NG	156, 226			190. 06
190. 07 19007 HME STORE	436, 464			190. 07
190. 08 19008 UNUSED SPACE	1, 810, 370			190. 08
190. 09 19009 CLI NI CAL TRI ALS	511, 490			190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0			190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	6, 051, 662			190. 11
191. 00 19100 RESEARCH	0			191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			192. 00
193. 00 19300 NONPALD WORKERS	0			193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0			194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0			194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0			194. 02
194. 03 07953 IU HEALTH SIP	928, 044			194. 03
194. 04 07954 HOME CARE	322, 231			194. 04
194. 05 07955 HOSPI CE	253, 637			194. 05
200.00 Cross Foot Adjustments	0			200. 00
201.00 Negative Cost Centers	0			201. 00
202.00   TOTAL (sum lines 118 through 201)	291, 896, 501			202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				10	12/31/2017	Date/lime Pre   5/27/2018 9:1	
			CAPI TAL REI	ATED COSTS		10,27,20.0 7	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS				'		
1. 00 2. 00 4. 00 5. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	98, 755 3, 169, 392		154, 014 4, 942, 841	154, 014 13, 843	1. 00 2. 00 4. 00 5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	1, 593, 237 22, 590	891, 505	2, 484, 742 35, 230	3, 565	7. 00 8. 00
9. 00 10. 00		0	48, 956 156, 753		76, 350 244, 465	2, 736 1, 217	9. 00 10. 00
11. 00 13. 00	01300 NURSING ADMINISTRATION	0	84, 477 236, 190		131, 746 368, 351	2, 029 6, 798	1
14. 00 15. 00	01500 PHARMACY	0	76, 292 72, 922	40, 804	118, 981 113, 726	0 6, 970	
16. 00 18. 00	01850 SOCIAL SERVICES	0	85, 782 0	0	133, 782	0	16. 00 18. 00
18. 01 23. 00	1	0	43, 663 2, 878		68, 095 4, 488	638 425	18. 01 23. 00
30. 00		O	1, 623, 254	908, 301	2, 531, 555	29, 234	30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT	0	144, 272 189, 030	80, 728	225, 000 294, 803	4, 231	31. 00
35. 00 41. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	95, 821	53, 617	149, 438	3, 578 2, 656	35. 00
42. 00 43. 00	04200 SUBPROVI DER	0	170, 737 0 68, 584	95, 537 0 38, 376	266, 274 0 106, 960	1, 308 0 1, 245	42. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	١	08, 384	36, 370	100, 400[	1, 245	43.00
50.00		0	689, 559	1	1, 075, 406	7, 852	50.00
50. 01 51. 00		0	48, 648		75, 869	0 4, 365	50. 01 51. 00
52. 00 53. 00	05300 ANESTHESI OLOGY	0	469, 529 0	262, 728 0	732, 257 0	4, 171 0	52. 00 53. 00
54. 00 55. 00	05500 RADI OLOGY-THERAPEUTI C	0	292, 559 308, 368	172, 549	456, 262 480, 917	4, 913 3, 380	55. 00
56. 00 57. 00	05700 CT SCAN	0	0 18, 181	0 10, 173	0 28, 354	0 963	56. 00 57. 00
58. 00 59. 00	05900 CARDI AC CATHETERI ZATI ON	0	27, 251 90, 949	15, 248 50, 891	42, 499 141, 840	627 1, 729	58. 00 59. 00
60. 00 64. 00		0	245, 329 0	0	382, 604 0	0	60. 00 64. 00
65. 00 66. 00	06600 PHYSI CAL THERAPY	0 0	18, 532 140, 481	10, 370 78, 607	28, 902 219, 088	3, 027 10, 145	
67. 00 68. 00	1	0 0	0	0 0	0	0	67. 00 68. 00
69. 00 70. 00	07000 ELECTROENCEPHALOGRAPHY	0	34, 439 60, 778		53, 710 94, 787	1, 349 256	1
71. 00 72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00 73. 01	07302 OP PHARMACY	0	0	0	0	162 0	
74. 00 75. 00	07500 ASC (NON-DISTINCT PART)	0	11, 063 0	6, 191 0	17, 254 0	0	74. 00 75. 00
75. 01 76. 97	07697 CARDI AC REHABI LI TATI ON	0	0 52, 775	0 29, 531	0 82, 306	0 987	75. 01 76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	124 205	70, 720	107 106	1 027	00.00
90.00		0	126, 385 47, 398	70, 720 26, 522	197, 105 73, 920	1, 837 1, 835	90. 00 90. 01
90. 02 90. 03		0	65, 565 42, 119		102, 252 65, 687	1, 194 342	
90. 05	09005 OP PSYCH CLINIC	0	126, 357	70, 704	197, 061	2, 479	90. 05
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	371, 743	208, 011	579, 754 0	7, 279	91. 00 92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DI ALYSI S	O	0	O	0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES	0	198, 704	111, 186	309, 890	7, 744	95. 00
	0 10000   I&R SERVICES-NOT APPRVD PRGM 0 10100   HOME   HEALTH   AGENCY	0	0	0	0		100. 00
113 0	SPECIAL PURPOSE COST CENTERS 0 11300   INTEREST EXPENSE						113. 00
114.0	0 11400 UTI LI ZATI ON REVI EW-SNF 0 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0	0	0	0	0	114. 00 115. 00
115.0	OF THE OF THE PROPERTY OF THE	<u>ı</u> 9	0	ا ا	Ч	0	1113.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				o 12/31/2017	Date/Time Prepared: 5/27/2018 9:18 am
		CAPI TAL REI	LATED COSTS		
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT
	0	1. 00	2.00	2A	4. 00
116. 00 11600 H0SPI CE	0	0	2.00		0 116, 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	11, 470, 297	6, 418, 268	17, 888, 565	147, 109 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 239	7, 408	20, 647	67 190. 00
190. 01 19001 PROMPTCARE	0	90, 359	50, 561	140, 920	1, 543 190. 01
190. 02 19002 RENTAL PROPERTIES	0	236, 948			
190. 03 19003 OLCOTT	0	38, 609	21, 604	60, 213	
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	C	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	90, 514	50, 648	141, 162	860 190. 05
190. 06 19006 MARKETI NG	0	0	C	0	0 190. 06
190. 07 19007 HME STORE	0	0	(	0	406 190. 07
190. 08 19008 UNUSED SPACE	0	480, 606			0 190. 08
190. 09 19009 CLINI CAL TRI ALS	0	7, 371	4, 124	11, 495	431 190. 09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0		0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	384, 800	215, 317	600, 117	3, 185 190. 11
191. 00 19100 RESEARCH	0	0		0	0 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0 192. 00
193. 00 19300 NONPAI D WORKERS	0	0		0	0 193. 00
194. 00 07950 IU HEALTH PAOLI HOSPITAL	0	0		0	0 194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0		0	0 194. 01
194. 02 07952 IU HEALTH MORGAN HOSPITAL	0	000 ((0		0 00	0 194. 02
194. 03 07953 I U HEALTH SI P	0	300, 660		300, 660	0 194. 03
194. 04 07954 HOME CARE 194. 05 07955 HOSPI CE	0	85, 544			0 194. 04
	U	67, 334	37, 677	105, 011	0 194. 05 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0			0 201. 00
202.00   TOTAL (sum lines 118 through 201)		13, 266, 281	7, 254, 985	20, 521, 266	
202.00   101/1L (3011 111163 110 till 00gil 201)	١	13, 200, 201	1, 234, 703	20, 321, 200	154, 514 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am

				. '		5/27/2018 9:1	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	0.00	7. 00	10.00	
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 05/ /04					4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	4, 956, 684	2 744 904				5. 00 7. 00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	258, 587 4, 772	2, 746, 894 7, 383	1			8.00
9. 00	00900 HOUSEKEEPING	71, 272	16, 000		166, 359		9.00
10. 00		34, 418	51, 230	1	0	331, 330	1
11. 00		38, 360	27, 609	1	O	0	11. 00
13. 00		146, 933	77, 192	1	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	217, 761	24, 934	0	0	0	14. 00
15. 00	01500 PHARMACY	134, 000	23, 832	85	0	0	15. 00
16. 00		61, 088	28, 035	1	0	0	16. 00
18. 00		0	0		0	0	18. 00
18. 01	01851 CENTRAL STERILIZATION	15, 257	14, 270	1		0	18. 01
23. 00		8, 324	941	0	0	0	23. 00
30. 00	I NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	677, 060	530, 516	18, 277	63, 892	264, 806	30.00
31. 00	1	97, 538	47, 151			25, 646	
32. 00	1	74, 941	61, 779	1		22, 244	
35. 00	1	65, 871	31, 316		39	0	35. 00
41. 00		32, 208	55, 800	1	11, 902	18, 634	
42.00	04200 SUBPROVI DER	o	0	0	0	0	42. 00
43.00		26, 042	22, 415	711	3, 257	0	43. 00
	ANCI LLARY SERVI CE COST CENTERS			1			
50.00		222, 244	225, 362	1	6, 823	0	50.00
50. 01	05001 CV SURGERY	0	15.000	0	10.041	0	50. 01
51.00	1	84, 594	15, 899			0	51.00
52. 00 53. 00		97, 327	153, 452	2, 540 0	18, 222	0	52. 00 53. 00
54. 00		113, 790	95, 614	1	2, 171	0	54.00
55. 00		95, 763	100, 781	0, 329	2, 1, 1	0	55.00
56. 00		0	0	Ö	o	0	56.00
57. 00		25, 935	5, 942	0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	16, 589	8, 906	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	46, 964	29, 724	1, 010	0	0	59. 00
60.00		272, 126	80, 179	9	0	0	60.00
64. 00	1	0	0	0	0	0	64. 00
65. 00		57, 826	6, 057	1	0	0	65. 00
66. 00	1	199, 523	45, 912	1	0	0	66.00
67. 00	1	0	0	0	0	0	67.00
68. 00 69. 00	1	26, 481	11, 255	0	0	0	68. 00 69. 00
70. 00	1	24, 270	19, 863	1	0	0	70.00
71. 00		184, 025	17,000	0	0	0	71.00
72. 00		342, 621	0	Ö	o	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	437, 080	0	•	4, 032	0	
73. 01	1	o	O	0	0	0	73. 01
74.00		25, 165	3, 616	0	0	0	74. 00
75. 00		0	0	0	0	0	75. 00
75. 01		0	0	0	0	0	75. 01
76. 97		20, 482	17, 248	747	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	27 017	44 205			0	00 00
90.00		37, 017	41, 305 15, 401	1	-	0	90.00
90. 01 90. 02		36, 849 24, 021	15, 491 21, 428	1	9, 925	0	90. 01 90. 02
90. 02		8, 481	13, 765	1	0	0	90.02
90. 05		40, 465	41, 296	1	5, 234	0	90. 05
91. 00		174, 066	121, 493	1	25, 122	0	
92.00		,	,				92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>					
94.00	09400 HOME PROGRAM DIALYSIS	0	C	0	0	0	94. 00
	09500 AMBULANCE SERVICES	159, 072	64, 940	1	0	0	
	0 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101. 0	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
446 -	SPECIAL PURPOSE COST CENTERS						1110 00
	0 11300 INTEREST EXPENSE						113.00
	O 11400 UTILIZATION REVIEW-SNF O 11500 AMBULATORY SURGICAL CENTER (D.P.)		0	_		0	114. 00 115. 00
	0 11500 AMBULATURY SURGICAL CENTER (D. P. )		0				116.00
118.0	1 1	4, 737, 208	2, 159, 931	47, 385	166, 359	331, 330	
. 10. 0	NONREI MBURSABLE COST CENTERS	., 757, 200	2, 107, 701	17,303	100,007	331, 330	1
190.0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 949	4, 327	0	0	0	190. 00
			·		1		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

					5/2//2018 9:1	8 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7.00	8. 00	9. 00	10.00	
190. 01 19001 PROMPTCARE	43, 132	29, 531	0	0	0	190. 01
190. 02 19002 RENTAL PROPERTI ES	8, 100	77, 439	0	0	0	190. 02
190. 03 19003 OLCOTT	9, 538	12, 618	0	0	0	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	21, 179	29, 582	0	0	0	190. 05
190. 06 19006 MARKETI NG	2, 653	0	0	0	0	190. 06
190.07 19007 HME STORE	7, 376	0	0	0	0	190. 07
190. 08 19008 UNUSED SPACE	15, 956	157, 072	0	0	0	190. 08
190. 09 19009 CLINICAL TRIALS	8, 125	2, 409	0	0	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	88, 993	125, 760	0	0	0	190. 11
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0	0	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0	0	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0	194. 02
194.03 07953 IU HEALTH SIP	6, 400	98, 262	0	0	0	194. 03
194.04 07954 HOME CARE	2, 840	27, 957	0	0	0	194. 04
194. 05 07955 HOSPI CE	2, 235	22, 006	0	0	0	194. 05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 956, 684	2, 746, 894	47, 385	166, 359	331, 330	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am

			10	12/31/201/	5/27/2018 9:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11 00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13. 00	14. 00	15. 00	16. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00   01000 DI ETARY						10.00
11. 00   01100   CAFETERI A	199, 744					11. 00
13.00 01300 NURSING ADMINISTRATION	8, 608	607, 893				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	361, 676			14. 00
15. 00   01500   PHARMACY	7, 950	0	860	287, 423		15. 00
16.00  01600   MEDICAL RECORDS & LIBRARY	0	0	0	0	222, 905	16. 00
18. 00   01850   SOCIAL SERVICES	0	0	0	0	0	18. 00
18. 01 O1851 CENTRAL STERILIZATION	1, 546	i i	2, 702	0	0	18. 01
23. 00 O2301 PARAMED ED PRGM-PHARMACY RESIDENCY	453	0	0	0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	48, 390		16, 152	2, 382	17, 790	30.00
31. 00   03100   INTENSI VE CARE UNI T	6, 389	34, 937	4, 032	1, 007	2, 618	31.00
32. 00 03200 CORONARY CARE UNIT	5, 204	29, 587	2, 232	365	2, 044	32.00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	3, 718		2, 126	218	1, 951	35.00
41. 00   04100   SUBPROVI DER -   I RF	2, 042	12, 122	524	19 0	752	41.00
42. 00   04200  SUBPROVI DER 43. 00   04300  NURSERY	1, 775	11 114	0 710	18	0 779	42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	1,773	11, 446	710	10	119	43.00
50. 00 05000 OPERATING ROOM	10, 663	38, 195	40, 711	1, 141	32, 107	50.00
50. 01   05001 CV SURGERY	0,009	30, 173	40, 711	1, 141	0	50. 01
51. 00   05100   RECOVERY ROOM	5, 952	35, 307	675	155	4, 766	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	5, 843	29, 376	3, 233	185	5, 653	52.00
53. 00   05300   ANESTHESI OLOGY	0,010	27, 070	0, 200	0	0,000	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	7, 187	8, 358	1, 914	338	9, 095	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 265	l	4, 432	42	13, 627	55. 00
56. 00   05600 RADI OI SOTOPE	0	0	0	o	0	56.00
57. 00   05700 CT SCAN	1, 330	o	1, 389	97	4, 395	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	865	1	136	16	1, 651	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	2, 480	10, 934	5, 059	144	11, 209	59. 00
60. 00   06000   LABORATORY	8, 012	o	0	o	20, 559	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	o	0	o	0	64.00
65. 00 06500 RESPIRATORY THERAPY	4, 057	0	4, 328	0	1, 996	65. 00
66. 00 06600 PHYSI CAL THERAPY	12, 995	35	260	131	4, 586	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00   06800   SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	1, 992	3, 645	306	40	3, 392	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	483	0	520	1	2, 188	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	88, 356	0	8, 979	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	164, 485	0	,	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	278, 135	25, 313	
73. 01 07302 OP PHARMACY	0	0	0	0	0	73. 01
74. 00   07400   RENAL DIALYSIS	0	0	148	77	610	74.00
75. 00   07500   ASC (NON-DISTINCT PART) 75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	U	0	75.00
75. 01   03550  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97   07697   CARDI AC REHABI LI TATI ON	0 1, 322	1, 846	0 92	0	0 550	75. 01 76. 97
OUTPATIENT SERVICE COST CENTERS	1, 322	1, 640	72		550	10. 71
90. 00 09000 CLINIC	2, 209	5, 501	202	27	440	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	2, 629	l	2, 021	206	2, 568	90. 01
90. 02 09002 WOUND CARE CENTER	1, 555		837	1	757	90. 02
90. 03   09003   PAIN CLINIC	496	l	212	5	343	90. 03
90. 05   09005   OP   PSYCH   CLINIC	2, 791	5, 411	7	ol	470	90. 05
91. 00   09100   EMERGENCY	11, 700		10, 935	2, 347	18, 117	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	,		,	,		92.00
OTHER REIMBURSABLE COST CENTERS				•		
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	14, 974	0	1, 657	304	6, 915	95. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	이	0	0		115.00
116. 00 11600 HOSPI CE	100 075	0 00 75	0	0 7 400		116.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)	189, 875	601, 755	361, 253	287, 408	222, 905	1118.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | T

					5/27/2018 9:18 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
		ADMI NI STRATI ON			RECORDS &
			SUPPLY		LI BRARY
	11. 00	13. 00	14. 00	15. 00	16. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	243		0	0	0 190. 00
190. 01 19001 PROMPTCARE	1, 983	1, 927	296	13	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0 190. 02
190. 03 19003 OLCOTT	573	441	2	0	0 190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	928	0	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	173	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0 190. 08
190. 09 19009 CLINI CAL TRIALS	541	870	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	5, 428	2, 900	125	2	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0	0 194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194.03 07953 IU HEALTH SIP	0	0	0	0	0 194. 03
194. 04 07954 HOME CARE	0	0	0	0	0 194. 04
194. 05 07955 HOSPI CE	0	o	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	o	0	o	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	199, 744	607, 893	361, 676	287, 423	222, 905 202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | To 12/31/2017 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				'	o 12/31/2017	Date/lime Pre 5/27/2018 9:1	
		OTHER GENER	RAL SERVICE			072772010 7. 1	O dill
	Cost Center Description	SOCI AL SERVI CES	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		18. 00	18. 01	23. 00	24. 00	25. 00	
1.00 0010 2.00 0020 4.00 0040 5.00 0050 7.00 0070 8.00 0080	RAL SERVICE COST CENTERS  O CAP REL COSTS-BLDG & FIXT  O CAP REL COSTS-MVBLE EQUIP  O EMPLOYEE BENEFITS DEPARTMENT  OO ADMINISTRATIVE & GENERAL  OO OPERATION OF PLANT  IO LAUNDRY & LINEN SERVICE  OO HOUSEKEEPING						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00
10. 00	DI ETARY CAFETERIA DI NURSI NG ADMI NI STRATI ON CICENTRAL SERVI CES & SUPPLY CICENTRAL SERVI CES & SUPPLY CICENTRAL SERVI CES & LI BRARY CICENTRAL SERVI CES CICENTRAL SERVI CES CICENTRAL STERI LI ZATI ON	0	•				10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 18. 00
23. 00 0230	PARAMED ED PRGM-PHARMACY RESIDENCY	0					23. 00
30. 00 0300 31. 00 0310 32. 00 0320 35. 00 0206 41. 00 0410 42. 00 0420	TIENT ROUTINE SERVICE COST CENTERS  101 ADULTS & PEDIATRICS  101 INTENSIVE CARE UNIT  102 CORONARY CARE UNIT  103 NEONATAL INTENSIVE CARE UNIT  104 SUBPROVIDER - IRF  105 SUBPROVIDER  106 NURSERY	0 0 0 0 0	0 1, 170 0 0		4, 462, 924 450, 514 503, 723 280, 697 402, 502 0 176, 829	0 0 0 0 0	30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
	LLARY SERVICE COST CENTERS	_				_	
50. 01 0500 51. 00 0510	10 OPERATING ROOM 11 CV SURGERY 10 RECOVERY ROOM 10 DELIVERY ROOM & LABOR ROOM	0 0 0	0		1, 756, 941 0 241, 855 1, 052, 259	0 0	50. 00 50. 01 51. 00 52. 00
53. 00 0530 54. 00 0540 55. 00 0550	00 ANESTHESI OLOGY 00 RADI OLOGY-DI AGNOSTI C 00 RADI OLOGY-THERAPEUTI C	0 0	0 535		703, 500 707, 093	0 0	53. 00 54. 00 55. 00
57. 00 0570 58. 00 0580	10 RADIOISOTOPE 10 CT SCAN 10 MAGNETIC RESONANCE IMAGING (MRI) 10 CARDIAC CATHETERIZATION	0 0 0	0 0 0 769		0 68, 405 71, 289 251, 862	0 0	56. 00 57. 00 58. 00 59. 00
64. 00 0640 65. 00 0650	10 LABORATORY 10 I NTRAVENOUS THERAPY 10 RESPI RATORY THERAPY 10 PHYSI CAL THERAPY	0 0 0	0 0 0 468		763, 489 0 106, 193 493, 236	0	60. 00 64. 00 65. 00 66. 00
67. 00 0670 68. 00 0680 69. 00 0690	O OCCUPATIONAL THERAPY O SPEECH PATHOLOGY O ELECTROCARDIOLOGY O ELECTROENCEPHALOGRAPHY	0 0 0	0		0 0 103, 039 142, 869	0 0 0	67. 00
71. 00 0710 72. 00 0720 73. 00 0730 73. 01 0730 74. 00 0740	MEDICAL SUPPLIES CHARGED TO PATIENTS IN IMPL. DEV. CHARGED TO PATIENTS IN DRUGS CHARGED TO PATIENTS IN IMPL. DEV. CHARGED TO PATIENTS IN IMPL.	0 0 0	0 0 0		281, 360 523, 791 744, 722 0 46, 870	0	71. 00 72. 00 73. 00 73. 01 74. 00
75. 01 0355 76. 97 0769	O ASC (NON-DISTINCT PART) O PSYCHIATRIC/PSYCHOLOGICAL SERVICES O CARDIAC REHABILITATION OTION	0 0	0 0		0 0 125, 587	0 0	75. 00 75. 01 76. 97
90. 00 0900 90. 01 0900 90. 02 0900 90. 03 0900	OCLINIC OF ONCOLOGY INFUSION CENTER OF WOUND CARE CENTER OF PAIN CLINIC	0 0 0	0 0 33		285, 643 160, 326 160, 343 90, 878	0 0 0	90. 01 90. 02 90. 03
91. 00 0910 92. 00 0920 0THE	DE OP PSYCH CLINIC DE EMERGENCY DE OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS	0	0 501		303, 393 1, 015, 881	0 0	90. 05 91. 00 92. 00
95. 00 0950 100. 00 1000 101. 00 1010	NO HOME PROGRAM DIALYSIS NO AMBULANCE SERVICES NO I&R SERVICES-NOT APPRVD PRGM NO HOME HEALTH AGENCY NI AL PURPOSE COST CENTERS	0 0 0 0	0		0 565, 497 0 0		
113. 00 1130	O INTEREST EXPENSE O UTILIZATION REVIEW-SNF						113. 00 114. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

			To	12/31/2017	
	OTHER GENER	DAI SEDVICE			5/27/2018 9:18 am
	OTHER GENER	KAL SERVICE			
Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &
oust defiter bescription	SERVI CES		PRGM-PHARMACY		Residents Cost
	02.00	0122.2	RESI DENCY		& Post
			NEO! BENO!		Stepdown
					Adjustments
	18. 00	18. 01	23.00	24. 00	25. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0 115. 00
116. 00 11600 HOSPI CE	0	0		0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	102, 288	0	17, 043, 510	0 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		28, 233	0 190. 00
190. 01 19001 PROMPTCARE	0	33		219, 378	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0		455, 072	0 190. 02
190. 03 19003 OLCOTT	0	0		83, 798	0 190. 03
190.04 19004 PHYSICIAN RECRUITMENT	0	0		0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0		193, 711	0 190. 05
190. 06 19006 MARKETI NG	0	0		2, 653	
190. 07 19007 HME STORE	0	0		7, 955	
190. 08 19008 UNUSED SPACE	0	0		922, 560	
190. 09 19009 CLINI CAL TRI ALS	0	0		23, 871	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0		0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0		826, 510	0 190. 11
191. 00 19100 RESEARCH	0	0		0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	0 192. 00
193.00 19300 NONPALD WORKERS	0	0		0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0		0	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0		0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0		0	0 194. 02
194. 03 07953 IU HEALTH SIP	0	602		405, 924	0 194. 03
194. 04 07954 HOME CARE	0	0		164, 208	
194. 05 07955 HOSPI CE	0	0		129, 252	
200.00 Cross Foot Adjustments			14, 631	14, 631	0 200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00   TOTAL (sum lines 118 through 201)	0	102, 923	14, 631	20, 521, 266	0 202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2017 Part II | To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

		5/27/2018 9: 18	
Cost Center Description	Total	0,27,2010 7.10	- CATH
	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 CAP REL COSTS-BLDG & FLXT			1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP			2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL			5. 00
7. 00 O0700 OPERATION OF PLANT			7. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE			8. 00
9. 00   00900   HOUSEKEEPI NG			9. 00
10. 00   01000   DI ETARY			10.00
11. 00   01100   CAFETERI A			11. 00
13. 00 01300 NURSING ADMINISTRATION			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00   01500   PHARMACY			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY			16. 00
18. 00   01850   SOCI AL   SERVI CES			18. 00
18. 01   01851   CENTRAL STERILIZATION			18. 01
23. 00   O2301   PARAMED ED   PRGM-PHARMACY   RESI DENCY			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00   03000   ADULTS & PEDI ATRI CS	4, 462, 924		30.00
31. 00   03100   I NTENSI VE CARE UNI T	450, 514		31. 00
32. 00   03200   CORONARY CARE UNIT	503, 723		32. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	280, 697		35. 00
41. 00   04100   SUBPROVI DER - I RF	402, 502		41. 00
42. 00   04200   SUBPROVI DER	0		42.00
43. 00   04300   NURSERY	176, 829		43.00
ANCI LLARY SERVI CE COST CENTERS			
50. 00   05000   OPERATING ROOM	1, 756, 941		50. 00
50. 01   05001   CV   SURGERY	0		50. 01
51. 00   05100   RECOVERY ROOM	241, 855		51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 052, 259		52.00
53. 00   05300   ANESTHESI OLOGY	0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	703, 500		54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	707, 093		55.00
56. 00   05600   RADI 0I SOTOPE	0		56.00
57.00 05700 CT SCAN	68, 405		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	71, 289		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	251, 862		59. 00
60. 00 06000 LABORATORY	763, 489		60.00
64. 00 06400 I NTRAVENOUS THERAPY	0		64. 00
65. 00 06500 RESPI RATORY THERAPY	106, 193		65. 00
66. 00   06600 PHYSI CAL THERAPY	493, 236		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	103, 039		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	142, 869		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	281, 360		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	523, 791		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	744, 722		73. 00
73. 01   07302   OP   PHARMACY	0		73. 01
74. 00   07400   RENAL DI ALYSI S	46, 870		74. 00
75. 00   07500   ASC (NON-DISTINCT PART)	40, 670		75. 00
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o		75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	125, 587		76. 97
OUTPATIENT SERVICE COST CENTERS	125, 507		10. 11
90. 00   09000   CLINIC	285, 643		90. 00
90. 01   09001 OP ONCOLOGY INFUSION CENTER	160, 326		90. 00
90. 02   09002   WOUND CARE CENTER	160, 343		90. 01
90. 03   09003   PAIN CLINIC	90, 878		90. 02
90. 03   09003 PATN CLINIC 90. 05   09005   0P PSYCH CLINIC	303, 393		90. 03
91. 00   09100   EMERGENCY	1, 015, 881		90.05
	1,015,881		91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS			1∠. UU
94. 00 O9400 HOME PROGRAM DIALYSIS	0		94. 00
	- 1		
95. 00 09500 AMBULANCE SERVICES	565, 497		95.00
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0		00.00
101. 00 10100 HOME HEALTH AGENCY	0		01. 00
SPECIAL PURPOSE COST CENTERS			12 00
113. 00 11300   NTEREST EXPENSE			13.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF			14.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		15.00
116. 00 11600 HOSPI CE	0		16. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	17, 043, 510	1	18. 00
NONREI MBURSABLE COST CENTERS	,		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28, 233		90.00
190. 01 19001 PROMPTCARE	219, 378	1	90. 01

		5/27/2018 9:18 am
Cost Center Description	Total	
	26. 00	
190. 02 19002 RENTAL PROPERTI ES	455, 072	190. 02
190. 03 19003 OLCOTT	83, 798	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	190. 04
190. 05 19005 FOUNDATI ON	193, 711	190. 05
190. 06 19006 MARKETI NG	2, 653	190. 06
190. 07 19007 HME STORE	7, 955	190. 07
190. 08 19008 UNUSED SPACE	922, 560	190. 08
190. 09 19009 CLI NI CAL TRI ALS	23, 871	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	826, 510	190. 11
191. 00 19100 RESEARCH	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	192. 00
193. 00 19300 NONPALD WORKERS	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	194. 02
194. 03 07953 I U HEALTH SIP	405, 924	194. 03
194. 04 07954 HOME CARE	164, 208	194. 04
194. 05 07955 HOSPI CE	129, 252	194. 05
200.00 Cross Foot Adjustments	14, 631	200. 00
201.00 Negative Cost Centers	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	20, 521, 266	202. 00

	•	O HEALTH BLOOMIT		N 15 0051 5		Wassissian D. 1	
COST	ALLOCATION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2017	Worksheet B-1	
				1	o 12/31/2017		
		CAPITAL REL	ATED COSTS			5/27/2018 9:1	o alli
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQ FEET)	BENEFITS		& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2. 00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	944, 913					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	7, 034	923, 498 7, 034				2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	225, 745	225, 745	9, 030, 193		232, 844, 554	5. 00
7. 00	00700 OPERATION OF PLANT	113, 481	113, 481	2, 325, 402		12, 147, 093	1
8.00	00800 LAUNDRY & LINEN SERVICE	1, 609	1, 609	(	0	224, 182	8. 00
9.00	00900 HOUSEKEEPI NG	3, 487	3, 487			3, 347, 999	1
10.00	01000 DI ETARY	11, 165	11, 165				
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	6, 017 16, 823	6, 017 16, 823			.,,	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	5, 434	5, 434				
15.00	01500 PHARMACY	5, 194	5, 194		0	6, 294, 642	
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 110	6, 110	(	0	2, 869, 613	
18. 00	01850 SOCIAL SERVICES	0	0	(	0		
18. 01	01851 CENTRAL STERILIZATION	3, 110 205	3, 110	416, 356 277, 098			
23. 00	O2301   PARAMED ED PRGM-PHARMACY RESIDENCY   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	205	205	211, 098	8 0	391, 034	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	115, 619	115, 619	19, 062, 268	3 0	31, 809, 685	30.00
31.00		10, 276	10, 276			4, 581, 848	31. 00
32. 00	03200 CORONARY CARE UNIT	13, 464	13, 464				1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 825	6, 825				
41. 00	04100 SUBPROVI DER - I RF	12, 161	12, 161 0	853, 211			
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	4, 885	4, 885	812, 112			
43.00	ANCI LLARY SERVI CE COST CENTERS	4,000	4, 003	012, 112	-	1, 220, 334	1 43.00
50.00	05000 OPERATI NG ROOM	49, 115	49, 115	5, 121, 723	0	10, 439, 881	50.00
50. 01	05001 CV SURGERY	O	0	(	0		50. 01
51.00	05100 RECOVERY ROOM	3, 465	3, 465				
52. 00 53. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY	33, 443	33, 443	2, 720, 701	0	4, 571, 925 0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 838	20, 838	3, 204, 669			
55. 00	05500 RADI OLOGY-THERAPEUTI C	21, 964	21, 964	2, 204, 830		4, 498, 457	
56.00	05600 RADI OI SOTOPE	o	0	(	0	0	1
57. 00	05700 CT SCAN	1, 295	1, 295			1, 218, 292	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 941	1, 941	408, 725			
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	6, 478 17, 474	6, 478 17, 474		0	_, _,	
64. 00	06400 I NTRAVENOUS THERAPY	17,474	17, 474				1
	06500 RESPI RATORY THERAPY	1, 320	1, 320	1, 974, 702	0		
	06600 PHYSI CAL THERAPY	10, 006	10, 006	6, 617, 675	0	9, 372, 573	
67. 00		0	0	(	0	0	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2, 453	0 2, 453	880, 195	0	0 1, 243, 948	
70.00	07000 ELECTROCARDI OLOGY	4, 329	4, 329			1, 140, 065	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	o o	8, 644, 552	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	(	0	16, 094, 549	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	105, 415	0	20, 531, 759	1
73. 01	07302 OP PHARMACY	0	0	(	0	0	
74. 00 75. 00	07400   RENAL DI ALYSI S   07500   ASC (NON-DI STI NCT PART)	788	788			1, 182, 135 0	1
75. 00	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES		0			· -	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	3, 759	3, 759	643, 683			1
	OUTPATIENT SERVICE COST CENTERS		·				
90.00	09000 CLI NI C	9, 002	9, 002				
90. 01	09001 OP ONCOLOGY INFUSION CENTER	3, 376	3, 376			1, 730, 987	
90. 02	O9002   WOUND CARE CENTER   O9003   PAIN CLINIC	4, 670 3, 000	4, 670 3, 000	· ·		1, 128, 402 398, 410	
90. 05	09005 OP PSYCH CLINIC	9,000	9, 000				
91.00	09100 EMERGENCY	26, 478	26, 478				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	1 0				1 0	04.00
	09400   HOME PROGRAM DI ALYSIS   09500   AMBULANCE SERVI CES	14, 153	0 14, 153	5, 051, 733	0	7, 472, 366	
	10000   AMBULANCE SERVICES   10000   L&R SERVICES-NOT APPRVD PRGM	14, 133 N	14, 133 N	J, US 1, 733			100.00
	10100 HOME HEALTH AGENCY	l o	0				101.00
	SPECIAL PURPOSE COST CENTERS	- 1				-	
	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF			l	<u> </u>	l	114. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 

			1	0 12/31/201/	5/27/2018 9:1	
	CAPI TAL REI	ATED COSTS				
Cost Center Description	BLDG & FLXT	MVBLE EQUIP	   EMPLOYEE	Reconciliation	ADMI NI STDATI VE	
cost center bescription	(SQUARE FEET)	(SQ FEET)	BENEFITS	Reconciliation	& GENERAL	
	(SQUARE TELT)	(SQ TELT)	DEPARTMENT		(ACCUM. COST)	
			(GROSS		(1000	
			SALARI ES)			
	1. 00	2. 00	4. 00	5A	5. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	l ~	1	-		115. 00
116. 00 11600 HOSPI CE	0	0		0	-	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	816, 991	816, 991	95, 953, 810	-59, 051, 947	222, 534, 699	118. 00
NONREI MBURSABLE COST CENTERS	0.42	0.42	42.074		120 520	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	943			_	138, 530	
190. 01 19001  PROMPTCARE 190. 02 19002  RENTAL   PROPERTI ES	6, 436 16, 877			0	2, 026, 113 380, 494	
190. 03 19003 OLCOTT	2, 750			0	448, 042	
190. 04 19004 PHYSI CLAN RECRUITMENT	2,730	2,730		0		190. 03
190. 05 19005 FOUNDATION	6, 447	6, 447	l ~	0	994, 870	
190. 06 19006 MARKETI NG	0	0	0	0	124, 621	
190. 07 19007 HME STORE	0	O	264, 947	0	346, 499	
190. 08 19008 UNUSED SPACE	34, 232	34, 232	0	0	749, 532	190. 08
190. 09 19009 CLINI CAL TRI ALS	525	525	281, 445	0	381, 665	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	·	0		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	27, 408	27, 408	2, 077, 882	0	4, 180, 407	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193.00 19300 NONPAID WORKERS 194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0		193. 00 194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0		194. 00
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0		0	-	194. 01
194. 03 07953  IU HEALTH SIP	21, 415	0	0	0	300, 660	
194. 04 07954 HOME CARE	6, 093		Ö	0	133, 411	
194. 05 07955 HOSPI CE	4, 796			0	105, 011	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	13, 266, 281	7, 254, 985	26, 847, 331		59, 051, 947	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 039685	7. 855983			0. 253611	
204.00 Cost to be allocated (per Wkst. B,			154, 014		4, 956, 684	204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part			0 001522		0 021200	205 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 001533		0. 021288	205.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

COST A	ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2017	Worksheet B-1	
					Fo 12/31/2017		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/27/2018 9: 1 CAFETERI A	8 alli
	·	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	(MANHOURS)	
		7. 00	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS BLDG & FIXT						1. 00 2. 00
4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT	598, 653					7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	1, 609	1, 279, 790		,		8. 00 9. 00
10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 487 11, 165	22	4, 29			10.00
11. 00	01100 CAFETERI A	6, 017	0		0	3, 077, 702	
13.00	01300 NURSING ADMINISTRATION	16, 823	304		0	132, 637	1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY	5, 434	0		0	122 500	
16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	5, 194 6, 110	2, 287 0			122, 500 0	15. 00 16. 00
18. 00	01850 SOCI AL SERVI CES	0	Ö		o o	Ō	1
18. 01	01851 CENTRAL STERILIZATION	3, 110	11, 213	1	0	23, 821	1
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	205	0	(	0	6, 986	23. 00
30. 00	O3000 ADULTS & PEDI ATRI CS	115, 619	493, 609	1, 648	181, 172	745, 585	30.00
31. 00	03100   NTENSI VE CARE UNI T	10, 276	46, 318		17, 546	98, 451	
32.00	03200 CORONARY CARE UNIT	13, 464	36, 822		15, 219		
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 825	7, 576	l .	0	57, 288	
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	12, 161	24, 759 0	1		31, 466 0	1
43. 00	04300 NURSERY	4, 885	19, 201	84			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	49, 115	93, 842	1		164, 294	
50. 01 51. 00	05001 CV SURGERY 05100 RECOVERY ROOM	0 3, 465	0 114, 299			0 91, 714	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	33, 443	68, 595	1		90, 033	
53.00	05300 ANESTHESI OLOGY	0	0			0	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	20, 838	89, 755	i		110, 734	
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	21, 964	0			65, 711 0	1
57. 00	05700 CT SCAN	1, 295	0			20, 492	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 941	0		0	13, 329	
59. 00	05900 CARDI AC CATHETERI ZATI ON	6, 478	27, 284	l .	0	38, 205	1
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	17, 474	252	1	0	123, 444 0	60.00
65. 00	06500 RESPIRATORY THERAPY	1, 320	0			62, 505	
66.00	06600 PHYSI CAL THERAPY	10, 006	2, 525		0	200, 227	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2, 453	0		0	20, 600	68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	4, 329	0				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07302 OP PHARMACY	0	0	104	0 0	0	73. 00 73. 01
74. 00	07400 RENAL DI ALYSI S	788	0		1	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	Ö		o o	Ō	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	1	0	0	
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	3, 759	20, 185		0	20, 371	76. 97
90. 00	09000 CLINIC	9, 002	0		0	34, 044	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	3, 376	0	250		40, 502	
90. 02	1	4, 670	0			23, 961	
90. 03 90. 05	O9003   PAIN CLINIC   O9005   OP PSYCH CLINIC	3, 000 9, 000	0 220, 907	13!	1	7, 636 43, 006	
91. 00	09100 EMERGENCY	26, 478	220, 907	648		180, 276	
92.00	1 1						92. 00
	OTHER REIMBURSABLE COST CENTERS	1		1			
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	14, 153	0 35	1	0	0 230, 728	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	1			100.00
	10100 HOME HEALTH AGENCY	0	0	(	0	0	101. 00
110 00	SPECIAL PURPOSE COST CENTERS			1			1112 00
	11300 INTEREST EXPENSE  11400 UTILIZATION REVIEW-SNF	}					113. 00 114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	О		ol	О	115. 00
116.00	11600 HOSPI CE	0	0		0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	470, 731	1, 279, 790	4, 29	1 226, 686	2, 925, 631	118. 00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL	_	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-0051	Peri od:	Worksheet B-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre	narodi
				10 12/31/201/	5/27/2018 9:1	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE		(MEALS SERVED)	(MANHOURS)	
	(SQUARE FEET)	(POUNDS OF	SERVICE)		, ,	
		LAUNDRY)				
	7. 00	8. 00	9. 00	10.00	11. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	943	C	) (	0		190. 00
190. 01 19001 PROMPTCARE	6, 436		) (	0		190. 01
190. 02 19002 RENTAL PROPERTI ES	16, 877		) (	0		190. 02
190. 03 19003 OLCOTT	2, 750	) C	) (	0		190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	1	) (	0		190. 04
190. 05 19005 FOUNDATI ON	6, 447	'  C	) (	0		190. 05
190. 06 19006 MARKETI NG	0	) C	) (	0		190. 06
190.07 19007 HME STORE	0	) C	) (	0		190. 07
190. 08 19008 UNUSED SPACE	34, 232	e C	)	0 0	0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	525	C	) (	0		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	) C	)	0 0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	27, 408	C	)	0 0	83, 637	190. 11
191. 00 19100 RESEARCH	0	) C	)	0 0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	) C	)	0 0		192. 00
193.00 19300 NONPALD WORKERS	0	) C	)	0 0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	) C	)	0 0		194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	) C	)	0 0		194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	) C	)	0 0		194. 02
194.03 07953 IU HEALTH SIP	21, 415	C	)	0 0	0	194. 03
194.04 07954 HOME CARE	6, 093	C	)	0 0		194. 04
194. 05 07955 HOSPI CE	4, 796	C	)	0 0	0	194. 05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	15, 227, 729	321, 965	4, 285, 792	2, 310, 788	2, 411, 986	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I		•	1		0. 783697	
204.00 Cost to be allocated (per Wkst. B,	2, 746, 894	47, 385	166, 359	9 331, 330	199, 744	204. 00
Part II)	4 500450	0.00700/	20.7/222	1 4/4/05	0.0/4000	205 00
205.00 Unit cost multiplier (Wkst. B, Part	4. 588458	0. 037026	38. 76928!	1. 461625	0. 064900	205.00
206.00 NAHE adjustment amount to be allocate	4					206. 00
(per Wkst. B-2)	u					200.00
207.00 NAHE unit cost multiplier (Wkst. D,		1				207. 00
Parts III and IV)						207.00
	T .	1	1	1	1	1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am OTHER GENERAL SERVI CE Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCI AL SERVI CES ADMI NI STRATI ON SERVICES & (COSTED RECORDS & REQUIS.) (TIME SPENT) SUPPLY LI BRARY (DI RECT NURS. (COSTED (GROSS REQUISITIONS) CHARGES) HRS.) 15.00 18. 00 13.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 1, 452, 934 13.00 01400 CENTRAL SERVICES & SUPPLY 35, 387, 176 14.00 14.00 15.00 01500 PHARMACY 0 84, 131 21, 059, 097 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 1, 381, 989, 100 16.00 01850 SOCIAL SERVICES 0 18.00 18.00 01851 CENTRAL STERILIZATION 0 0 18.01 18.01 264, 310 15 0 23.00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 621, 414 1, 580, 289 174, 547 110, 499, 241 0 30.00 03100 INTENSIVE CARE UNIT 31.00 83.503 394.484 73.764 16, 263, 677 0 31.00 32.00 03200 CORONARY CARE UNIT 70, 717 218, 351 26, 752 12, 692, 647 0 32.00 02060 NEONATAL INTENSIVE CARE UNIT 52, 374 15, 999 12, 115, 793 35.00 35.00 208, 042 0 04100 SUBPROVIDER - IRF 41.00 28, 973 51, 290 1, 383 4, 669, 026 41.00 0 42.00 04200 SUBPROVI DER 0 42.00 04300 NURSERY 43.00 27, 357 69, 497 1, 290 4, 841, 088 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 91, 291 3, 983, 109 83, 622 196, 889, 625 0 50.00 05001 CV SURGERY 50.01 0 50.01 05100 RECOVERY ROOM 84, 388 65, 995 11, 349 29, 604, 389 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 70.212 316, 307 13, 551 35, 111, 417 0 52.00 05300 ANESTHESI OLOGY 53 00 Λ 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 976 187, 266 24.748 56, 490, 313 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 9, 289 433, 635 3,080 84, 641, 454 0 55.00 05600 RADI OI SOTOPE 56.00 56.00 0 27, 300, 845 05700 CT SCAN 135, 923 57.00 0 7, 120 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 13, 296 1, 156 10, 256, 829 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 26, 133 494, 972 10, 567 69, 622, 027 0 59.00 06000 LABORATORY 127, 697, 749 60 00 0 C 0 60 00 06400 INTRAVENOUS THERAPY 64.00 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 423, 482 11 12, 396, 354 0 65.00 66.00 06600 PHYSI CAL THERAPY 84 25, 418 9,590 28, 482, 733 0 66.00 06700 OCCUPATIONAL THERAPY 67 00 0 67 00 C 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 29, 903 2,896 21, 069, 992 69.00 69.00 8.711 0 70.00 07000 ELECTROENCEPHALOGRAPHY 50, 827 13, 592, 218 0 70.00 0 66 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 55, 768, 244 71.00 71 00 8, 644, 552 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 16, 094, 549 103, 635, 962 0 72.00 07300 DRUGS CHARGED TO PATIENTS 157, 222, 079 73.00 20, 378, 473 73.00 07302 OP PHARMACY 0 73.01 0 73.01  $\cap$ 07400 RENAL DIALYSIS 0 3, 788, 222 74.00 14, 476 5.659 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75.01 75 01 C 0 07697 CARDIAC REHABILITATION 9, 006 4.413 518 3, 415, 739 0 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 13, 149 19.758 1.952 2, 733, 803 0 90.00 09001 OP ONCOLOGY INFUSION CENTER 197, 749 15, 953, 288 90. 01 90.01 35.570 15, 125 0 09002 WOUND CARE CENTER 19, 833 81, 850 4, 703, 568 90 02 90.02 68 0 90.03 09003 PAIN CLINIC 3,618 20, 747 394 2, 131, 755 0 90.03 2, 919, 690 09005 OP PSYCH CLINIC 90.05 12, 934 720 90.05 09100 EMERGENCY 1,069,808 171, 980 112, 529, 791 91.00 91.00 154, 323 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 0 95.00 95.00 162, 145 22, 294 42, 949, 542 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 C 0 100, 00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE l113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am OTHER GENERAL SERVI CE MEDI CAL Cost Center Description NURSI NG CENTRAL PHARMACY SOCI AL ADMI NI STRATI ON (COSTED RECORDS & SERVI CES SERVICES & REQUIS.) LI BRARY (TIME SPENT) SUPPLY (DI RECT NURS. (COSTED (GROSS HRS.) REQUISITIONS) CHARGES) 13.00 14.00 15.00 16.00 18. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 1, 438, 262 35, 345, 887 21, 057, 969 1, 381, 989, 100 0 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 C 190. 01 19001 PROMPTCARE 28, 939 972 0 190. 01 4,606 190. 02 19002 RENTAL PROPERTIES 0 0 190. 02 190. 03 19003 OLCOTT 0 0 190. 03 1,054 158 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 190, 04 0 C 0 190. 05 190. 05 19005 FOUNDATI ON 0 0 0 190. 06 19006 MARKETI NG 0 0 0 0 190.06 190. 07 19007 HME STORE 0 0 0 190. 07 0 190.08 19008 UNUSED SPACE 0 0 190. 08 0 Ω 190. 09 19009 CLINICAL TRIALS 2,080 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 0 190. 11 6,932 12, 187 156 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 194.00|07950|IU HEALTH PAOLI HOSPITAL 0 0 194. 00 0 0 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 194. 01 0 0 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 194. 02 194. 03 07953 IU HEALTH SIP 0 194. 03 0 0 194. 04 07954 HOME CARE 0 0 0 194. 04 194. 05 07955 HOSPI CE 0 0 194. 05 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 12, 961, 772 8, 150, 544 3, 752, 796 0 202. 00 202.00 Cost to be allocated (per Wkst. B, 9, 184, 568 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 6. 321394 0.366284 0.387032 0.002716 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 607, 893 287, 423 222, 905 0 204. 00 361.676 Part II) 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0 418390 0.010221 0.013648 0.000161 II) 206.00 NAHE adjustment amount to be allocated 206.00

207. 00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 | Period: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/27/2018 9:18 am Provider CCN: 15-0051

						5/27/2018 9:18 am
			OTHER GENERAL			
			SERVI CE			
		Cost Center Description	CENTRAL	PARAMED ED		
			STERI LI ZATI ON			
			(TIME SPENT)	RESIDENCY (TIME SPENT)		
			18. 01	23. 00		
	GENER	AL SERVICE COST CENTERS				
1.00		CAP REL COSTS-BLDG & FIXT				1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP				2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 7. 00	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT				5. 00 7. 00
8.00		LAUNDRY & LINEN SERVICE				8.00
9. 00	1	HOUSEKEEPI NG				9. 00
10.00	1	DI ETARY				10. 00
11. 00	1	CAFETERI A				11. 00
13. 00		NURSI NG ADMI NI STRATI ON				13. 00
14.00		CENTRAL SERVICES & SUPPLY PHARMACY				14.00
15. 00 16. 00	1	MEDICAL RECORDS & LIBRARY				15. 00 16. 00
18. 00		SOCIAL SERVICES				18. 00
18. 01	1	CENTRAL STERILIZATION	3, 079			18. 01
23. 00	02301	PARAMED ED PRGM-PHARMACY RESIDENCY	0	100		23. 00
		IENT ROUTINE SERVICE COST CENTERS	T			
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	86	0		30. 00 31. 00
32.00		CORONARY CARE UNIT	0	0		32.00
35. 00	1	NEONATAL INTENSIVE CARE UNIT	35	0		35. 00
41.00		SUBPROVIDER - IRF	0	0		41. 00
42.00		SUBPROVI DER	0	0		42.00
43. 00		NURSERY	44	0		43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	2, 781	0		50. 00
50. 01		CV SURGERY	0	0		50. 01
51.00		RECOVERY ROOM	0	0		51.00
52.00	1	DELIVERY ROOM & LABOR ROOM	0	0	l .	52. 00
53.00	1	ANESTHESI OLOGY	0	0		53.00
54. 00 55. 00	1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	16	0	l .	54. 00 55. 00
56. 00	1	RADI OI SOTOPE	0	0	l .	56. 00
57.00	1	CT SCAN	0	0		57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
59.00		CARDI AC CATHETERI ZATI ON	23	0	l .	59.00
60. 00 64. 00	1	LABORATORY INTRAVENOUS THERAPY	0	0		60.00
65. 00	1	RESPI RATORY THERAPY	0	0		65. 00
66.00	1	PHYSI CAL THERAPY	14	0		66. 00
67. 00		OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00	1	SPEECH PATHOLOGY	0	0		68. 00
69. 00 70. 00		ELECTROCARDI OLOGY   ELECTROENCEPHALOGRAPHY	26 15		l .	69. 00 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	100		73. 00
73. 01		OP PHARMACY	0	0	1	73. 01
74. 00 75. 00	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0		74. 00 75. 00
75. 00		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	1	75. 01
76. 97	1	CARDIAC REHABILITATION	0	0		76. 97
		TIENT SERVICE COST CENTERS				
90.00		CLINIC	0	0		90.00
90. 01 90. 02		OP ONCOLOGY INFUSION CENTER WOUND CARE CENTER	0	0		90. 01
90. 02		PAIN CLINIC	1	0		90. 03
90. 05	4	OP PSYCH CLINIC	0	0		90. 05
91.00	1	EMERGENCY	15	0		91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS	0	0		94. 00
	1	AMBULANCE SERVICES	0	0		95. 00
		I &R SERVICES-NOT APPRVD PRGM	0	0	•	100. 00
101.00		HOME HEALTH AGENCY	0	0		101. 00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE				113. 00
	1	UTILIZATION REVIEW-SNF				114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00

				To	12/31/2017	Date/Time Prep	
		OTHER GENERAL				5/27/2018 9: 18	3 am
		SERVI CE					
Cost Center Descr	rintion	CENTRAL	PARAMED ED				
COST CONTEN DESCR		STERI LI ZATI ON					
		(TIME SPENT)	RESI DENCY				
		(112 01.2.11)	(TIME SPENT)				
		18. 01	23. 00				
116. 00 11600 HOSPI CE		0	0				116. 00
118.00 SUBTOTALS (SUM OF	- LINES 1 through 117)	3, 060	100				118. 00
NONREI MBURSABLE COST C							
190.00 19000 GIFT, FLOWER, COP	FEE SHOP & CANTEEN	0	0				190. 00
190. 01 19001 PROMPTCARE		1	0				190. 01
190. 02 19002 RENTAL PROPERTIES	S	0	0				190. 02
190. 03 19003 OLCOTT		0	0				190. 03
190. 04 19004 PHYSI CLAN RECRUIT	TMENT	0	0				190. 04
190. 05 19005 FOUNDATI ON		0	0				190. 05
190. 06 19006 MARKETI NG		0	0				190. 06
190.07 19007 HME STORE		0	0				190. 07
190.08 19008 UNUSED SPACE		0	0				190. 08
190. 09 19009 CLINICAL TRIALS		0	0				190. 09
190. 10 19010 MORGAN OP BEHAVIO		0	0				190. 10
190. 11 19011 COMMUNI TY HEALTH	SERVI CES	0	0				190. 11
191. 00 19100 RESEARCH		0	0				191. 00
192. 00 19200 PHYSI CLANS' PRI VA	ATE OFFICES	0	0				192. 00
193.00 19300 NONPALD WORKERS		0	0				193. 00
194.00 07950 IU HEALTH PAOLI H		0	0				194. 00
194. 01 07951 I U HEALTH BEDFORD		0	0				194. 01
194.02 07952 IU HEALTH MORGAN	HOSPI TAL	0	0				194. 02
194.03 07953 IU HEALTH SIP		18	0				194. 03
194.04 07954 HOME CARE		0	0				194. 04
194. 05 07955 HOSPI CE		0	0			•	194. 05
200.00 Cross Foot Adjust							200. 00
201.00 Negative Cost Cer							201. 00
202.00 Cost to be allocated Part I)	ated (per Wkst. B,	1, 095, 898	500, 895				202. 00
203.00 Unit cost multipl	ier (Wkst. B, Part I)	355. 926600	5, 008. 950000				203. 00
204.00 Cost to be allocated Part II)	ated (per Wkst. B,	102, 923	14, 631				204. 00
205.00 Unit cost multipl	ier (Wkst. B, Part	33. 427411	146. 310000				205. 00
206.00   II) NAHE adjustment a (per Wkst. B-2)	amount to be allocated		0				206. 00
207.00 NAHE unit cost mu	ultiplier (Wkst. D,		0. 000000				207. 00
Parts III and IV)	,	I	l			l	

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/27/2018 9:18 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 51, 924, 582 51, 924, 582 8.750 51, 933, 332 7, 022, 399 03100 INTENSIVE CARE UNIT 7, 022, 399 7, 022, 399 31.00 31.00 03200 CORONARY CARE UNIT o 32.00 5, 698, 504 5, 698, 504 5, 698, 504 32.00 02060 NEONATAL INTENSIVE CARE UNIT 4, 559, 270 4, 559, 270 35.00 4, 559, 270 0 35, 00 04100 SUBPROVIDER - IRF 41.00 2,888,609 2, 888, 609 0 2, 888, 609 41.00 42.00 04200 SUBPROVI DER 0 42.00 04300 NURSERY 1, 995, 710 1, 995, 710 1, 995, 710 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 18, 257, 319 18, 257, 319 0 18, 257, 319 50.00 50.01 05001 CV SURGERY 0 50.01 0 51.00 05100 RECOVERY ROOM 6, 071, 464 6, 071, 464 6, 071, 464 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 799, 643 7, 799, 643 7, 799, 643 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 7, 759, 825 54.00 7, 759, 825 0 7, 759, 825 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 6, 698, 135 6, 698, 135 6, 698, 135 55 00 56.00 05600 RADI OI SOTOPE Λ 56.00 57.00 05700 CT SCAN 1, 702, 955 1, 702, 955 1, 702, 955 57.00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1,069,910 1,069,910 1,069,910 58.00 05900 CARDIAC CATHETERIZATION 3, 515, 071 3 515 071 3, 515, 071 59 00 59 00 0 60.00 06000 LABORATORY 16, 913, 133 16, 913, 133 16, 913, 133 60.00 64.00 06400 INTRAVENOUS THERAPY 0 64.00 0 65 00 06500 RESPIRATORY THERAPY 3 676 634 3, 676, 634 3, 676, 634 65 00 06600 PHYSI CAL THERAPY 66.00 12, 257, 527 0 12, 257, 527 12, 257, 527 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 0 0 1, 779, 502 06900 ELECTROCARDI OLOGY 1, 779, 502 1, 779, 502 69 00 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 1,606,040 1, 606, 040 1, 606, 040 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 14, 154, 733 14, 154, 733 14, 154, 733 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26, 352, 970 26, 352, 970 26, 352, 970 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 34, 657, 747 34, 657, 747 34, 657, 747 73 00 73.01 07302 OP PHARMACY 0 73.01 0 07400 RENAL DIALYSIS 0 1, 519, 762 74.00 1, 519, 762 1, 519, 762 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 75.00 0 C 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75 01 0 0 75 01 07697 CARDIAC REHABILITATION 1, 363, 507 1, 363, 507 1, 363, 507 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2.534.071 90.00 2.534.071 0 2, 534, 071 09001 OP ONCOLOGY INFUSION CENTER 90.01 2, 889, 755 2, 889, 755 0 2, 889, 755 90 01 90.02 09002 WOUND CARE CENTER 1, 720, 297 1, 720, 297 0 1, 720, 297 90.02 90. 03 09003 PAIN CLINIC 618, 513 618, 513 0 618, 513 90.03

2, 925, 929

6, 096, 836

10, 092, 945

281, 580, 634

275, 483, 798

6, 096, 836

0

13, 457, 337

5,079

13, 829

13, 829

2, 931, 008

6, 096, 836

10, 092, 945

Λ 94 00

0 100.00

281, 594, 463 200. 00

275, 497, 627 202. 00

6, 096, 836 201. 00

13, 457, 337

90.05

91.00

92.00

95.00

0 101.00

113.00

114. 00

0 115, 00

0 116.00

2, 925, 929

13, 457, 337

6, 096, 836

10, 092, 945

281, 580, 634

275, 483, 798

6, 096, 836

C

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 $\cap$ 

09005 OP PSYCH CLINIC

09200 OBSERVATION BEDS (NON-DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

09400 HOME PROGRAM DIALYSIS

100.00 10000 I &R SERVICES-NOT APPRVD PRGM

SPECIAL PURPOSE COST CENTERS

115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

101.00 10100 HOME HEALTH AGENCY

114.00 11400 UTI LI ZATI ON REVI EW-SNF

113. 00 11300 | INTEREST EXPENSE

116. 00 11600 HOSPI CE

90.05

91.00

92.00

94 00

200.00

201.00

202.00

COMPUT	COMPUTATION OF RATIO OF COSTS TO CHARGES				From 01/01/2017 To 12/31/2017	Part I Date/Time Prepared: 5/27/2018 9:18 am	
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	86, 745, 756		86, 745, 75	5		30. 00
31.00	03100 INTENSIVE CARE UNIT	16, 263, 677		16, 263, 67	7		31.00
32.00	03200 CORONARY CARE UNIT	12, 692, 647		12, 692, 64	7		32. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	12, 115, 793		12, 115, 79	3		35.00
41.00	04100 SUBPROVI DER - I RF	4, 669, 026		4, 669, 02	5		41.00
42.00	04200 SUBPROVI DER	0			)		42.00
43.00	04300 NURSERY	4, 841, 088		4, 841, 08	3		43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	84, 664, 379	112, 225, 246	196, 889, 62		0. 000000	1
50. 01	05001 CV SURGERY	0	0	1	0. 000000	0. 000000	1
51. 00	05100 RECOVERY ROOM	8, 798, 095	20, 806, 294			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	31, 554, 418	3, 556, 999	35, 111, 41		0. 000000	1
53. 00	05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 131, 470	40, 358, 843			0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	3, 501, 197	81, 140, 257	1		0.000000	
56. 00	05600 RADI OI SOTOPE	0 105 000	0		0.000000	0.000000	
57. 00	05700 CT SCAN	8, 185, 389	19, 115, 456			0.000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 505, 919	7, 750, 910			0.000000	1
59.00	05900 CARDI AC CATHETERI ZATI ON	25, 646, 583	43, 975, 444			0.000000	1
60.00	06000 LABORATORY	48, 898, 088	78, 799, 661	1		0.000000	
64.00	06400 I NTRAVENOUS THERAPY	10 114 224	2 202 110		0.000000	0.000000	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	10, 114, 236	2, 282, 118			0. 000000 0. 000000	1
67. 00	06700 OCCUPATIONAL THERAPY	12, 709, 464	15, 773, 269	1	0. 430349 0. 000000	0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0.000000	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	10, 472, 183	10, 597, 809	21, 069, 99		0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 909, 097	11, 683, 121			0. 000000	1
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 291, 479	33, 476, 765			0. 000000	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	67, 228, 288	36, 407, 674			0. 000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	75, 229, 945	81, 992, 134			0. 000000	
73. 00	07302 OP PHARMACY	75,227,745	01, 772, 104	137, 222, 07	0.000000	0. 000000	1
74. 00	07400 RENAL DI ALYSI S	2, 785, 615	1, 002, 607	3, 788, 22		0. 000000	1
75. 00	07500 ASC (NON-DISTINCT PART)	2, 700, 010	1, 002, 007	0, 700, 22		0. 000000	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0. 000000	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	420, 001	2, 995, 738	3, 415, 73		0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	22, 733	2, 711, 070	2, 733, 80	0. 926940	0. 000000	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	1, 034, 430	14, 918, 858	15, 953, 28	0. 181139	0.000000	90. 01
90. 02	09002 WOUND CARE CENTER	10, 976	4, 692, 592	4, 703, 56	0. 365743	0.000000	90. 02
90. 03	09003 PAIN CLINIC	1, 247	2, 130, 508	2, 131, 75	0. 290143	0.000000	90. 03
90.05	09005 OP PSYCH CLINIC	5, 374	2, 914, 316			0.000000	90. 05
91.00	09100 EMERGENCY	24, 013, 482	88, 516, 309	112, 529, 79	0. 119589	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 400, 208	21, 353, 277	23, 753, 48	0. 256671	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	1	0.000000	0. 000000	1
	09500 AMBULANCE SERVICES	122, 075	42, 827, 467	42, 949, 54	0. 234995	0. 000000	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	1	)		100. 00
101.00	10100 HOME HEALTH AGENCY	0	0		)		101. 00
440.5	SPECIAL PURPOSE COST CENTERS			1			140.00
	11300   INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF	_	-				114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)		0				115. 00
	11600 HOSPI CE	E07 004 350	794 004 740	1 201 000 10			116. 00
200. 00 201. 00		597, 984, 358	704,004,742	1, 381, 989, 10	ا		200. 00 201. 00
201.00		597, 984, 358	784 004 742	1, 381, 989, 10	ا		201.00
202.00	Total (See That detrons)	377, 704, 330	704,004,742	1,301,707,10	- I		1202.00

5/27/2018 9:18 am Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 32.00 03200 CORONARY CARE UNIT 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.092729 50.00 05001 CV SURGERY 50.01 0.000000 50.01 05100 RECOVERY ROOM 51.00 0. 205087 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 222140 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.137366 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.079135 55.00 05600 RADI OI SOTOPE 0.000000 56.00 56.00 57.00 05700 CT SCAN 0.062377 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 0.104312 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.050488 59.00 06000 LABORATORY 60.00 0.132447 60.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0. 296590 65.00 66.00 06600 PHYSI CAL THERAPY 0. 430349 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.084457 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 118159 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 253813 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 254284 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 220438 73.00 07302 OP PHARMACY 73. 01 0.000000 73.01 74 00 07400 RENAL DIALYSIS 0 401181 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 75.00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 75.01 07697 CARDIAC REHABILITATION 76. 97 0. 399184 76. 97 OUTPATIENT SERVICE COST CENTERS 0. 926940 90.00 09000 CLI NI C 90.00 09001 OP ONCOLOGY INFUSION CENTER 90. 01 0. 181139 90.01 90 02 09002 WOUND CARE CENTER 0.365743 90.02 09003 PAIN CLINIC 90.03 0.290143 90.03 90.05 09005 OP PSYCH CLINIC 1.003876 90.05 91.00 09100 EMERGENCY 0.119589 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 256671 92 00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 95. 00 09500 AMBULANCE SERVICES 0. 234995 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00

115.00

116.00

200. 00

201. 00

202.00

116. 00 11600 HOSPI CE

200.00

201.00

202.00

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

MPAT SMT ROUTINE SERVICE COST CENTERS	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/27/2018 9:1	pared: 8 am	
Cost Center Description				Ti tl	e XIX			
NPATI ENT ROUTI NE SERVICE COST CENTERS   1,00   2,00   3,00   4,00   5,00		Cost Center Description	(from Wkst. B, Part I, col.		Total Costs	RCE	Total Costs	
IMPAIL FOR TROUTIES SERVICE COST CENTERS   1,924,582   1,924,582   3,750   1,933,332   30   03   30   00   3030 QUBUES & PEDIA TRICS   5,098,504   5,098,504   5,098,504   3,009   3,000   3,000 QUBONARY CARE UNIT   7,022,399   7,022,399   0,7022,399   31 00   3,000 QUBONARY CARE UNIT   4,559,270   4,559,270   0,4559,270   35 00   4,559,270   0,4559,270   0,4559,270   35 00   4,559,270   35 00   4,559,270   0,4559,270				2.00	3. 00	4. 00	5. 00	
31.00   03100   INTENSI VE CARE UNIT   7,022,390   7,022,390   0   7,022,390   31.00   32.00   03200   CRINARY CARE UNIT   5,698,504   5,698,504   0   5,698,504   32.00   32.00   32.00   03200   CRINARY CARE UNIT   4,559,270   4,559,270   0   4,559,270   32.00   32.00   32.00   32.00   03200   CRINARY CARE UNIT   4,559,270   2,888,609   0   2,888,6		INPATIENT ROUTINE SERVICE COST CENTERS						
32.00   03200 (CORDMARY CARE UNIT   5,608,504   5,698,504   0   5,698,504   32.00   10.00   04.00 (April Corporation Control								1
35.00   2000   MEDMATAL INTERSIVE CARE UNIT   4,559,270   4,559,270   0   4,559,270   37.00   20.00   20.00   20.00   20.00   20.00   0   0   0   0   0   0   0   0   0								1
1.0   0.4100   SUBPROVIDER - IFF   2.888,600   2.888,600   0. 2.888,600   4.1   0.0   4.20   0.420								1
A2 00   04200   MISSERY   0   0   0   0   0   0   0   20.00   0   0   0   0   0   0   0   0   0								1
33.00   0.4500   NURSERY   1, 995, 710   1, 995, 710   0   1, 995, 710   43.00			1					
## ANCIL LARY SERVICE COST CENTERS  50. 00   05000   05000   05000   05000   0		l l	1			-		•
50.01   05001   CV SURGERY   0   0   0   0   0   0   0   0   0								
15.1 0.0   05100   RECOVERY ROOM   6.071, 464   0.6,071, 464   0.6,071, 464   0.53.00   05200   DELYCERY ROOM & LABOR ROOM   7,799, 463   7,799, 643   7,799, 6			1					
1.00   0.520.0   0.520.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.54.0   0.55.0   0			1			-		ł
53.00   05300   ARSTHESI OLOCY   0   0   0   0   53.00								
54. 00   05400   ARDIOLOGY-DIAGNOSTIC   7, 759, 825   7, 759, 825   0, 7, 759, 825   50. 00   550. 00   05600   ARDIOLOGY-THERAPEUTIC   6, 698, 135   50. 00   0   0   0   56. 00   56. 00   05600   ARDIOLOGY-THERAPEUTIC   6, 698, 135   50. 00   0   0   56. 00   0   0   56. 00   0   0   56. 00   0   0   56. 00   0   0   56. 00   0   0   56. 00   0   0   56. 00   0   0   56. 00   0   57. 00   05700   CT SCAN   1, 702, 955   51. 00   0   0   0   0   0   0   0   0   0			1					
55.00   OSGOO   RADIO LOGY-THERAPEUTIC   6, 698, 135   6, 698, 135   0   6, 698, 135   55.00   57.00   OSGOO   RADIO LOGY-THERAPEUTIC   0   0   0   0   56.00   OSGOO   RADIO LOGY-THERAPEUTIC   RESONANCE IMAGING (MRI )   1,702, 955   1,702, 955   0, 1,702, 955   57.00   OSGOO   OSGOO   AGROPEIT CRESONANCE IMAGING (MRI )   1,009, 910   1,009, 910   0   1,009, 910   0   1,009, 910   0   1,009, 910   0   1,009, 910   0   0   0   0   0   0   0   0   0			-			ຶ່ງ		1
1, 702, 955   1, 702, 955   1, 702, 955   1, 702, 955   0   1, 702, 955   7, 00   850, 00   0, 00								ł
SB. 00   OSBOO   MAGNETIC RESONANCE I MAGING (MRI)   1,069,910   1,069,910   0,000	56.00	05600 RADI OI SOTOPE	0			o o	0	56. 00
59.00   0.00								
0.0   0.0								1
64.00   06400   INTRAVENDUS THERAPY   3, 676, 634   0   3, 676, 634   0   3, 676, 634   65.00   65.00   06500   RESPIRATORY THERAPY   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   12, 257, 527   0   10, 00   0   0   0   0   0   0   0   0			1					1
65.00   06500   RESPI RATORY THERAPY   3,676,634   0   3,676,634   0   3,676,634   65.00   66.00   06600   PHYSI CAL THERAPY   12,257,527   0   12,257,527   0   12,257,527   0   12,257,527   0   12,257,527   0   67.00   68.00   06800   OSCUPATI ONAL THERAPY   0   0   0   0   0   0   0   0   0								•
66.00   06600   PAYSI CAL THERAPY   12, 257, 527   0   12, 257, 527   0   06700   0COUPATI ONAL THERAPY   0   0   0   0   0   0   0   0   0			-	0		۳ <sub>ا</sub> ۳ <sub>ا</sub>		•
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   1,779,502   1,779,502   0   1,779,502   69. 00   70. 00   07000   ELECTROCARDI OLOGY   1,606,040   1,606,040   0   0   0   0   0   0   0   0   0								1
69.00   06900   06900   06900   06900   06900   06900   06900   06900   06900   0690000   0690000   0690000   0690000   0690000   06900000000   0690000000000			1 ' ' 1	0				1
70. 00 07000   ILECTROENCEPHALLOGRAPHY   1,606,040   1,606,040   0   1,606,040   70.00   71. 00 07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   14,154,733   14,154,733   0   14,154,733   71.00   72. 00 07300   DRUGS CHARGED TO PATIENTS   26,352,970   26,352,970   0   26,352,970   72.00   73. 00 07300   DRUGS CHARGED TO PATIENTS   34,657,747   34,657,747   0   34,657,747   73.00   73. 01 07302   DP PHARMACY   0   0   0   0   0   0   74. 00 07400   RENAL DIALYSIS   1,519,762   1,519,762   0   1,519,762   74.00   75. 00 07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   75.00   75. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   75. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   75. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   76. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   76. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   0   76. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   76. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   0   76. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   0   76. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   76. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   76. 01 07500   ASC (NON-DISTINCT PART)   0   0   0   76. 02 07000   CLINIC   0   0   0   76. 03 07000   CLINIC   0   0   0   76. 04 07000   0   0   0   76. 07000   0   0   0   0   76. 07000   0   0	68. 00	06800 SPEECH PATHOLOGY	0	0		o o	0	68. 00
171.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   14, 154, 733   14, 154, 733   0   14, 154, 733   71.00     72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   26, 352, 970   26, 352, 970   72.00     73.00   07300   DRUGS CHARGED TO PATIENTS   26, 352, 970   20, 34, 657, 747   0   34, 657, 747     73.01   07302   DR PHARMACY   0   0   0   0   0   0   73.01     74.00   07400   RENAL DI ALYSIS   1,519, 762   1,519, 762   0   0   0   0   0   75.00     75.00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   75.00     75.01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   75.01     76.97   07967   CARDIA CREMBAIL LITATION   1,363, 507   0   1,363, 507     70.00   07900   DRUGOLOGY INFUSION CENTER   2,889, 755   2,889, 755   0   2,889, 755   0   0     90.01   099001   DP DNCOLOGY INFUSION CENTER   2,889, 755   2,289, 755   0   2,889, 755   0   0     90.02   09002   WOUND CARE CENTER   1,720,297   1,720,297   0   1,720,297   90.03     90.03   09003   DP SYCHI LINI C   618,513   618,513   0   618,513   0   0     90.05   099050   DP SYCH CLINI C   2,925,929   2,925,929   5,079   2,931,008   90.05     91.00   09100   DERROENCY   13,457,337   13,457,337   13,457,337   0   13,457,337   91.00     90.01   09900   DERROENCY   13,457,337   13,457,337   13,457,337   0   13,457,337   91.00     90.02   09900   09800   DERROENCY   0   0   0   0     90.01   09900   MBULANCE SERVICES   0   0   0   0     00.01   0000   18R SERVATION BEDS (NON-DISTINCT PART)   0   0   0   0     00.01   0000   18R SERVICES NOT APPRVD PRGM   0   0   0   0     00.01   0000   18R SERVICES NOT APPRVD PRGM   0   0   0   0     00.01   0000   18R SERVICES NOT APPRVD PRGM   0   0   0   0     01.00   01000   10000								1
72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   26, 352, 970   26, 352, 970   0   26, 352, 970   72. 00   73. 01   07302   DRUGS CHARGED TO PATIENTS   34, 657, 747   34, 657, 747   0   34, 657, 747   73. 01   07302   DP PHARMACY   0   0   0   0   0   0   0   0   73. 01   74. 00   07400   RENAL DI ALYSIS   1, 519, 762   1, 519, 762   1, 519, 762   0   1, 519, 762   74. 00   75. 00   0   0   0   0   0   0   0   0   0								
73. 00   07300   DRUGS CHARGED TO PATIENTS   34, 657, 747   0   0   34, 657, 747   73. 00   73. 01   07300   0   0   0   0   0   0   0   0   73. 01   73. 01   07300   0   0   0   0   0   0   0   0   0						-		
73. 01   07302   OP PHARMACY   O   O   O   O   O   73. 01   74. 00   O7400   RENAL DIALYSIS   1,519,762   1,519,762   0   1,519,762   0   75. 00   07500   ASC (NON-DISTINCT PART)   O   O   O   O   O   75. 01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   O   O   O   O   O   76. 97   O7697   CARDI AC REHABILI TATI ON   1,363,507   O   1,363,507    90. 00   O9000   CLI NI C   O   O   O   O   O   90. 00   O9000   CLI NI C   O   O   O   O   90. 01   O9001   PONCOLOGY INFUSI ON CENTER   D   O   O   90. 02   O9002   WOUND CARE CENTER   O   O   O   O   90. 03   O9003   PAIN CLI NI C   O   O   O   90. 04   O9005   OP PSYCH CLI NI C   O   O   O   90. 05   O9005   OP PSYCH CLI NI C   O   O   O   90. 00   O9000   OP PSYCH CLI NI C   O   O   O   91. 00   O9000   OP PSYCH CLI NI C   O   O   O   92. 00   O9000   OBSERVATI ON BEDS (NON-DISTI NCT PART)   O   O9000   O   O   O   95. 00   O9500   OBSERVATI ON BEDS (NON-DISTI NCT PART)   O   O   O   O   95. 00   O9500   OF OSO   OF OSO   OF OSO   OF OSO   OF OSO   O   95. 00   O9500   OF OSO   OF OSO   OF OSO   OF OSO   O   96. 00   O9500   OF OSO   OF OSO   OF OSO   O   O   O   97. 00   OF OSO   OF OSO   O   O   O   O   98. 00   OF OSO   OF OSO   OF OSO   O   O   O   99. 00   OF OSO   OF OSO   OF OSO   O   O   O   99. 00   OF OSO   OF OSO   O   O   O   99. 00   OF OSO   OF OSO   OF OSO   O   O   O   99. 00   OF OSO   OF OSO   OF OSO   O   O   O   99. 00   OF OSO   OF OSO   OF OSO   O   O   O   99. 00   OF OSO   OF OSO   OF OSO   O   O   O   99. 00   OF OSO   OF OSO   OF OSO   OF OSO   OF OSO   OF OSO   O   99. 00   OF OSO   OF OSO   OF OSO   OF OSO   O   O   O   99. 00   OF OSO   OSO   OSO   OSO   OSO   OSO   OSO								1
74. 00   07400   RENAL DI ALYSIS   1,519,762   1,519,762   0   1,519,762   74. 00   75. 00   75. 00   0.0			0		0 1, 00 7, 7 1	ol ol		•
75. 01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   75. 01     76. 97   O7697   CARDIJAC REHABILITATION   1,363,507   0   1,363,507     70. 90   07090   CLINIC   2,534,071   2,534,071   0   2,534,071     90. 00   09001   0P ONCOLOGY INFUSI ON CENTER   2,889,755   2,889,755   0   2,889,755     90. 00   09002   WOUND CARE CENTER   1,720,297   1,720,297   0   1,720,297   0   0,720,297     90. 03   09003   PAIN CLINIC   618,513   618,513   0   618,513   0   618,513     90. 05   09005   OP PSYCH CLINIC   2,925,929   2,925,929   5,079   2,931,008     91. 00   09100   EMERGENCY   13,457,337   13,457,337   0   13,457,337   91.00     92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   6,096,836   6,096,836   6,096,836     09400   HOME PROGRAM DIALYSIS   0   0   0   0   0   0     95. 00   09500   AMBULANCE SERVI CES   10,092,945   10,092,945   0   10,000,00     100. 00   10000   LAB SERVI CES NOT APPRVD PRGM   0   0   0   0   0     101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   115.00     115. 00   11400   UTI LI ZATI ON REVIEW-SNF   114. 00     115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   0   0   0   0   115.00     116. 00   1000   Less Observation Beds   6,096,836   6,096,836   6,096,836   6,096,836   0,096,836   0,000,			1, 519, 762		1, 519, 76	2 0	1, 519, 762	
76. 97   07697   CARDI AC REHABILITATION   1, 363, 507   1, 363, 507   0   1, 363, 507   76. 97			0			ຶ່ງ ທ		1
OUTPATI ENT SERVICE COST CENTERS   OUTPATI ENT SERVICE COST CENTERS   OUTPATI ENT SERVICE COST CENTERS   OUTPATI ENT SERVICE COST CENTERS   OUTPATI ENT SERVICE COST CENTER   OUTPATI ENT SERVICE COST CENTERS   OUTPATI ENT SERVICE COST CENTER   OUTPATI ENT SERVICE COST COST CENTER   OUTPATI ENT SERVICE COST COST CENTER   O			-1			-		1
90. 00	76. 97		1, 363, 507		1, 363, 50	7  0	1, 363, 507	76. 97
90. 01	90 00		2 534 071		2 534 07	1 0	2 534 071	90 00
90. 02								1
90. 05								1
91. 00   09100   EMERGENCY   13, 457, 337   0   13, 457, 337   0   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   6, 096, 836   6, 096, 836   6, 096, 836   92. 00								
92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   6, 096, 836   6, 096, 836   6, 096, 836   92. 00								1
OTHER REIMBURSABLE COST CENTERS  94. 00								1
94. 00	92.00	,	6, 096, 836		6, 096, 83	6	6, 096, 836	92.00
95. 00   09500   AMBULANCE SERVI CES   10, 092, 945   10, 092, 945   0   10, 092, 945   95. 00   100. 00   10000   1&R SERVI CES-NOT APPRVD PRGM   0   0   0   100. 00   100. 00   101. 00   10100   HOME HEALTH AGENCY   0   0   0   101. 0	94 00						0	94 00
100. 00   10000   1 &R SERVI CES-NOT APPRVD PRGM   0   0   100. 00   101. 00			1					1
101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   1011. 00			1					
113. 00   114. 00   114. 00   114. 00   115. 00   115. 00   115. 00   116. 00   116. 00   116. 00   116. 00   200. 00   Subtotal (see instructions)   281, 580, 634   201. 00   113. 00   114. 00   114. 00   115. 00   0		10100 HOME HEALTH AGENCY	0			0	0	101. 00
114.00			1		1	1		
115.00   115								
116. 00     116.00       200. 00     Subtotal (see instructions)     281, 580, 634     0       201. 00     Less Observation Beds     6, 096, 836     6, 096, 836							0	
200. 00     Subtotal (see instructions)     281, 580, 634     0     281, 580, 634     13, 829     281, 594, 463     200. 00       201. 00     Less Observation Beds     6, 096, 836     6, 096, 836     6, 096, 836     6, 096, 836						ŏ I		
201.00 Less Observation Beds 6,096,836 6,096,836 6,096,836 6,096,836			281, 580, 634	0	281, 580, 63	4 13, 829		1
202.00   Total (see instructions)   275, 483, 798  0  275, 483, 798  13, 829  275, 497, 627 202.00		Less Observation Beds	6, 096, 836		6, 096, 83	6	6, 096, 836	201. 00
	202. 00	Total (see instructions)	275, 483, 798	0	275, 483, 79	8  13, 829	275, 497, 627	202. 00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/27/2018 9:18 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 86, 745, 756 03000 ADULTS & PEDIATRICS 86, 745, 756 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 263, 677 16, 263, 677 31.00 03200 CORONARY CARE UNIT 12, 692, 647 32.00 12, 692, 647 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 12, 115, 793 12, 115, 793 35.00 04100 SUBPROVIDER - IRF 41.00 4, 669, 026 4, 669, 026 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 4, 841, 088 4, 841, 088 43 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 84, 664, 379 112, 225, 246 196, 889, 625 0 092729 0.000000 50.00 50.01 05001 CV SURGERY 0.000000 0.000000 50.01 51.00 05100 RECOVERY ROOM 8, 798, 095 20, 806, 294 29, 604, 389 0.205087 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 3, 556, 999 0.000000 52.00 31, 554, 418 35, 111, 417 0.222140 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 16, 131, 470 40, 358, 843 56, 490, 313 0. 137366 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 501, 197 81, 140, 257 84, 641, 454 0.079135 0.000000 55.00 05600 RADI OI SOTOPE 0.000000 56,00 0.000000 56,00 57.00 05700 CT SCAN 8, 185, 389 19, 115, 456 27, 300, 845 0.062377 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 505, 919 7, 750, 910 10, 256, 829 58.00 0.104312 0.000000 58.00 05900 CARDIAC CATHETERIZATION 43, 975, 444 0.050488 0.000000 59.00 25, 646, 583 69, 622, 027 59.00 60.00 06000 LABORATORY 48, 898, 088 78, 799, 661 127, 697, 749 0.132447 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 10, 114, 236 2, 282, 118 12, 396, 354 0. 296590 0.000000 65.00 12, 709, 464 06600 PHYSI CAL THERAPY 15, 773, 269 28, 482, 733 0 430349 0 000000 66 00 66 00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0.000000 67.00 C 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 10, 472, 183 10, 597, 809 21, 069, 992 0.084457 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 909, 097 13, 592, 218 70.00 11, 683, 121 0.118159 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 22, 291, 479 33, 476, 765 55, 768, 244 0. 253813 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 67, 228, 288 36, 407, 674 103, 635, 962 0.254284 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 75, 229, 945 81, 992, 134 157, 222, 079 0 220438 0.000000 73 00 07302 OP PHARMACY 73.01 0.000000 0.000000 73.01 07400 RENAL DIALYSIS 2, 785, 615 1,002,607 3, 788, 222 0.401181 0.000000 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75 01 0 0.000000 0.000000 75 01 07697 CARDIAC REHABILITATION 420,001 0.399184 0.000000 76.97 2, 995, 738 3, 415, 739 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 22, 733 2, 711, 070 2, 733, 803 0.926940 0.000000 90.00 09001 OP ONCOLOGY INFUSION CENTER 0.181139 90 01 14, 918, 858 15, 953, 288 90 01 1.034.430 0.000000 90.02 09002 WOUND CARE CENTER 10, 976 4, 692, 592 4, 703, 568 0.365743 0.000000 90.02 90.03 09003 PAIN CLINIC 1, 247 2, 130, 508 2, 131, 755 0.290143 0.000000 90.03 09005 OP PSYCH CLINIC 2, 919, 690 90.05 5.374 2, 914, 316 1.002137 0.000000 90.05

24.013.482

2, 400, 208

122,075

88, 516, 309

21, 353, 277

42, 827, 467

112, 529, 791

23, 753, 485

42, 949, 542

0.119589

0.256671

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91 00

92.00

94.00

95.00

91.00

92.00

94.00

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS
09400 HOME PROGRAM DIALYSIS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | Date/Time Prepared: | 5/27/2018 9:18 am | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Period: | Per

			Title XIX	Hospi tal	PPS	_
	Cost Center Description	PPS Inpatient				
	·	Ratio				
		11.00				
IN	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS				30.0	00
31. 00   03	3100 INTENSIVE CARE UNIT				31.0	00
32. 00   03	3200 CORONARY CARE UNIT				32.0	00
35. 00   02	2060 NEONATAL INTENSIVE CARE UNIT				35. C	00
41.00 04	4100 SUBPROVI DER - I RF				41.0	00
42. 00 04	4200 SUBPROVI DER				42.0	00
43.00 04	4300 NURSERY				43.0	00
AN	NCILLARY SERVICE COST CENTERS					
50.00 05	5000 OPERATING ROOM	0. 092729			50.0	00
50. 01 05	5001 CV SURGERY	0. 000000			50.0	01
51.00 05	5100 RECOVERY ROOM	0. 205087			51.0	00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0. 222140			52.0	00
53.00 05	5300 ANESTHESI OLOGY	0. 000000			53.0	00
54. 00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 137366			54.0	00
55. 00 05	5500 RADI OLOGY-THERAPEUTI C	0. 079135			55. C	00
56. 00 05	5600 RADI 0I S0T0PE	0. 000000			56.0	00
	5700 CT SCAN	0. 062377			57. 0	00
58. 00   05	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 104312			58.0	00
	5900 CARDI AC CATHETERI ZATI ON	0. 050488			59. 0	00
60.00 06	6000 LABORATORY	0. 132447			60.0	00
64. 00   06	6400 INTRAVENOUS THERAPY	0. 000000			64. 0	00
65. 00 06	6500 RESPIRATORY THERAPY	0. 296590			65.0	00
66. 00 06	6600 PHYSI CAL THERAPY	0. 430349			66.0	00
67. 00 06	6700 OCCUPATIONAL THERAPY	0. 000000			67. 0	00
	6800 SPEECH PATHOLOGY	0. 000000			68.0	00
69. 00 06	6900 ELECTROCARDI OLOGY	0. 084457			69. 0	00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	0. 118159			70.0	00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 253813			71. 0	00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 254284			72. 0	00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	0. 220438			73. 0	00
73. 01 07	7302 OP PHARMACY	0. 000000			73. 0	01
74. 00 07	7400 RENAL DIALYSIS	0. 401181			74. 0	00
75. 00 07	7500 ASC (NON-DISTINCT PART)	0. 000000			75. 0	00
75. 01 03	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			75. 0	01
76. 97 07	7697 CARDIAC REHABILITATION	0. 399184			76. 9	97
	JTPATIENT SERVICE COST CENTERS	·				
	9000 CLI NI C	0. 926940			90.0	00
	9001 OP ONCOLOGY INFUSION CENTER	0. 181139			90.0	
	9002 WOUND CARE CENTER	0. 365743			90.0	02
	9003 PAIN CLINIC	0. 290143			90.0	03
	9005 OP PSYCH CLINIC	1. 003876			90.0	
1	9100 EMERGENCY	0. 119589			91. 0	00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 256671			92. 0	
	THER REIMBURSABLE COST CENTERS					
	9400 HOME PROGRAM DIALYSIS	0. 000000			94.0	00
	9500 AMBULANCE SERVICES	0. 234995			95. C	
	0000 I&R SERVICES-NOT APPRVD PRGM				100. 0	
	0100 HOME HEALTH AGENCY				101. 0	
	PECIAL PURPOSE COST CENTERS					-
	1300 I NTEREST EXPENSE				113. 0	00
	1400 UTI LI ZATI ON REVI EW-SNF	1			114. 0	
	1500 AMBULATORY SURGICAL CENTER (D. P.)	1			115. 0	
	1600 HOSPI CE	1			116. 0	
200. 00	Subtotal (see instructions)	1			200. 0	
201.00	Less Observation Beds	1			201. 0	
202. 00	Total (see instructions)	1			202. 0	
1		1			, , , ,	

Health Financial Systems

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

I U HEALTH BLOOMINGTON HOSPITAL RATIOS NET OF Provider CO In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am Provider CCN: 15-0051

					'	0 12/01/201/	5/27/2018 9:1	8 am
				Ti t	le XIX	Hospi tal	PPS	
		Cost Center Description	Total Cost		Operating Cost		Operating Cost	
		,			t Net of Capital		Reduction	
			I, col. 26)	11 col. 26)	Cost (col. 1 -		Amount	
			1, 3011 20)	11 0011 20)	col . 2)		7 0	
			1.00	2. 00	3.00	4. 00	5. 00	
	ANCLLI	_ARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00		OPERATING ROOM	18, 257, 319	1, 756, 94	1 16, 500, 378	0	0	50. 00
50. 00		CV SURGERY	10, 237, 317		0 10, 300, 370		-	
51. 00		RECOVERY ROOM	6, 071, 464	241, 85	-1		0	51.00
52. 00	1 1		1		1		0	
53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESI OLOGY	7, 799, 643	1, 052, 25	9 6, 747, 384 0 0		0	
54. 00		RADI OLOGY-DI AGNOSTI C	7, 759, 825		-1	0	0	54.00
55. 00			1		1		0	
		RADI OLOGY-THERAPEUTI C	6, 698, 135		3 5, 991, 042 0 0	0	0	
56.00		RADI OI SOTOPE	1 702 055		-1	0		56. 00
57.00		CT SCAN	1, 702, 955		1	0	0	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 069, 910			0	0	
59. 00		CARDI AC CATHETERI ZATI ON	3, 515, 071	251, 86			0	
60.00		LABORATORY	16, 913, 133			0	0	60.00
64. 00		INTRAVENOUS THERAPY	0		0 0	0	0	64. 00
65. 00		RESPI RATORY THERAPY	3, 676, 634	106, 19		0	0	65. 00
66. 00		PHYSI CAL THERAPY	12, 257, 527	493, 23	6 11, 764, 291	0	0	66. 00
67. 00		OCCUPATIONAL THERAPY	0		0 0	0	0	67. 00
68. 00		SPEECH PATHOLOGY	0		0 0	0	0	68. 00
69. 00	06900	ELECTROCARDI OLOGY	1, 779, 502	103, 03	9 1, 676, 463	0	0	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	1, 606, 040	142, 86	9 1, 463, 171	0	0	70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 154, 733	281, 36	0 13, 873, 373	0	0	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26, 352, 970	523, 79	1 25, 829, 179	0	0	72. 00
73.00		DRUGS CHARGED TO PATIENTS	34, 657, 747	744, 72	2 33, 913, 025	0	0	73. 00
73. 01	07302	OP PHARMACY	0		ol d	0	0	73. 01
74.00	07400	RENAL DIALYSIS	1, 519, 762	46, 87	0 1, 472, 892	0	0	74. 00
75.00		ASC (NON-DISTINCT PART)	0		ol c	0	0	75. 00
75. 01		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		ol d	0	0	1
76. 97	1 1	CARDI AC REHABI LI TATI ON	1, 363, 507	125, 58	7 1, 237, 920	0		
		TIENT SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		., ., .,	-		1
90.00		CLI NI C	2, 534, 071	285, 64	3 2, 248, 428	0	0	90. 00
90. 01		OP ONCOLOGY INFUSION CENTER	2, 889, 755				l o	90. 01
90. 02		WOUND CARE CENTER	1, 720, 297		1		Ö	
90. 03		PAIN CLINIC	618, 513				0	
90. 05		OP PSYCH CLINIC	2, 925, 929				0	90. 05
91. 00		EMERGENCY	13, 457, 337		1		0	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	6, 096, 836			_	0	
92.00		REIMBURSABLE COST CENTERS	0,090,830	523, 73	0 5, 572, 670	1 0	0	92.00
04.00		HOME PROGRAM DIALYSIS	1		ol c		0	94. 00
94. 00 95. 00			10 002 045		-1	-		
		AMBULANCE SERVICES	10, 092, 945			0		
		I&R SERVICES-NOT APPRVD PRGM	0		0	_		100.00
101.00		HOME HEALTH AGENCY	0		0 0	0	0	101. 00
		AL PURPOSE COST CENTERS					I	
		I NTEREST EXPENSE						113. 00
		UTI LI ZATI ON REVI EW-SNF						114.00
		AMBULATORY SURGICAL CENTER (D. P. )	0		0	0		115. 00
		HOSPI CE	0		O C	0		116. 00
200.00	1 1	Subtotal (sum of lines 50 thru 199)	207, 491, 560					200. 00
201.00	1 1	Less Observation Beds	6, 096, 836					201. 00
202.00	)	Total (line 200 minus line 201)	201, 394, 724	10, 766, 32	1 190, 628, 403	0	0	202. 00

Health Financial Systems

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

I U HEALTH BLOOMINGTON HOSPITAL RATIOS NET OF Provider CO In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am Provider CCN: 15-0051

							'	127 017 2017	5/27/2018 9:	
					Titl	e XIX		Hospi tal	PPS	
		Cost Center Description	Cost Net of	Tota	I Charges					
		,	Capital and			Cost to Char	ae			
			Operating Cost							
			Reducti on		8)	/ col. 7)				
			6. 00		7. 00	8.00				
	ANCLL	LARY SERVICE COST CENTERS		'						
50.00		OPERATI NG ROOM	18, 257, 319	10	96, 889, 625	0. 0927	29			50.00
50. 01		CV SURGERY	0		0.007	1				50. 01
51. 00		RECOVERY ROOM	6, 071, 464	íl s	29, 604, 389					51.00
52. 00		DELIVERY ROOM & LABOR ROOM	7, 799, 643	1	35, 111, 417					52. 00
53. 00		ANESTHESI OLOGY	7, 777, 043		0.00					53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	7, 759, 825		56, 490, 313					54. 00
55. 00		RADI OLOGY-THERAPEUTI C	6, 698, 135	1	30, 470, 313 34, 641, 454					55. 00
56. 00		RADI OLOGI - THERAPEUTI C	0,090,133	. i	04, 041, 404 0					
57.00		CT SCAN		1	-					56. 00 57. 00
	1		1, 702, 955	1	27, 300, 845	1				
58.00		MAGNETIC RESONANCE IMAGING (MRI)	1, 069, 910		10, 256, 829					58. 00
59.00		CARDI AC CATHETERI ZATI ON	3, 515, 071		69, 622, 027	0. 0504				59. 00
60.00	1	LABORATORY	16, 913, 133	1	27, 697, 749					60.00
64. 00	1	INTRAVENOUS THERAPY	0	1	0					64. 00
65.00		RESPI RATORY THERAPY	3, 676, 634		12, 396, 354					65. 00
66. 00		PHYSI CAL THERAPY	12, 257, 527	7 2	28, 482, 733					66. 00
67. 00		OCCUPATI ONAL THERAPY	0		0					67. 00
68. 00		SPEECH PATHOLOGY	0	1	0					68. 00
69. 00	06900	ELECTROCARDI OLOGY	1, 779, 502	2 2	21, 069, 992	0. 0844	57			69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	1, 606, 040	) 1	13, 592, 218	0. 1181	59			70.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 154, 733	3 5	55, 768, 244	0. 2538	13			71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26, 352, 970	10	03, 635, 962	0. 2542	84			72. 00
73.00		DRUGS CHARGED TO PATIENTS	34, 657, 747		57, 222, 079					73. 00
73. 01	07302	OP PHARMACY	0		0	0.0000	00			73. 01
74.00	07400	RENAL DIALYSIS	1, 519, 762	2	3, 788, 222	0. 4011	81			74. 00
75.00		ASC (NON-DISTINCT PART)	0	ol			00			75. 00
75. 01		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	ol	0					75. 01
76. 97	1	CARDIAC REHABILITATION	1, 363, 507	7	3, 415, 739					76. 97
		TIENT SERVICE COST CENTERS	.,	1						1
90.00		CLINIC	2, 534, 071	1	2, 733, 803	0. 9269	40			90.00
90. 01		OP ONCOLOGY INFUSION CENTER	2, 889, 755		15, 953, 288					90. 01
90. 02	1	WOUND CARE CENTER	1, 720, 297		4, 703, 568					90. 02
90. 03		PAIN CLINIC	618, 513		2, 131, 755					90. 03
90. 05		OP PSYCH CLINIC	2, 925, 929		2, 919, 690					90. 05
91. 00		EMERGENCY	13, 457, 337	1	12, 519, 090 12, 529, 791					91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	6, 096, 836		23, 753, 485					92.00
92.00		REIMBURSABLE COST CENTERS	0,090,030	2 ار	23, 753, 465	0. 2500	<i>/</i> I			72.00
04.00		HOME PROGRAM DIALYSIS	0	\	0	0.0000	00			94. 00
94. 00 95. 00			-	1	-					95.00
		AMBULANCE SERVICES	10, 092, 945		42, 949, 542					•
		I&R SERVICES-NOT APPRVD PRGM	0		0					100.00
101.00		HOME HEALTH AGENCY	0	<u>/ </u>	0	0.0000	UU			101. 00
440.5		AL PURPOSE COST CENTERS		1						440.00
		INTEREST EXPENSE								113. 00
		UTI LI ZATI ON REVI EW-SNF	1							114. 00
		AMBULATORY SURGICAL CENTER (D. P. )	0	7	0					115. 00
		HOSPI CE	0	P	0	0.0000	00			116. 00
200.00	1	Subtotal (sum of lines 50 thru 199)	207, 491, 560		44, 661, 113					200. 00
201.00	1	Less Observation Beds	6, 096, 836	1	0					201. 00
202.00	)	Total (line 200 minus line 201)	201, 394, 724	1, 24	44, 661, 113					202. 00

Hoal th	Financial Systems	IU HEALTH BLOOMI	NCTON HOSDITAL		In lie	eu of Form CMS-2	2552_10
	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider C	CN: 15-0051 F	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I	pared:
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col.	Total Patient Days	Per Diem (col. 3 / col. 4)	
		26) 1, 00	2.00	2) 3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00	ADULTS & PEDIATRICS	4, 462, 924	0	4, 462, 924	44, 456	100.39	30.00
31. 00	INTENSIVE CARE UNIT	450, 514		450, 514			
32. 00	CORONARY CARE UNIT	503, 723		503, 723			
35. 00	NEONATAL INTENSIVE CARE UNIT	280, 697	l .	280, 697			
41. 00	SUBPROVIDER - IRF	402, 502	l .	402, 502			
42. 00	SUBPROVI DER	0	o c			1	
43.00	NURSERY	176, 829		176, 829	3, 616	48. 90	43.00
200.00	Total (lines 30 through 199)	6, 277, 189		6, 277, 189	60, 720	,	200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col. 6)				
		6. 00	7.00	1			
-	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	16, 711					30.00
31. 00	INTENSIVE CARE UNIT	1, 965		•			31.00
32.00	CORONARY CARE UNIT	1, 593	l .	1			32. 00
35. 00	NEONATAL INTENSIVE CARE UNIT	0		1			35. 00
41. 00	SUBPROVIDER - IRF	1, 627		1			41.00
12 NO	SURDPOVI DED	1		NI			12 00

237, 184 0 0

42.00 43. 00 200. 00

42.00 SUBPROVI DER 43.00 NURSERY 200.00 Total (lines 30 through 199)

Heal th Financial	Systems	IU HEALTH BLOOMINGTON	I HOSPI	TAL	 In Lie	u of Form	CMS-2552-10

Health Financial Systems	Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co	CN: 15-0051	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/27/2018 9:1	pared: 8 am		
		Title	: XVIII	Hospi tal	PPS			
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs			
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x			
	(from Wkst. B,	Part I, col.	(col. 1 + col	. Charges	column 4)			
	Part II, col.	8)	2)					
	26)							
	1.00	2. 00	3. 00	4. 00	5. 00			
ANCILLARY SERVICE COST CENTERS								
50.00   05000   OPERATING ROOM	1, 756, 941	196, 889, 625						
50. 01  05001  CV SURGERY	0				0			
51.00   05100   RECOVERY ROOM	241, 855					51.00		
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 052, 259	35, 111, 417			991			
53. 00   05300   ANESTHESI OLOGY	0	0			0	53.00		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	703, 500			7, 927, 450	98, 721	54.00		
55. 00   05500 RADI OLOGY-THERAPEUTI C	707, 093	84, 641, 454			17, 924	55. 00		
56. 00   05600   RADI 0I SOTOPE	0	0	0.00000	0 0	0	56. 00		
57. 00   05700   CT   SCAN	68, 405				10, 174	57. 00		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	71, 289	10, 256, 829	0.00695			58. 00		
59. 00   05900 CARDI AC CATHETERI ZATI ON	251, 862	69, 622, 027	0. 00361		39, 852	59. 00		
60. 00   06000   LABORATORY	763, 489	127, 697, 749	0.00597	19, 522, 525	116, 725	60.00		
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64.00		
65. 00 06500 RESPIRATORY THERAPY	106, 193	12, 396, 354	0. 00856	6 4, 844, 262	41, 496	65. 00		
66. 00 06600 PHYSI CAL THERAPY	493, 236	28, 482, 733	0. 01731	7 3, 878, 837				
67. 00 06700 OCCUPATI ONAL THERAPY	0			0	0	67. 00		
68. 00 06800 SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68. 00		
69. 00 06900 ELECTROCARDI OLOGY	103, 039	21, 069, 992	0.00489	5, 580, 994	27, 291	69. 00		
70. 00 07000 ELECTROENCEPHALOGRAPHY	142, 869	13, 592, 218	0. 01051	1 906, 379		70. 00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	281, 360	55, 768, 244	0. 00504	5 10, 105, 377	50, 982	71. 00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	523, 791	103, 635, 962	0.00505	32, 340, 585	163, 449	72. 00		
73.00 07300 DRUGS CHARGED TO PATIENTS	744, 722	157, 222, 079	0.00473	33, 729, 354	159, 776	73. 00		
73. 01 07302 OP PHARMACY	0	0	0. 00000		0	73. 01		
74.00 07400 RENAL DIALYSIS	46, 870	3, 788, 222	0. 01237	1, 875, 299	23, 203	74. 00		
75.00 07500 ASC (NON-DISTINCT PART)	0	0			0	75. 00		
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0. 00000		0	75. 01		
76. 97 07697 CARDI AC REHABI LI TATI ON	125, 587	3, 415, 739			7, 665	76. 97		
OUTPATIENT SERVICE COST CENTERS	<u> </u>							
90. 00 09000 CLI NI C	285, 643	2, 733, 803	0. 10448	10, 356	1, 082	90.00		
90. 01 09001 OP ONCOLOGY INFUSION CENTER	160, 326	15, 953, 288	0. 01005	548, 523	5, 513	90. 01		
90. 02 09002 WOUND CARE CENTER	160, 343	4, 703, 568	0. 03409			90. 02		
90. 03   09003   PAIN CLINIC	90, 878					90. 03		
90. 05 09005 OP PSYCH CLINIC	303, 393		•	· ·		90. 05		
91. 00 09100 EMERGENCY	1, 015, 881					91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	523, 938					92.00		
OTHER REIMBURSABLE COST CENTERS						1		
94. 00 09400 HOME PROGRAM DI ALYSIS	0	0	0.00000	00 0	0	94. 00		
95. 00 09500 AMBULANCE SERVICES						95. 00		
200.00 Total (lines 50 through 199)	10, 724, 762	1, 201, 711, 571		195, 225, 136	1, 359, 680	200.00		
	•					•		

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet D Part III Date/Time Pre 5/27/2018 9:1	pared: 8 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 32. 00   03200   CORONARY CARE UNIT 35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	0 0	0 0	1	_	1	30. 00 31. 00 32. 00 35. 00
41. 00   04100   SUBPROVI DER -   I RF 42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	0	0	0	0	0	41. 00 42. 00 43. 00
200.00   Total (lines 30 through 199)  Cost Center Description	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200. 00
	4. 00	5.00	6. 00	7. 00	8. 00	
NPATIENT ROUTINE SERVICE COST CENTERS	Inpatient Program Pass-Through Cost (col. 7 x	000000000000000000000000000000000000000	44, 456 3, 800 3, 296 2, 791 2, 761 0	0.00 0.00 0.00 0.00 0.00 0.00	16, 711 1, 965 1, 593 0 1, 627	31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
	col . 8)					
INPATIENT ROUTINE SERVICE COST CENTERS	9. 00					
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   32. 00   03200   CORONARY CARE UNIT   35. 00   02060   NEONATAL   INTENSIVE CARE UNIT   41. 00   04100   SUBPROVI DER   -   IRF   42. 00   04200   SUBPROVI DER   43. 00   04300   NURSERY   200. 00   Total (lines 30 through 199)	000000000000000000000000000000000000000					30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00 200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Par 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

				0 12/31/2017	5/27/2018 9:1	
		Ti tl e	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	C	1		-	0	50. 00
50. 01  05001  CV SURGERY	C	) (		0	0	50. 01
51.00   05100   RECOVERY ROOM	C	) (	) (	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	C	) (	) (	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	C	) (		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C	) (		0	0	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	C	) (		0	0	55. 00
56. 00   05600   RADI OI SOTOPE	C	) (		0	0	56. 00
57.00  05700   CT SCAN	C	) (	) (	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	) (	) (	0	0	58. 00
59. 00  05900  CARDI AC CATHETERI ZATI ON	C	) (	) (	0	0	59. 00
60. 00  06000   LABORATORY	C	0	0	0	0	60.00
64.00   06400   I NTRAVENOUS THERAPY	C	) (		0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	C	) (		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	C	0	) (	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	) (		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	C			0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0			0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0	0	70. 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	500, 895	73.00
73. 01 07302 0P PHARMACY				0	0	73. 01
74. 00   07400   RENAL DI ALYSI S				0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)					0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				-	0	75. 01 76. 97
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS		)	)	<u> </u>	0	76.97
90. 00   09000 CLINIC				0	0	90.00
90. 00   09000  CETNIC 90. 01   09001  OP ONCOLOGY INFUSION CENTER					0	90.00
90. 02 09002 WOUND CARE CENTER					0	90.01
90. 03   09003   PAIN CLINIC					0	90. 02
90. 05 09005 OP PSYCH CLINIC					0	90.05
91. 00   09100   EMERGENCY					Ö	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		á	1		, O	92.00
OTHER REIMBURSABLE COST CENTERS		1		1		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	C			0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	C	) c		0	500, 895	200. 00
						-

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

				T	o 12/31/2017	Date/Time Pre 5/27/2018 9:1	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATI NG ROOM	0	0			0. 000000	
50. 01	05001 CV SURGERY	0	0			0. 000000	
51.00	05100 RECOVERY ROOM	0	0	0		0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	35, 111, 417	0. 000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	56, 490, 313	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	84, 641, 454	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0.000000	56. 00
57.00	05700 CT SCAN	0	0	0	27, 300, 845	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10, 256, 829	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0	0		0.000000	59. 00
60.00	06000 LABORATORY	o	0	0	127, 697, 749	0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	o	0	0	0	0.000000	64. 00
65.00	06500 RESPIRATORY THERAPY	ol	0	0	12, 396, 354	0. 000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	28, 482, 733	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0.000000	
68. 00	06800 SPEECH PATHOLOGY	o	0	0	0	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	أم	0	0	21, 069, 992	0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	أم	0	0		0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	· -		0. 000000	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS		500, 895	1		0. 003186	
73. 01	07302 OP PHARMACY		000, 070	000,070		0. 000000	
74. 00	07400 RENAL DIALYSIS		0	ĺ	_	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)		0		0, 700, 222	0. 000000	
75. 01	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES		0	٥	ı .	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON		0			0. 000000	
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>			3, 413, 737	0.000000	70. 77
90.00	09000 CLINI C	O	0	0	2, 733, 803	0.000000	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER		0			0. 000000	
90. 02	09002 WOUND CARE CENTER		0			0. 000000	
90. 03	09003 PAIN CLINIC		0			0. 000000	
90. 05	09005 OP PSYCH CLINIC		0	· -		0.000000	
91.00	09100 EMERGENCY		0	-		0.000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	_		0.000000	
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	1 0	23, 133, 463	0.000000	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0. 000000	94. 00
95.00	09500 AMBULANCE SERVICES	١	U	l "		0.00000	95.00
200.00		0	500, 895	500 005	1, 201, 711, 571		200.00
200. UC	Tiotal (Titles 50 tillough 199)	١	300, 893	J 300, 893	1,201,711,571	I	1200.00

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT (OUTDATIENT	MICH LARY CERVILOE OTHER DACC	D CON 15 0051	D!!	Wasaliala a de D

Peri od: From 01/01/2017 To 12/31/2017 Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Date/Time Prepared: 5/27/2018 9:18 am Title XVIII Hospi tal PPS Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges  $(col. 6 \div col$ Costs (col. Costs (col. x col. 10) x col. 12) 7) 13. 00 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 38, 694, 485 50.00 25, 992, 545 0 0 50.01 05001 CV SURGERY 0.000000 0 50.01 05100 RECOVERY ROOM 0.000000 3, 884, 619 0 51.00 51.00 4, 737, 974 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 33.081 05300 ANESTHESI OLOGY 0.000000 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 7, 927, 450 0 14, 171, 538 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 2, 145, 531 36, 380, 382 0 55.00 05600 RADI OI SOTOPE 0.000000 0 56 00 0 56 00 0 57.00 05700 CT SCAN 0.000000 4, 059, 707 5, 748, 929 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 1, 081, 288 1, 848, 439 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 11, 014, 968 0 17, 545, 374 0 59.00 0 06000 LABORATORY 0.000000 9, 392, 959 60 00 60 00 19, 522, 525 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 0.000000 4, 844, 262 744, 763 0 65.00 06600 PHYSI CAL THERAPY 66 00 0.000000 3, 878, 837 189 922 0 66 00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 5, 580, 994 5, 690, 832 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0.000000 906, 379 3, 249, 548 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 10, 105, 377 0 13, 129, 093 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 32, 340, 585 15, 605, 610 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.003186 33, 729, 354 107, 462 26, 063, 938 83,040 73.00 07302 OP PHARMACY 0.000000 73.01 73 01 0 0 0 07400 RENAL DIALYSIS 0 74.00 0.000000 1, 875, 299 219, 428 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 75.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75. 01 0.000000 0 75.01 07697 CARDIAC REHABILITATION 0 76.97 0.000000 208, 470 1, 485, 884 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0.000000 10, 356 1, 255, 211 09001 OP ONCOLOGY INFUSION CENTER 0.000000 0 5, 707, 173 90.01 90.01 548, 523 0 09002 WOUND CARE CENTER 0 90 02 0.000000 7.084 1, 953, 613 0 90 02 1, 038 09003 PAIN CLINIC 0.000000 691, 614 90.03 90.03 09005 OP PSYCH CLINIC 0 90.05 0.000000 1, 974 410, 827 0 90.05 09100 EMERGENCY 11, 490, 540 0 91.00 0.000000 20, 125, 017 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 1, 332, 410 10, 179, 307 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95. 00 09500 AMBULANCE SERVICES 95 00

195, 225, 136

107, 462

222, 519, 920

83, 040 200. 00

200.00

Total (lines 50 through 199)

Heal th	Financial Systems I	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0051	Peri od:	Worksheet D	
					From 01/01/2017	Part V	
					To 12/31/2017	Date/Time Pre 5/27/2018 9:1	
			Ti +l o	xVIII	Hospi tal	PPS	o alli
			11110	Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge	DDC Doimburcod		Cost	PPS Services	
	Cost Center Description	Cost to Charge Ratio From	Servi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9	11151.)	Subject To	Subject To		
		rait i, coi. 9		Ded. & Coins			
				(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATI NG ROOM	0. 092729	25, 992, 545		0 0	2, 410, 263	50.00
50. 01	05001 CV SURGERY	0. 000000	20, 772, 010		0 0	0	50. 01
51. 00	05100 RECOVERY ROOM	0. 205087	4, 737, 974		0 0	971, 697	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 222140	4, 737, 774 O		0 0	771,077	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 137366	14, 171, 538		0 0	1, 946, 687	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	1			0 0		
	1 1	0. 079135	36, 380, 382	1	0 0	2, 878, 962	1
56. 00	05600 RADI OI SOTOPE	0. 000000	0			0	56.00
57. 00	05700 CT SCAN	0. 062377	5, 748, 929	l .		358, 601	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 104312	1, 848, 439		-	192, 814	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 050488	17, 545, 374	l .	0	885, 831	
60.00	06000 LABORATORY	0. 132447	9, 392, 959		0	1, 244, 069	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 296590	744, 763		0	220, 889	
66. 00	06600 PHYSI CAL THERAPY	0. 430349	189, 922		0 0	81, 733	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 084457	5, 690, 832		0	480, 631	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 118159	3, 249, 548		0	383, 963	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 253813	13, 129, 093		0	3, 332, 334	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 254284	15, 605, 610		0	3, 968, 257	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 220438	26, 063, 938		0 190, 384	5, 745, 482	73. 00
73. 01	07302 OP PHARMACY	0. 000000	0		0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 401181	219, 428		0 0	88, 030	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	75. 01
76. 97	07697 CARDI AC REHABI LITATI ON	0. 399184	1, 485, 884		0 0	593, 141	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 926940	1, 255, 211		0 36	1, 163, 505	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 181139	5, 707, 173		0	1, 033, 792	90. 01
90. 02	09002 WOUND CARE CENTER	0. 365743	1, 953, 613		0	714, 520	90. 02
90. 03	09003 PAIN CLINIC	0. 290143	691, 614		0 0	200, 667	90. 03
90.05	09005 OP PSYCH CLINIC	1. 002137	410, 827	53	0	411, 705	90. 05
91.00	09100 EMERGENCY	0. 119589	20, 125, 017		0 37	2, 406, 731	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 256671	10, 179, 307	54	5 2	2, 612, 733	92.00
	OTHER REIMBURSABLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·				1
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0		94.00
95.00	09500 AMBULANCE SERVI CES	0. 234995			0		95.00
200.00	1 1		222, 519, 920	1, 07	6 190, 459	34, 327, 037	
201.00	,	1			0 0		201. 00
	Only Charges						
202.00		1	222, 519, 920	1, 07	'6 190, 459	34, 327, 037	202. 00
	,	. '		•		•	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/27/2018 9:18 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 50.01 05001 CV SURGERY 0000000000000000000000000000 0 50.01 51. 00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 41, 968 73.00 73. 01 07302 OP PHARMACY 0 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75.01 0 75.01 07697 CARDIAC REHABILITATION 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 0 90.00 90.00 33 09001 OP ONCOLOGY INFUSION CENTER 90. 01 0 90.01 09002 WOUND CARE CENTER 0 90. 02 0 90.02 09003 PAIN CLINIC 0 90.03 0 90.03 09005 OP PSYCH CLINIC 90.05 532 0 90.05 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 140 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95. 00 09500 AMBULANCE SERVICES 0 95.00 Subtotal (see instructions) Less PBP Clinic Lab. Services-Program 200.00 42,006 200.00 672

672

42, 006

201. 00

202.00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems II	J HEALTH BLOOMI	NGTON HOSPITAL		Inlia	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0051 CCN: 15-T051	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/27/2018 9:1	pared:
		Title	· XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost (from Wkst. B,	(from Wkst. C, Part I, col.		Program . Charges	(column 3 x column 4)	
	Part II, col.	8)	2)	. Charges	COT dillit 4)	
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	,					
50. 00 05000 OPERATI NG ROOM	1, 756, 941	196, 889, 625	0. 00892		466	
50. 01   05001 CV SURGERY	0	0	0.0000		0	50. 01
51. 00   05100   RECOVERY ROOM	241, 855	29, 604, 389			96	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	1, 052, 259	35, 111, 417	0.02996		0	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	703, 500	56, 490, 313	0. 00000 0. 0124		0 1, 138	
55. 00   05500   RADI OLOGY - THERAPEUTI C	703, 500	84, 641, 454			1, 130	55.00
56. 00   05600   RADI 01 SOTOPE	707,093	04, 041, 454	0.0000		0	
57. 00  05700 CT SCAN	68, 405	27, 300, 845	0. 00250		60	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	71, 289	10, 256, 829			37	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	251, 862	69, 622, 027	0.0036		0	
60. 00   06000   LABORATORY	763, 489	127, 697, 749			2, 089	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000	00	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	106, 193	12, 396, 354	0. 00856	66 40, 285	345	65. 00
66. 00 06600 PHYSI CAL THERAPY	493, 236	28, 482, 733	0. 0173		56, 043	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	103, 039	21, 069, 992			534	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	142, 869	13, 592, 218	l .		21	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	281, 360 523, 791	55, 768, 244 103, 635, 962	0. 00504 0. 00505		318 155	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	744, 722	157, 222, 079	l .		3, 885	
73. 01 07302 OP PHARMACY	744, 722	137, 222, 079	0.0000		3, 663	73. 00
74. 00 07400 RENAL DI ALYSI S	46, 870	3, 788, 222	0. 0123		867	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0,700,222	0.00000		0	
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	O	0.00000		0	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	125, 587	3, 415, 739	0. 03676	57 279	10	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	285, 643	2, 733, 803	0. 10448	36 551	58	90. 00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	160, 326				0	, , , , , ,
90. 02 09002 WOUND CARE CENTER	160, 343	4, 703, 568			0	90. 02
90. 03   09003   PAIN CLINIC	90, 878	2, 131, 755	l .		0	90. 03
90. 05   09005   OP PSYCH CLINIC	303, 393				0	90.05
91. 00 09100 EMERGENCY	1, 015, 881	112, 529, 791	0.00902		188	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	23, 753, 485	0.00000	00 14, 770	0	92.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0.0000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		١	0.00000		O	95.00
200.00 Total (lines 50 through 199)	10, 200, 824	1, 201, 711, 571		4, 944, 293	66, 327	

Health Financial Systems	IU HEALTH BLOOMING	ΓΟΝ HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0051 Component CCN: 15-T051	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/27/2018 9:18 am
•		T1 11 10 11	0 1 1 1	550

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			Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	cost center bescription	Anesthetist	Post-Stepdown		Post-Stepdown	Airred hearth	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	J.A	3.00	
50.00	05000 OPERATING ROOM				0	0	50.00
50. 00	05001 CV SURGERY					0	50. 00
51. 00	05100 RECOVERY ROOM					0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		í .			0	52.00
	05300 ANESTHESI OLOGY					ı .	1
53.00	1					0	53.00
54. 00	O5400   RADI OLOGY - DI AGNOSTI C					0	54.00
55. 00	05500   RADI OLOGY-THERAPEUTI C					0	55. 00
56. 00	05600 RADI OI SOTOPE				0	0	56. 00
57. 00	05700 CT SCAN				0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)		)	)	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	)	)	0	0	59. 00
60. 00	06000 LABORATORY		)  (	)	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	C	)	) (	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	) (	) (	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	C	) (	) (	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	)  C	) (	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	C	)	) (	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	) (	) (	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	C	) (	) (	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	) (	) (	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	) (		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	C			0	500, 895	73.00
73. 01	07302 OP PHARMACY	C	) (		0	0	73. 01
74.00	07400 RENAL DIALYSIS		) c		0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)		) c		0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON		) c		0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	•	•	•			
90.00	09000 CLI NI C	C	) (	) (	0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER		) c		0	0	90. 01
	09002 WOUND CARE CENTER				0	0	90. 02
90. 03	09003 PAIN CLINIC				0	0	90. 03
90. 05	09005 OP PSYCH CLINIC				0	0	90. 05
91. 00	09100 EMERGENCY				0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1		0	92. 00
, 2. 50	OTHER REIMBURSABLE COST CENTERS			`	-1		1
94. 00	09400 HOME PROGRAM DIALYSIS				0	0	94. 00
95. 00	09500 AMBULANCE SERVICES			`		Ĭ	95. 00
200.00	1				o	500, 895	
_00.00	1 1.2.2. (	1	1	`1	-1	1 225, 076	1-30.00

Heal th	Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APP0R	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2017		
			Component	CCN: 15-T051	To 12/31/2017	Date/Time Pre 5/27/2018 9:1	
			Ti tl e	e XVIII	Subprovi der -	PPS	J dill
				, ,,,,,,	I RF	1.0	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS		_				
50. 00	05000 OPERATING ROOM	0	0	)	0 196, 889, 625	l .	50. 00
50. 01	05001 CV SURGERY	0	0		0	0. 000000	50. 01
51. 00	05100 RECOVERY ROOM	0	0		0 29, 604, 389	l	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 35, 111, 417	0.000000	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0.000000	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		56, 490, 313	l e	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	)	0 84, 641, 454		55.00
56. 00	05600 RADI OI SOTOPE	0	0	)	0	0.000000	56. 00
57. 00	05700 CT SCAN	0	0	)	0 27, 300, 845	l e	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0 10, 256, 829	l e	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	)	0 69, 622, 027	0.000000	59. 00
60.00	06000 LABORATORY	0	0	)	0 127, 697, 749		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	)	0	0.000000	64.00
65. 00	06500 RESPI RATORY THERAPY				0 12, 396, 354		65.00
66.00	06600 PHYSI CAL THERAPY			<u>'</u>	0 28, 482, 733		66.00
67. 00	06700 OCCUPATI ONAL THERAPY			'	0	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY		1 0	ון	U <sub>I</sub> 0	0.000000	68. 00

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500, 895

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21, 069, 992

13, 592, 218

55, 768, 244

103, 635, 962

157, 222, 079

3, 788, 222

3, 415, 739

2, 733, 803

15, 953, 288

4, 703, 568

2, 131, 755

2, 919, 690

112, 529, 791

23, 753, 485

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500, 895 1, 201, 711, 571

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75. 01

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90.03

90.05

91.00

92.00

94.00

200.00

06900 ELECTROCARDI OLOGY

07302 OP PHARMACY

09000 CLI NI C

09003 PAIN CLINIC

95. 00 09500 AMBULANCE SERVICES

09100 EMERGENCY

07400 RENAL DIALYSIS

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

07500 ASC (NON-DISTINCT PART)

07697 CARDIAC REHABILITATION

09002 WOUND CARE CENTER

09005 OP PSYCH CLINIC

OUTPATIENT SERVICE COST CENTERS

09001 OP ONCOLOGY INFUSION CENTER

OTHER REIMBURSABLE COST CENTERS
09400 HOME PROGRAM DIALYSIS

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

07200 IMPL. DEV. CHARGED TO PATIENTS

Health Financial Systems I APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	U HEALTH BLOOMIN	Provider CO	CN: 15-0051 P	eriod:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	KVI OL OTTLEK TASS		F	rom 01/01/2017	Part IV	
		Component (	CCN: 15-T051 T	o 12/31/2017	Date/Time Pre 5/27/2018 9:1	
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0. 000000	52, 268	0		0	
50. 01   05001   CV SURGERY	0. 000000	0	0	0	0	
51. 00   05100   RECOVERY ROOM	0. 000000	11, 756	0	0	0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	
53. 00   05300   ANESTHESI OLOGY	0. 000000	0	0	0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	91, 388	0	0	0	
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	2, 067	0	0	0	
56. 00   05600   RADI 0I SOTOPE	0. 000000	0	0	0	0	
57. 00  05700   CT SCAN	0. 000000	24, 063	0	0	0	
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	5, 279	0	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59. 00
60. 00   06000   LABORATORY	0. 000000	349, 444	0	0	0	60.00
64. 00   06400   I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	40, 285	0	0	0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 000000	3, 236, 296	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 000000	0	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	109, 148	0	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 020	0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	63, 009	0	0	0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	30, 730	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 003186	820, 042	2, 613	0	0	73. 00
73. 01   07302   OP PHARMACY	0. 000000	0	0	0	0	
74. 00   07400   RENAL DI ALYSI S	0. 000000	70, 073	0	0	0	
75. 00   07500   ASC (NON-DISTINCT PART)	0. 000000	0	0	0	0	
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	0	0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	279	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0. 000000	551	0	0	0	90.00
90. 01   09001   OP ONCOLOGY INFUSION CENTER	0. 000000	0	0	0	0	90. 01
90. 02   09002   WOUND CARE CENTER	0. 000000	0	0	0	0	
90. 03   09003   PAIN CLINIC	0. 000000	0	0	0	0	90. 03
90. 05 09005 OP PSYCH CLINIC	0. 000000	0	0	0	0	
91. 00   09100   EMERGENCY	0. 000000	20, 825	0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	14, 770	0	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0	0	0	0	
95. 00   09500   AMBULANCE SERVI CES	1					95.00
200.00 Total (lines 50 through 199)	1	4, 944, 293		ol		200.00

			Component	0014. 10 1001	12/01/201/	5/27/2018 9: 1	8 am
			Title	· XVIII	Subprovi der -	PPS	
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50.00	05000 OPERATING ROOM	0. 092729	0		0	0	50.00
	05001 CV SURGERY	0. 000000	0			0	
	05100 RECOVERY ROOM	0. 205087	0		-	0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 222140	0	1	0	Ö	1
	05300 ANESTHESI OLOGY	0. 000000	0		0	Ö	
	05400 RADI OLOGY-DI AGNOSTI C	0. 137366	0		0	0	
	05500 RADI OLOGY-THERAPEUTI C	0. 079135	0		0	0	1
	05600 RADI OI SOTOPE	0. 000000	0		0	0	
	05700 CT SCAN	0. 062377	0		0	0	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 104312	0		0	0	1
	05900 CARDI AC CATHETERI ZATI ON	0. 050488	0		0	Ö	1
60. 00	06000 LABORATORY	0. 132447	0		0	0	
	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64.00
	06500 RESPI RATORY THERAPY	0. 296590	0		0	Ö	
	06600 PHYSI CAL THERAPY	0. 430349	0		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	1
	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	1
69. 00	06900 ELECTROCARDI OLOGY	0. 084457	0		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 118159	0		0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 253813	0		0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 254284	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 220438	0		69	0	73. 00
73. 01	07302 OP PHARMACY	0. 000000	0		0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 401181	0		0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	75. 01
76. 97	07697 CARDIAC REHABILITATION	0. 399184	0	(	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 926940	0	(	0	0	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 181139	0	(	0	0	90. 01
90. 02	09002 WOUND CARE CENTER	0. 365743	0	(	0	0	90. 02
90. 03	09003 PAIN CLINIC	0. 290143	0	(	0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	1. 002137	0	(	0	0	90. 05
91.00	09100 EMERGENCY	0. 119589	0	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 256671	0	(	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS				_		
	09400 HOME PROGRAM DIALYSIS	0. 000000			O		94. 00
	09500 AMBULANCE SERVICES	0. 234995					95. 00
200.00			0	(	69	0	200. 00
201.00					0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		0		0 69	0	202. 00

Health Financial Systems II	U HEALTH BLOOMIN	GTON HOSPITAL		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der Co		Peri od: From 01/01/2017	Worksheet D	
		Component	CCN: 15-T051	To 12/31/2017	Date/Time Prep 5/27/2018 9:18	
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Contar Description	Cost	ts				

Cost Center Description						IRF	
Reimbursed Services Subject To Ded. & Coins. (See Inst.)   See Services Not Subject To Ded. & Coins. (See Inst.)   See I			Cos	sts			
Services   Subject To   Ded. & Coins.   Code.   Code.   Coins.   Code.   Code.   Coins.   Code.   Code		Cost Center Description	Cost	Cost			
Subject To   Ded. & Coins.   Subject To   D			Rei mbursed	Reimbursed			
Ded. & Coins.   Cose inst.			Servi ces	Services Not			
ANCILLARY SERVICE COST CENTERS			Subject To	Subject To			
ANCILLARY SERVICE COST CENTERS			Ded. & Coins.				
ANCILLARY SERVICE COST CENTERS							
50.00   05000   0FEATING ROOM   0   0   55.0   00   55.0   01   0501   05010			6. 00	7. 00			
50.00   05000   CV SURGERY   0 0 0 51.00   55.00   51.00   52.00   52.00   05200   DELLVERY ROOM & 0 0 0   52.00   52.00   52.00   05200   DELLVERY ROOM & 0 0 0   53.00   05300   0							
51.00   05100   RECOVERY ROOM   0   0   0   51.00	4	l e e e e e e e e e e e e e e e e e e e	0				
S2 00   05200   05200   05200   05200   05200   05200   05200   05300   05300   05300   05300   05300   0550	4	l e e e e e e e e e e e e e e e e e e e	0				50. 01
53. 00   05300   ANESTHESI DLOGY   0   0   55. 00	51.00	05100 RECOVERY ROOM	0	0			51. 00
54.00   05400   RADIO LOGY-DIAGNOSTIC   0 0 0   55.00   05500   RADIO LOGY-THERAPEUTIC   0 0 0   55.00   05500   RADIO LOGY-THERAPEUTIC   0 0 0 0   56.00   57.00   05700   CT SCAN   0 0 0 0   0 0   57.00   58.00   58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)   0 0 0   58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)   0 0 0   0 0			0		1		1
55.00   05500   RADIO LOGY-THERAPEUTIC   0   0   0   55.00		l e e e e e e e e e e e e e e e e e e e	0	· ·	1		
56.00   05.00   05.00   05.00   0.	4	l e e e e e e e e e e e e e e e e e e e	0				1
57.00   05700   CT SCAN   0   0   0   0   0   0   58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   0   0   0   0   0   0			0	l ~	1		
58. 00   05900   AGRIDAC CATHETERI ZATION   0   0   0   0   0   0   0   0   0		l e e e e e e e e e e e e e e e e e e e	0	0			56. 00
59.00   05900   CARDIAC CATHETERIZATION   0 0 0   0   0   0   0   0   0   0	57.00	05700 CT SCAN	0	0			57. 00
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58. 00
64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0			0	0			59. 00
65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   0   0   0   0   0	60.00	06000 LABORATORY	0	0			60.00
66. 00   06600   PHYSICAL THERAPY   0   0   0   67. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   70. 00   07000   ELECTROCARDI OLOGY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   15   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   73. 01   07302   0P PHARMACY   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   75. 01   07500   ASC (NON-DI STI NCT PART)   0   0   0   75. 01   07507   CARDI AC REHABI LI TATI ON   0   0   76. 97   07607   CARDI AC REHABI LI TATI ON   0   0   76. 97   07607   CARDI AC REHABI LI TATI ON   0   0   76. 97   0700   O9000   CLI NI C   0   0   79. 01   09001   OP ONCOLOGY I NFUSI ON CENTER   0   0   79. 02   09002   WOUND CARE CENTER   0   0   0   79. 03   09003   PPSYCH CLI NI C   0   0   79. 04   09000   OP PSYCH CLI NI C   0   0   79. 05   09005   OP PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79. 00   09000   OB PSYCH CLI NI C   0   0   79.	64.00	06400 INTRAVENOUS THERAPY	0	0			64. 00
67. 00   06700   06700   06700   06700   06700   06800	65.00	06500 RESPI RATORY THERAPY	0	0			65. 00
68.00   06800   SPEECH PATHOLOGY   0 0 0   68.00   69.	66.00	06600 PHYSI CAL THERAPY	0	0			66. 00
69. 00   66900   ELECTROCARDI OLOGY   0   0   0   0   70. 00   77.	67.00	06700 OCCUPATI ONAL THERAPY	0	0			67. 00
70. 00	68.00	06800 SPEECH PATHOLOGY	0	0			68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0	0			69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   07300   DRUGS CHARGED TO PATIENTS   0   15   073. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   15   15   173. 00   173. 01   07302   OP PHARMACY   0   0   0   0   0   173. 01   174. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   174. 00   175. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   0   0   0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71. 00
73. 01 07302	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 00
74.00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	15			73. 00
75. 00	73. 01	07302 OP PHARMACY	0	0			73. 01
75. 01	74.00	07400 RENAL DIALYSIS	0	0			74. 00
76. 97   O7697   CARDI AC REHABILITATION   O O O   O     OUTPATI ENT SERVI CE COST CENTERS     90. 00   O9000   CLI NI C   O O     90. 01   O9001   OP ONCOLOGY I NFUSI ON CENTER   O O O     90. 02   O9002   WOUND CARE CENTER   O O O O     90. 03   O9003   PAI N CLI NI C   O O O O     90. 05   O9005   OP PSYCH CLI NI C   O O O O     90. 05   O9005   OP PSYCH CLI NI C   O O O O     91. 00   O9100   EMERGENCY   O O O O     92. 00   O9200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   O O O O     91. 00   OTHER REI MBURSABLE COST CENTERS     94. 00   O9500   AMBULANCE SERVI CES   O O O O O O O O O O O O O O O O O O	75.00	07500 ASC (NON-DISTINCT PART)	0	0			75. 00
OUTPATIENT SERVICE COST CENTERS   O	75. 01 C	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			75. 01
90. 00			0	0			76. 97
90. 01			1				
90. 02   09002   WOUND CARE CENTER   0   0   0   90. 02   90. 03   09003   PAI N CLINIC   0   0   0   0   90. 03   90. 05   09005   0P PSYCH CLINIC   0   0   0   0   0   90. 05   91. 00   09100   EMERGENCY   0   0   0   0   0   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0			0				
90. 03	90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0			90. 01
90. 05	90. 02	09002 WOUND CARE CENTER	0	0			90. 02
91.00   09100   EMERGENCY   0   0   0   0   92.00   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0	90. 03	09003 PAIN CLINIC	0	0			90. 03
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   92. 00			0	0			90. 05
OTHER REIMBURSABLE COST CENTERS   94.00   O9400   HOME PROGRAM DIALYSIS   0 0 0 95.00   O9500   AMBULANCE SERVICES   0 0 95.00   O9500   O95			0	0			91.00
94. 00			0	0			92. 00
95. 00							
200.00 Subtotal (see instructions) 0 15 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0nly Charges		9400 HOME PROGRAM DIALYSIS	0	0			94.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges		l l	0				
Only Charges	200.00	Subtotal (see instructions)	0	15			
	201.00	Less PBP Clinic Lab. Services-Program	0				201. 00
202.00   Net Charges (line 200 - line 201)   0							
	202. 00	Net Charges (line 200 - line 201)	0	15			202. 00

Heal th	Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORT	TIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
					From 01/01/2017 To 12/31/2017		nared.
					12/01/201/	5/27/2018 9: 1	8 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col. 1 - col			
		26)		2)			
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T	_	1			
30. 00	ADULTS & PEDIATRICS	4, 462, 924		4, 462, 92			
31. 00	INTENSIVE CARE UNIT	450, 514		450, 51			
32. 00	CORONARY CARE UNIT	503, 723	1	503, 72	·		
35. 00	NEONATAL INTENSIVE CARE UNIT	280, 697	•	280, 69	·		
41. 00	SUBPROVI DER - I RF	402, 502	l .	402, 50			
42. 00	SUBPROVI DER	C	ή	1	0	0.00	
	NURSERY	176, 829	<b>1</b>	176, 82	·		43. 00
200.00	Total (lines 30 through 199)	6, 277, 189		6, 277, 18	60, 720		200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)	-			
	LABORT FAIT POLITICAL OFFICE OF COOT OFFITEDS	6. 00	7. 00				
00.00	INPATIENT ROUTINE SERVICE COST CENTERS		F0 100				
30.00	ADULTS & PEDIATRICS	589					30.00
31.00	INTENSIVE CARE UNIT	367		1			31.00
32. 00	CORONARY CARE UNIT	0	0				32. 00
35. 00	NEONATAL INTENSIVE CARE UNIT	218					35. 00
41. 00	SUBPROVIDER - IRF	14	2, 041				41.00
	SUBPROVI DER	1 000	0 411	1			42.00

1, 808 2, 996

88, 411 215, 018

42. 00 43. 00 200. 00

42.00 SUBPROVI DER 43.00 NURSERY 200.00 Total (lines 30 through 199)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS    Capital Cost   Capi		U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
Cost Center Description	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	pared: 8 am
Related Cost   Cfrom Wists, C.   Col.   1 × col.   Col.   Col.   1 × col.   Col.   Col.   1 × col.   Col.   Col.   1 × col.   Col.						PPS	
ANCILLARY SERVICE COST CENTERS   Part II, col.   20   2,00   3,00   4,00   5,00	Cost Center Description						
ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00							
ANCILLARY SERVICE COST CENTERS					. Charges	column 4)	
NOTE   NOTE		· ·	8)	2)			
AMCILLARY SERVICE COST CENTERS							
50.00	ANCILLADY CEDVICE COCT CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 01   05001   V SURGERY   0   0   0   0   0   0   0   0   0		1 754 041	104 000 435	0 0000	D2 E14 272	1 407	E0 00
51.00   05100   RECOVERY ROOM   ALADOR ROOM   1,052,259   35,111,417   0.02996   506,888   51.00   52.00   52.00   05200   DELL'VERY ROOM   & LABOR ROOM   1,052,259   35,111,417   0.02996   506,888   51.90   52.00   53.00   05300   ARESTHESI OLOGY   0   0   0.000000   0   0   53.00   054.00   05500   RADI OLOGY-DI AGNOSTIC   707,053   84,641,454   0.008354   54,733   3,381   54.00   0.00500   0   0.000000   0   0.000000   0   0		1 ' '				l	
52.00   05200   05200   05200   05200   05200   0500   0		_	·			1	
53.00   OS300   AMESTHESI OLOGY   0   0   0   0   0   0   0   55.00							
54. 00		1	l			l	
55. 00   05500   RADIO LOGY-THERAPEUTIC   707,093   84,641,454   0.008354   54,733   457   55. 00   05600   RADIO I SOTOPE   0 0 0 0.000000   0 0 0 0 56. 00   05700   0.000000   0 0 0 0 56. 00   05700   0.05900   0.05800   0.00801   0.0080500   0.0080500   0.0080500   0.0080500   0.0080500   0.0080500   0.0080500		_				1	
56. 00   05600   RADI OI SOTOPE   0   0   0   0.000000   0   0   0   56. 00							
57. 00		707,093				•	
58. 00   OSBOOD   MAGNIETI C RESONANCE I IMAGI NG (IMRI)   71, 289   10, 256, 829   0. 006950   48, 195   335   58. 00   05900   CARDI AC CATHETERI ZATI ON   251, 862   69, 622, 027   0. 003618   166, 820   604   59. 00   06000   LABORATORY   763, 489   127, 697, 749   0. 005979   1, 357, 964   8, 119   60. 00   06000   LABORATORY   10, 193   12, 396, 354   0. 008566   573, 154   4, 191   65. 00   06000   06000   06000   07   07		40 405	ļ				
59.00         05900 CARDIAC CATHETERIZATION         251,862         69,622,027         0.03618         166,820         604         59.00           64.00         06000 LABORATORY         763,489         127,697,749         0.005979         1,357,964         8,119         60.00           65.00         06500 RESPI RATORY THERAPY         106,193         12,396,354         0.008566         573,154         4,910         65.00           66.00         06600 PHYSI CAL THERAPY         493,236         28,482,733         0.017317         217,956         3,74         66.00           67.00         06700 OCUPATI ONAL THERAPY         493,236         28,482,733         0.017317         217,956         3,74         66.00           68.00         06800 SPEECH PATHOLOGY         0         0.000000         0         0.000000         0         0.000000         0         0.68.00           90.00         0900 ELECTROCARDI OLOGY         103,039         21,069,992         0.004890         187,429         917         69.00         0           71.00         07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         281,360         55,768,244         0.005045         351,053         1,771         71.00           73.01         07300 DRUGS CHARGED TO PATI ENTS         523,791	· · · · · · · · · · · · · · · · · · ·					l	1
60. 00         06000 LABORATORY         763, 489         127, 697, 749         0, 005979         1, 357, 964         8, 119         00, 00           64. 00         06400 INTRAVENOUS THERAPY         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0         0, 000000         0         0         0         0, 000000         0         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0         0, 000000         0         0 <t< td=""><td></td><td></td><td></td><td>1</td><td>·</td><td>1</td><td></td></t<>				1	·	1	
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0							
65. 00   06500   RESPI RATORY THERAPY   106, 193   12, 396, 354   0.008566   573, 154   4, 910   65. 00   66. 00   06600   PHYSI CAL THERAPY   493, 236   28, 482, 733   0.017317   217, 956   3, 774   66. 00   67. 00   6700   0CCUPATI ONAL THERAPY   0 0.000000   0 0.000000   0 0   68. 00   68. 00   069. 00						l	
66. 00   06600   PHYSI CAL THERAPY   493, 236   28, 482, 733   0. 017317   217, 956   3, 774   66. 00   67. 00   0. 0000000   0   0. 0000000   0		_	_				1
67. 00   06700   06700   06700   06700   06700   06800					·		
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   103,039   21,069,992   0.004890   187,429   917   69. 00   07000   ELECTROENCEPHALOGRAPHY   142,869   13,592,218   0.010511   90,620   953   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   281,360   55,768,244   0.005045   351,053   1,771   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   523,791   103,635,962   0.005054   304,803   1,540   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   744,722   157,222,079   0.004737   2,153,649   10,202   73. 00   74. 00   07400   RENAL DI ALYSI S   46,870   3,788,222   0.012373   62,436   773   74. 00   75. 01   07500   ASC (NON-DI STINCT PART)   0   0   0.000000   0   0   75. 01   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0.000000   0   0   0.000000   75. 01   07697   CARDI AC REHABI LITATI ON   125,587   3,415,739   0.036767   10,004   368   769   76. 07   07697   CARDI AC REHABI LITATI ON   125,587   3,415,739   0.036767   10,004   368   779   79. 00   07000   CLI NI C   285,643   2,733,803   0.10486   0   0   0.000000   0   0   0.000000   79. 02   09000   CLI NI C   285,643   2,733,803   0.10486   0   0   0.000000   79. 03   09000   CLI NI C   285,643   2,733,803   0.10486   0   0   0.000000   79. 04   09000   CLI NI C   90,878   2,131,755   0.042631   0   0   90.02   79. 05   09000   O9000							
69. 00		-	-				1
70. 00   07000   ELECTROENCEPHALOGRAPHY   142, 869   13, 592, 218   0. 010511   90, 620   953   70. 00   71. 00		_	ļ			1	
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   281, 360   55, 768, 244   0.005045   351, 053   1, 771   71. 00   72. 00   72. 00   1MPL. DEV. CHARGED TO PATI ENTS   523, 791   103, 635, 962   0.005054   304, 803   1, 540   72. 00   73. 00   0.007300   DRUGS CHARGED TO PATI ENTS   744, 722   157, 222, 079   0.004737   2, 153, 649   10, 202   73. 00   74. 00   0.000000   0   0   0.000000   0						l	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   523, 791   103, 635, 962   0.005054   304, 803   1, 540   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   744, 722   157, 222, 079   0.004737   2, 153, 649   10, 202   73. 00   73. 01   07302   0P PHARMACY   0   0   0.000000   0   0   73. 01   07400   RENAL DIALYSIS   46, 870   3, 788, 222   0.012373   62, 436   773   74. 00   0.000000   0   0   0.000000   0							
73. 00   07300   DRUGS CHARGED TO PATIENTS   744, 722   157, 222, 079   0.004737   2, 153, 649   10, 202   73. 00   73. 01   07302   OP PHARMACY   0   0   0.000000   0   0   73. 01   74. 00   74. 00   0.7400   RENAL DIALYSIS   46, 870   3, 788, 222   0.012373   62, 436   773   74. 00   75. 00   0.0550   ASC (NON-DISTINCT PART)   0   0   0.000000   0   0   0.000000   0							1
73. 01 07302							
74. 00       07400       RENAL DIALYSIS       46, 870       3, 788, 222       0.012373       62, 436       773       74. 00         75. 00       07500       ASC (NON-DISTINCT PART)       0       0       0.000000       0       0       75. 00         76. 97       O7697       CARDI AC REHABI LI TATI ON       125, 587       3, 415, 739       0.036767       10, 004       368       76. 97         90. 00       O9000       CLI NI C       285, 643       2, 733, 803       0. 104486       0       0       0       90. 00         90. 01       O9001       OP ONCOLOGY INFUSION CENTER       160, 326       15, 953, 288       0. 010050       35, 706       359       90. 01         90. 02       O9002       WOUND CARE CENTER       160, 343       4, 703, 568       0. 034090       0       0       0       90. 02         90. 03       O9003       PAI N CLINIC       90, 878       2, 131, 755       0. 042631       0       0       0       90. 03         90. 05       O9005       OP PSYCH CLINIC       303, 393       2, 919, 690       0. 103913       346       36       90. 05         91. 00       O9100       EMERGENCY       1, 015, 881       112, 529, 791       0. 0090028 </td <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td>		1					
75. 00		_					
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0.000000 0.000000 0 0.000000 0 75. 01 76. 97 07697 CARDI AC REHABI LI TATI ON 125, 587 3, 415, 739 0.036767 10, 004 368 76. 97  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 285, 643 2, 733, 803 0.104486 0 0 0 0 0  90. 01 09001 OP ONCOLOGY I NFUSI ON CENTER 160, 326 15, 953, 288 0.010050 35, 706 359 90. 01  90. 02 09002 WOUND CARE CENTER 160, 343 4, 703, 568 0.034090 0 0 0 90. 02  90. 03 09003 PAI N CLI NI C 90, 878 2, 131, 755 0.042631 0 0 0 90. 03  90. 05 09005 OP PSYCH CLI NI C 303, 393 2, 919, 690 0.103913 346 36 90. 05  91. 00 09100 EMERGENCY 1, 015, 881 112, 529, 791 0.009028 478, 263 4, 318 91. 00  92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 523, 938 23, 753, 485 0.022057 20, 798 459  94. 00 09500 AMBULANCE SERVI CES						l e	
76. 97 O7697 CARDI AC REHABI LI TATI ON 125, 587 3, 415, 739 0. 036767 10, 004 368 76. 97 OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 285, 643 2, 733, 803 0. 104486 0 0 0 90. 00 90. 01 09001 OP ONCOLOGY I NFUSI ON CENTER 160, 326 15, 953, 288 0. 010050 35, 706 359 90. 01 90. 02 09002 WOUND CARE CENTER 160, 343 4, 703, 568 0. 034090 0 0 90. 02 90. 03 09003 PAI N CLI NI C 90, 878 2, 131, 755 0. 042631 0 0 90. 03 09003 PAI N CLI NI C 303, 393 2, 919, 690 0. 103913 346 36 90. 05 09 09005 OP PSYCH CLI NI C 303, 393 2, 919, 690 0. 103913 346 36 90. 05 09005 OP DSYCH CLI NI C 303, 393 2, 919, 690 0. 103913 346 36 90. 05 09005 DP DSYCH CLI NI C 303, 393 2, 919, 690 0. 103913 346 36 90. 05 09005 OP DSERVATI ON BEDS (NON-DI STI NCT PART) 523, 938 23, 753, 485 0. 022057 20, 798 459 92. 00 OTHER REI MBURSABLE COST CENTERS  94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0.000000 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES		1	_				
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTER   OUTPATIENT SERVICE   OUTPATIENT SE		_				1	
90. 00   09000   CLINIC   285, 643   2,733,803   0.104486   0   0   0   00   00   00   00   00		123,307	3,413,737	0.03070	10,004	300	70.77
90. 01   09001   0P ONCOLOGY I NFUSI ON CENTER   160, 326   15, 953, 288   0.010050   35, 706   359   90. 01   90. 02   90.02   WOUND CARE CENTER   160, 343   4, 703, 568   0.034090   0   0   90. 02   90. 03   09003   PAI N CLI NI C   90, 878   2, 131, 755   0.042631   0   0   90. 03   90. 05   09005   0P PSYCH CLI NI C   303, 393   2, 919, 690   0.103913   346   36   90. 05   91. 00   09100   EMERGENCY   1, 015, 881   112, 529, 791   0.009028   478, 263   4, 318   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   523, 938   23, 753, 485   0.022057   20, 798   459   94. 00   09500   AMBULANCE SERVI CES   0   0   0.000000   0   0   94. 00   95. 00   09500   AMBULANCE SERVI CES   95. 00		285, 643	2, 733, 803	0. 10448	36 0	0	90.00
90. 02   09002   WOUND CARE CENTER   160, 343   4, 703, 568   0. 034090   0   0   0   90. 02   90. 03   09003   PAI N CLINIC   90, 878   2, 131, 755   0. 042631   0   0   90. 03   90. 05   09005   0P PSYCH CLINIC   303, 393   2, 919, 690   0. 103913   346   36   90. 05   91. 00   09100   EMERGENCY   1, 015, 881   112, 529, 791   0. 009028   478, 263   4, 318   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   523, 938   23, 753, 485   0. 022057   20, 798   459   92. 00   94. 00   09500   AMBULANCE SERVICES   0   0   0. 000000   0   94. 00   95. 00   09500   AMBULANCE SERVICES   95. 00				1			
90. 03   09003   PAIN CLINIC   90. 878   2, 131, 755   0. 042631   0   0   0   90. 03   90. 05   90. 05   09005   09 PSYCH CLINIC   303, 393   2, 919, 690   0. 103913   346   36   90. 05   91. 00   09100   EMERGENCY   1, 015, 881   112, 529, 791   0. 009028   478, 263   4, 318   91. 00   92. 00   085ervation   BEDS (NON-DISTINCT PART)   523, 938   23, 753, 485   0. 022057   20, 798   459   92. 00   07   09500   MBULANCE SERVICES   0   0   0. 000000   0   0   0   94. 00   95. 00   09500   AMBULANCE SERVICES						l	
90. 05   09005   09 PSYCH CLINIC   303, 393   2, 919, 690   0. 103913   346   36   90. 05   91. 00   09100   EMERGENCY   1, 015, 881   112, 529, 791   0. 009028   478, 263   4, 318   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   523, 938   23, 753, 485   0. 022057   20, 798   459   92. 00   07   000000   0000000000000000000						0	
91. 00   09100   EMERGENCY   1, 015, 881   112, 529, 791   0. 009028   478, 263   4, 318   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   523, 938   23, 753, 485   0. 022057   20, 798   459   92. 00   OTHER REI MBURSABLE COST CENTERS   09400   HOME PROGRAM DI ALYSI S   0 09500   AMBULANCE SERVI CES   0 95. 00   09500   AMBULANCE SERVI CES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
92. 00						•	
OTHER REI MBURSABLE COST CENTERS           94. 00         09400 HOME PROGRAM DI ALYSI S         0         0.000000         0         0         94. 00           95. 00         09500 AMBULANCE SERVI CES         95. 00         0         0.000000         95. 00				1	·		
94. 00		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1
95. 00   09500   AMBULANCE   SERVI CES   95. 00		0	C	0.00000	00 0	0	94. 00
	200.00   Total (lines 50 through 199)	10, 724, 762	1, 201, 711, 571		7, 647, 034	64, 076	200. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	TS Provider Co		Period: From 01/01/2017 To 12/31/2017		pared:
		Titl	e XIX	Hospi tal	PPS	o alli
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adj ustments	1 00	Adjustments		Education Cost	
INPATIENT ROUTINE SERVICE COST CENTERS	1A	1.00	2A	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	J (	0	0	30.00
31. 00   03100   NTENSI VE CARE UNI T		_	1		0	
32. 00 03200 CORONARY CARE UNIT		0			0	32. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	0	Ö		o o	Ö	1
41. 00   04100   SUBPROVI DER -   RF	0	0		0	0	41. 00
42. 00   04200   SUBPROVI DER	0	0		0	0	42.00
43. 00   04300   NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0	(	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpatient	
	Adjustment Amount (see	(sum of cols. 1 through 3,	Days	5 ÷ col . 6)	Program Days	
	instructions)	minus col. 4)				
	4. 00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1,			30. 00
31.00  03100   INTENSIVE CARE UNIT		0	-,		367	1
32.00 03200 CORONARY CARE UNIT		0	3, 29		0	32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0	2, 79			1
41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER	0	_	_,,,			
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY			1			
200.00 Total (lines 30 through 199)						200. 00
Cost Center Description	I npati ent	-		-	=/	
· ·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8) 9.00	_				
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00   03000   ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
41. 00   04100   SUBPROVI DER -   RF	0					41. 00
42. 00   04200   SUBPROVI DER	0					42. 00
43. 00   04300   NURSERY	0					43. 00
200.00   Total (lines 30 through 199)	0					200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

			1	To 12/31/2017	Date/Time Pre 5/27/2018 9:1	pared: 8 am
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Non Physician		Nursing School	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	C	) C	) (	0	0	50.00
50. 01   05001   CV   SURGERY	C	) C	) (	0	0	50. 01
51.00   05100   RECOVERY ROOM	C	) C	) (	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	C	) C	) (	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	C	) C	) (	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C	) C	) (	0	0	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	C	) C	) (	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	C	) C	) (	0	0	56. 00
57.00  05700 CT SCAN	C	) C	) (	0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	C	) C	) (	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	C	) C	) (	0	0	59. 00
60. 00  06000 LABORATORY	C	) C	) (	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	C	) C	) (	0	0	64. 00
65. 00  06500 RESPIRATORY THERAPY	C	) C	) (	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	C	) C	) (	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	C	) C	) (	0	0	67. 00
68.00   06800   SPEECH PATHOLOGY	C	) C	) (	0	0	68. 00
69. 00  06900  ELECTROCARDI OLOGY	C	) C	) (	0	0	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY	C	) C	) (	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	) C	) (	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	) C	) (	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	) C	) (	0	500, 895	73. 00
73. 01   07302   OP PHARMACY	C	) C	) (	0	0	73. 01
74. 00   07400   RENAL DI ALYSI S	C	) C	) (	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	C	) C	) (	0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	) C	) (	0	0	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	C	) C	) (	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	C		) (	0	0	90. 00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	C	) C	) (	0	0	90. 01
90. 02 09002 WOUND CARE CENTER	C	) C	) (	0	0	90. 02
90. 03   09003   PAIN CLINIC	C	)  C	) (	0	0	90. 03
90. 05   09005   OP PSYCH CLINIC	C	)  C	) (	0	0	90. 05
91. 00  09100 EMERGENCY	C	1	) (	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	)			0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	C	) C		0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	C	)  C	)  C	0	500, 895	200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

			Т	o 12/31/2017	Date/Time Prep 5/27/2018 9:18	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of col 1		(from Wkst. C,	to Charges	
	Education Cost	9	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				10/ 000 /05	0.000000	F0 00
50. 00   05000   OPERATI NG ROOM	0	0			0.000000	
50. 01   05001 CV SURGERY	0	0			0.000000	
51. 00   05100   RECOVERY ROOM	0	0	0		0.000000	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	35, 111, 417	0.000000	
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	F/ 400 313	0.000000	
	0	0	0	56, 490, 313 84, 641, 454	0.000000	
55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	0	0	0	84, 641, 454	0. 000000 0. 000000	55. 00 56. 00
57. 00   05700   CT   SCAN	0	0		27 200 045	0. 000000	57.00
58. 00   05700   CT   SCAN 58. 00   05800   MAGNETIC   RESONANCE   MAGING (MRI)		0			0. 000000	
59. 00   05900 CARDI AC CATHETERI ZATI ON		0			0. 000000	59.00
60. 00   06000   LABORATORY		0			0. 000000	60.00
64. 00   06400   NTRAVENOUS THERAPY		0			0. 000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		_	0. 000000	
66. 00   06600   PHYSI CAL THERAPY	0	0	0		0. 000000	
67. 00   06700 OCCUPATI ONAL THERAPY	0	0	0	28, 482, 733 0	0. 000000	
68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0. 000000	
69. 00   06900   ELECTROCARDI OLOGY	0	0	0		0. 000000	
70. 00 07000 ELECTROCARDI OLOGT		0			0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	·		0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS		500, 895	1		0. 000000	
73. 01   07302   OP   PHARMACY		300, 693	500, 693		0.003188	
74. 00   07400   RENAL DI ALYSI S		0		_	0. 000000	
75. 00   07500   ASC (NON-DISTINCT PART)		0	0	3, 700, 222	0. 000000	
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0			0. 000000	75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			0. 000000	
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		3, 415, 737	0.000000	70. 77
90. 00 09000 CLINIC	0	0	0	2, 733, 803	0. 000000	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER		0			0. 000000	
90. 02   09002   WOUND CARE CENTER		0			0. 000000	
90. 03   09003   PAIN CLINIC	o o	0	0		0. 000000	
90. 05   09005   OP PSYCH CLINIC		0	·		0. 000000	
91. 00   09100   EMERGENCY	o o	0	1		0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o o	0			0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	,			20, 700, 400	0.00000	, 2. 00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0. 000000	94. 00
95. 00   09500   AMBULANCE   SERVI CES		O			2. 000000	95. 00
200.00 Total (Lines 50 through 199)	0	500, 895	500, 895	1, 201, 711, 571		200. 00
( <del>-</del>	1	, 0,0	1 222, 070	,, , 0, .	'	

| In Lieu of Form CMS-2552-10 | Period: Worksheet D | From 01/01/2017 Part IV | To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

						5/27/2018 9: 1	8 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS				*		
50.00	05000 OPERATI NG ROOM	0. 000000	516, 272		0 0	0	50. 00
50. 01	05001 CV SURGERY	0. 000000	. 0		0 0	l o	50. 01
51. 00	05100 RECOVERY ROOM	0. 000000	71, 650		0 0	O	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	506, 858		0 0	Ö	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	i	0 0	Ö	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	271, 503		0 0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	54, 733	•	0 0	- 1	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	04, 739		0 0	٥	56. 00
57. 00	05700 CT SCAN	0.000000	166, 822		0 0		57. 00
58. 00		0. 000000			0 0		58. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)		48, 195		0 0	_	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000	166, 820		-1	0	59. 00
60.00	06000 LABORATORY	0. 000000	1, 357, 964		0 0	_	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	573, 154		0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	217, 956		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	187, 429		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	90, 620		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	351, 053		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	304, 803		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 003186	2, 153, 649	6, 86	2 0	l o	73. 00
73. 01	07302 OP PHARMACY	0. 000000	0	,	0 0	O	73. 01
74. 00	07400 RENAL DIALYSIS	0. 000000	62, 436		0 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	02, .00	l	0 0	- 1	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0		75. 01
	07697 CARDI AC REHABI LI TATI ON	0. 000000	10, 004		0 0		76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	0.000000	10, 004	l .	0		70.77
90. 00	09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 00	09001 OP ONCOLOGY INFUSION CENTER	0. 000000	35, 706		0 0		90.00
90. 01	09002 WOUND CARE CENTER	0. 000000	33, 700		0 0	0	90.01
	09003 PALN CLINIC	1	0		-	- 1	
90. 03		0.000000	0		0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	0. 000000	346		0		90. 05
91. 00	09100 EMERGENCY	0. 000000	478, 263		0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	20, 798	L	0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS				_		
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		7, 647, 034	6, 86	2 0	0	200. 00

Cost Center Description	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/27/2018 9:1	pared:
Cost Center Description			Ti tl	e XIX	Hospi tal	PPS	
Ratio From				Charges		Costs	
Morksheet C, Part I, col. 9	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
ANCI LLARY SERVICE COST CENTERS		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
Ded. & Coins.   See inst.		Worksheet C,	inst.)	Servi ces	Services Not		
NOTE   NOTE		Part I, col. 9	)	Subject To	Subject To		
1.00   2.00   3.00   4.00   5.00				Ded. & Coins.			
ANCILLARY SERVICE COST CENTERS				(see inst.)	(see inst.)		
50.00   GS000  OPERATING ROOM   0.092729   0 1.197.038   0 0   0 50.00		1. 00	2.00	3. 00	4. 00	5. 00	
50.01   05001   CV SURGERY   0.000000   0   0   0   0   50.01			_			_	
51.00   05100   RECOVERY ROOM   C. 205087   0   265, 421   0   0   51.00   52.00   0520   0ELIVERY ROOM   LABOR ROOM   0. 202140   0   140, 072   0   52.00   53.00   05300   ARESTHESIOLOGY   0. 000000   0   0   0   0   53.00   05300   ARESTHESIOLOGY   0. 000000   0   0   0   0   53.00   0. 000000   0   0   0   0   0   0			1			_	
52.00   05200   05200   05200   05200   05200   05200   052.00   052.00   053.00   053.00   053.00   053.00   053.00   053.00   054.00   054.00   054.00   054.00   055.00   05500   05500   05500   05500   0800   0207-HERAPEUTI C   0.079135   0.56.38,377   0.0   0.54.00   0.0500   0.0			1				
53. 00   05300   ANESTHESI OLOGY   0.0000000   0   0   0   0   53. 00				265, 42	1 0	0	51. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 137366   0   633, 972   0   0   54. 00	52.00  05200 DELIVERY ROOM & LABOR ROOM	0. 222140	0	140, 07	2 0	0	52. 00
55.00   05500   RADIO LOGY-THERAPEUTIC   0.079135   0.53,837   0.055.00   0.55.00   0.0500	53. 00   05300   ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
56.00   05600 RADI DI SOTOPE	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 137366	0	633, 97	2 0	0	54.00
57. 00   05700   CT SCAN   0.062377   0   243, 512   0   0   57. 00   59. 00   05800   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.104312   0.55. 031   0   0.58. 00   05900   CARDIAC CATHETERIZATION   0.050488   0.100, 979   0   0.59. 00   060. 00   06000   CARDIAC CATHETERIZATION   0.132447   0   1, 169, 470   0   0.60. 00   0.00	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 079135	0	563, 83	7 0	0	55. 00
58. 00   05800   MAGNETIC RESONANCE I INAGING (MRI )   0. 104312   0   55, 031   0   0   58, 00   059, 00   059, 00   06000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
58. 00   05800   MAGNETIC RESONANCE I INAGING (MRI )   0. 104312   0   55, 031   0   0   58, 00   059, 00   059, 00   06000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	57. 00 05700 CT SCAN	0. 062377	· O	243, 51	2 0	0	57. 00
59. 00   05900   CARDIAC CATHETERI ZATION   0. 05048B   0   100, 979   0   0   59, 00	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)					0	58. 00
60. 00   06000   LABORATORY   0. 132447   0   1, 169, 470   0   0   0   0   0   0   0   0   0						0	1
64.00   06400   INTRAVENOUS THERAPY   0.000000   0   0   0   64.00							
65. 00   06500   06500   06500   06500   06500   06500   066				1, 10,, 1,		_	
66.00	· · · · · · · · · · · · · · · · · · ·		l control of the cont	31 36	-	_	
67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0.000000   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0.084457   0   94. 991   0   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0.118159   0   151, 058   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.253813   0   392, 122   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.254284   0   561, 046   0   0   72. 00   73. 01   07300   DRUGS CHARGED TO PATI ENTS   0.220438   0   1, 135, 693   0   0   73. 00   73. 01   07302   DP PHARMACY   0.000000   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0.401181   0   76, 344   0   0   74. 00   75. 01   07500   ASC (NON-DISTINCT PART)   0.000000   0   0   0   0   0   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0.000000   0   0   0   0   76. 97   07697   CARDII AC REHABI LI TATI ON   0.399184   0   279   0   0   76. 97   000000   CLI NI C   0   0.926940   0   16, 970   0   0   0   70. 01   09001   0P ONCOLOGY I NFUSI ON CENTER   0.365743   0   61, 002   0   90. 01   70. 02   09002   WOUND CARE CENTER   0.365743   0   61, 002   0   90. 02   70. 03   09003   PAIN CLI NI C   0   0.290143   0   15, 746   0   0   90. 02   71. 00   09001   0P ONCOLOGY I NFUSI ON CENTER   0.365743   0   61, 002   0   90. 03   71. 00   09003   OP PSYCH CLI NI C   0.290143   0   17, 98, 788   0   0   90. 03   71. 00   09004   DEBROENCY   0.119589   0   1, 798, 788   0   0   90. 05   71. 00   09004   DEBROENCY   0.119589   0   1, 198, 788   0   0   90. 00   72. 00   09004   DEBROENCY   0.119589   0   1, 198, 785   95. 00   73. 01   07004   DEBROENCH   0.256671   0   496, 573   0   0   90. 00   74. 00   09004   DEBROENCH   0.256671   0   496, 573   0   0   90. 00   74. 00   09004   DEBROENCH   0.256671   0   496, 573   0   0   90. 00   74. 00   09004   09004   09004   09004   09004   09004   09004   09004   09004   09004   09004   09004   09004   09004   09004   09004   09004	· · · · · · · · · · · · · · · · · · ·		l control of the cont				1
68. 00   06800   SPEECH PATHOLOGY   0.000000   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDIOLOGY   0.084457   0   94,991   0   0   69. 00   71. 00   07000   ELECTROCARDIOLOGY   0.118159   0   151,058   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.253813   0   392,122   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.254284   0   561,046   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.254284   0   561,046   0   0   73. 00   73. 01   07300   DRUGS CHARGED TO PATIENTS   0.254284   0   561,046   0   0   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.254284   0   561,046   0   0   0   73. 01   07302   OP PHARMACY   0.000000   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0.401181   0   76,344   0   0   74. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0.000000   0   0   0   0   0   75. 01   07507   CARDI AC REHABILITATION   0.399184   0   279   0   0   0   76. 97   O7697   CARDI AC REHABILITATION   0.399184   0   279   0   0   0   76. 97   O7000   CLI NI C   0.926940   0   16,970   0   0   76. 90. 01   09001   OP ONCOLOGY INFUSION CENTER   0.181139   0   252,846   0   0   90. 01   76. 90. 02   09002   WOUND CARE CENTER   0.365743   0   61,002   0   90. 02   76. 90. 03   09003   PIN CLI NI C   0.290143   0   15,746   0   0   90. 03   76. 90. 05   09005   OP PSYCH CLINIC   1.002137   0   12,142   0   0   90. 03   76. 90. 05   09005   OP PSYCH CLINIC   1.002137   0   12,142   0   0   90. 05   77. 00   09100   EMERGENCY   0.119589   0   1,798,788   0   0   91. 00   77. 00   09100   MBLLANCE SERVI CES   0.000000   0   0   11,1422,126   0   0   90. 00   77. 00   09500   AMBULANCE SERVI CES   0.234995   0   1,197,875   95. 00   78. 00   09500   AMBULANCE SERVI CES   0.0200000   0   0   0   0   79. 00   09500   AMBULANCE SERVI CES   0.234995   0   1,197,875   95. 00   79. 00   09500   09500   AMBULANCE SERVI CES   0.0200000   0   0   0   0   79. 00   09500   09500   09500   09500   09500   09500   09500   09500   09500	· · · · · · · · · · · · · · · · · · ·		l control of the cont	757,75			
69.00   06900   ELECTROCARDI OLOGY   0.084457   0   94,991   0   0   69.00     70.00   07000   ELECTROCARDI OLOGY   0.118159   0   151,058   0   0   70.00     70.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.253813   0   392,122   0   0   71.00     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.254284   0   561,046   0   0   72.00     73.00   07300   DRUGS CHARGED TO PATI ENTS   0.220438   0   1,135,693   0   0   73.00     73.01   07302   OP PHARMACY   0.000000   0   0   0   0   0   74.00     74.00   07400   RENAL DI ALYSI S   0.401181   0   76,344   0   0   74.00     75.01   03550   PSVCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0.000000   0   0   0   0   0     76.97   07697   CARDI AC REHABI LI TATI ON   0.399184   0   279   0   0   76.97     09.00   09000   CLI NI C   0.926940   0   16,970   0   90.00     09.01   09001   OP ONCOLOGY I NFUSI ON CENTER   0.181139   0   252,846   0   0   90.01     90.02   09002   WOUND CARE CENTER   0.365743   0   61,002   0   90.03     90.03   09003   PAIN CLI NI C   0.290143   0   15,746   0   0   90.03     90.05   09905   OP PSYCH CLI NI C   0.290143   0   15,746   0   0   90.05     90.06   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0.256671   0   496,573   0   92.00     09200   09500   AMBULANCE SERVI CES   0.234995   0   1,197,875   95.00     200.00   Subtotal (see instructions)   0   11,422,126   0   0   200.00     201.00   001   Charges				-	_	1	
70.00   07000   ELECTROENCEPHALOGRAPHY   0.118159   0   151, 058   0   0   70.00   7				04 00			
71. 00						_	1
72. 00			l control of the cont			_	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 220438   0   1, 135, 693   0   0   73. 00   73. 01   07302   OP PHARMACY   0. 0000000   0   0   0   0   0   73. 01   074. 00   07400   RENAL DIALYSIS   0. 401181   0   76, 344   0   0   74. 00   07500   ASC (NON-DISTINCT PART)   0. 000000   0   0   0   0   0   0   0	· · · · · · · · · · · · · · · · · · ·		l control of the cont				
73. 01	· · · · · · · · · · · · · · · · · · ·		1				1
74. 00				1, 135, 69		_	1
75. 00   07500   ASC (NON-DISTINCT PART)   0. 0000000   0   0   0   0   0   0				7, 0,	-		
75. 01				/6, 34			
76. 97 O7697 CARDI AC REHABILITATION 0. 399184 0 279 0 0 76. 97 OUTPATI ENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 0. 926940 0 16, 970 0 0 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 9002 WOUND CARE CENTER 0. 365743 0 61, 002 0 0 90. 02			l control of the cont		-	_	
OUTPATIENT SERVICE COST CENTERS   O. 926940   O			1		-	_	
90. 00		0. 399184	1 0	27	9  0	0	/6.9/
90. 01		0.00/040		1/ 07		0	00.00
90. 02			l .				
90. 03			1	, .		_	
90. 05						_	
91. 00   09100   EMERGENCY   0. 119589   0   1,798,788   0   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0. 256671   0   496,573   0   0   92. 00    OTHER REI MBURSABLE COST CENTERS   09400   HOME PROGRAM DI ALYSI S   0. 000000   0   94. 00   95. 00   09500   AMBULANCE SERVI CES   0. 234995   0   1,197,875   95. 00   200. 00   Subtotal (see instructions)   0   11,422,126   0   0   200. 00   201. 00   Less PBP Clinic Lab. Services-Program   0   0   201. 00			1			_	
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 256671   0   496, 573   0   0   92. 00							1
OTHER REIMBURSABLE COST CENTERS   O9400   HOME PROGRAM DI ALYSIS   O. 000000   O9500   AMBULANCE SERVICES   O. 234995   O 1, 197, 875   O9500   O950	· · · · · · · · · · · · · · · · · · ·		1			_	
94. 00 95. 00 95. 00 200. 00 201. 00 09400 HOME PROGRAM DIALYSIS 0, 000000 09500 AMBULANCE SERVICES 0, 234995 0 1, 197, 875 0 11, 422, 126 0 0 200. 00 201. 00 0 0 201. 00		0. 256671	0	496, 57	3 0	0	92. 00
95. 00   09500   AMBULANCE SERVICES   0. 234995   0   1, 197, 875   95. 00   200. 00   201. 00   Less PBP Clinic Lab. Services-Program   0   0   0   201. 00   0   0   0   0   0   0   0   0   0				1			
200.00 Subtotal (see instructions) 0 11,422,126 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					~		
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges		0. 234995	l l				
Only Charges			0	11, 422, 12		0	
					0		201. 00
202.00   Net unarges (line 200 - line 201)     0  11,422,126  0  0 202.00			_	44 100 1-	,	_	000 00
	202.00   Net unarges (line 200 - line 201)	l	1 0	11, 422, 12	b  0	0	1202.00

	O HEALTH BLOOMI			1 of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 15		Worksheet D
			From 01/01/2017	Part V
			To 12/31/2017	Date/Time Prepared:
		TI.I. VI.V		5/27/2018 9:18 am
		Title XIX	Hospi tal	PPS
		sts		
Cost Center Description	Cost	Cost		
	Rei mbursed	Rei mbursed		
	Servi ces	Services Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
ANOTHER DESIGNATION OF THE PROPERTY OF THE PRO	6. 00	7.00		
ANCI LLARY SERVI CE COST CENTERS	1			
50.00   05000   OPERATING ROOM	111, 000			50.00
50. 01  05001 CV SURGERY	0	0		50. 01
51. 00   05100 RECOVERY ROOM	54, 434	o		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	31, 116	l ol		52. 00
53. 00   05300   ANESTHESI OLOGY	0.7.10	o o		53. 00
	_	1		
54. 00   05400   RADI OLOGY - DI AGNOSTI C	87, 086	1		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	44, 619			55. 00
56. 00   05600   RADI 0I SOTOPE	0	0		56. 00
57. 00   05700 CT SCAN	15, 190	o		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 740	l ol		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 098	1		59. 00
60. 00   06000   LABORATORY		1		60.00
	154, 893	1		
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00  06500  RESPI RATORY THERAPY	9, 303	0		65. 00
66. 00   06600   PHYSI CAL THERAPY	326, 185	0		66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	l ol		67.00
68. 00 06800 SPEECH PATHOLOGY	0	ol		68. 00
69. 00 06900 ELECTROCARDI OLOGY	8, 023	1		69. 00
· · · · · · · · · · · · · · · · · · ·	17, 849			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	99, 526	1		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	142, 665	0		72. 00
73.00   07300   DRUGS CHARGED TO PATIENTS	250, 350	0		73.00
73. 01 07302 OP PHARMACY	0	o		73. 01
74.00 07400 RENAL DIALYSIS	30, 628	l ol		74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	l ol		75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		75. 01
	_	1 -1		
76. 97 O7697 CARDI AC REHABI LITATION	111	0		76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00  09000  CLI NI C	15, 730	0		90.00
90. 01   09001 OP ONCOLOGY INFUSION CENTER	45, 800	O		90. 01
90. 02 09002 WOUND CARE CENTER	22, 311	l ol		90. 02
90. 03   09003   PAIN CLINIC	4, 569	ol		90. 03
90. 05   09005   OP PSYCH CLINIC		1		90. 05
	12, 168			
91. 00   09100   EMERGENCY	215, 115	1		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	127, 456	0		92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	281, 495			95. 00
200.00 Subtotal (see instructions)	2, 118, 460			200.00
201.00 Less PBP Clinic Lab. Services-Program	2, 110, 400	1		201. 00
9		]		201.00
Only Charges (Line 200 Line 201)	2 110 4/0			202 00
202.00   Net Charges (line 200 - line 201)	2, 118, 460	0		202. 00

llool +h	Financial Systems	LUEALTH DLOOM	NCTON HOSDITAL		la li o	u of Form CMC	2552 10
	Financial Systems II TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		NGTON HOSPITAL  Provider C		Peri od:	u of Form CMS-: Worksheet D	2552-10
AFFURI	TONNIENT OF THEATTENT ANCIELARY SERVICE CAPITA	L 00313	FIOVIDE		From 01/01/2017	Part II	
			Component		To 12/31/2017	Date/Time Pre 5/27/2018 9:1	
			Titl	e XIX	Subprovi der – I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	· ·		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	TANGLEL ARY OF DUTY OF COOK OF STATERS	1.00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	4.75/.044	404 000 405	0.0000		0	
50.00	05000 OPERATING ROOM	1, 756, 941		1		0	
50. 01	05001 CV SURGERY	0		0.00000		0	50. 01
51.00	05100 RECOVERY ROOM	241, 855		1		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 052, 259	1			0	
53. 00	05300 ANESTHESI OLOGY	0	1	0.00000		0	00.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	703, 500				17	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	707, 093	1			0	55. 00
56. 00	05600 RADI OI SOTOPE	0	1	0.00000		0	56. 00
57. 00	05700 CT SCAN	68, 405		1		0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	71, 289		1		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	251, 862				0	
60.00	06000 LABORATORY	763, 489				33	1
64. 00	06400 I NTRAVENOUS THERAPY	0	1	0.00000		0	64. 00
65. 00	06500 RESPI RATORY THERAPY	106, 193				3	65. 00
66. 00	06600 PHYSI CAL THERAPY	493, 236		1		1, 402	1
67. 00	06700 OCCUPATI ONAL THERAPY	0				0	07.00
68. 00	06800 SPEECH PATHOLOGY	0	1	0.00000		0	
69. 00	06900 ELECTROCARDI OLOGY	103, 039				0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	142, 869				0	,
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	281, 360		1		0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	523, 791				0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	744, 722				85	1
73. 01	07302 OP PHARMACY	0	٦	0.00000		0	
74. 00	07400 RENAL DI ALYSI S	46, 870				0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	1			0	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1	0. 00000		0	,
76. 97	07697 CARDI AC REHABI LI TATI ON	125, 587	3, 415, 739	0. 03676	7 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	285, 643	2, 733, 803	0. 10448	6 0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	160, 326		1		15	1
90. 02	09002 WOUND CARE CENTER	160, 343				0	1 /0.02
90. 03	09003 PAIN CLINIC	90, 878	2, 131, 755	0. 04263	1 0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	303, 393	2, 919, 690	0. 10391	3 0	0	90. 05
91. 00	09100 EMERGENCY	1, 015, 881	112, 529, 791	0. 00902		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	23, 753, 485	0.00000	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0	0	94.00

0

10, 200, 824 1, 201, 711, 571

0

107, 559

0 94.00 95.00 1,555 200.00

Health Financial Systems	IU HEALTH BLOOMING	TON HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0051 Component CCN: 15-T051	Peri od: From 01/01/2017 To 12/31/2017	Date/Time Prepared:
		T: +I - VIV	Culturate at all and	5/27/2018 9:18 am

			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	C	_	1	0	0	50.00
	05001 CV SURGERY	C	0	) (	0	0	50. 01
51. 00	05100 RECOVERY ROOM	C	0	) (	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	0	)	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	C	0		0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	C	0		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	0		0	0	55. 00
56. 00	05600   RADI OI SOTOPE	C	0		0	0	56. 00
57. 00	05700 CT SCAN		0		0	0	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)		0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				0	0	59. 00
60.00	06000 LABORATORY				0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY				0	0	64.00
65. 00	06500 RESPIRATORY THERAPY				0	0	65.00
66. 00	06600 PHYSI CAL THERAPY				0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY				0	0	67.00
	06800 SPEECH PATHOLOGY				0	0	68. 00
	06900 ELECTROCARDI OLOGY				0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY				0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS				0	500 005	72.00
	07300 DRUGS CHARGED TO PATIENTS				0	500, 895	73.00
	07302 OP PHARMACY				0	0	73. 01
	07400 RENAL DI ALYSI S				0	0	74.00
	07500 ASC (NON-DISTINCT PART)					0	75. 00
	03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   07697   CARDI AC REHABI LI TATI ON					0	75. 01 76. 97
76. 97	OUTPATIENT SERVICE COST CENTERS		0	1	) 0	0	76.97
90.00	09000 CLINI C	C	0	) (	0	0	90.00
	09001 OP ONCOLOGY INFUSION CENTER				0	0	90. 01
	09002 WOUND CARE CENTER		l o		Ö	0	90. 02
	09003 PAIN CLINIC				0	0	90. 03
	09005 OP PSYCH CLINIC				0	0	90.05
	09100 EMERGENCY	C	o c		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C			)	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DIALYSIS	C	C	) (	0	0	94. 00
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	c	O	) (	0	500, 895	200. 00

Health Financial Systems	J HEALTH BLOOMI	NCTON HOSDITAL		In Lie	u of Form CMS-2	)EE2 10
Health Financial Systems II APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od:	Worksheet D	2552-10
THROUGH COSTS	VIOL OTHER TAGE			From 01/01/2017	Part IV	
		Component	CCN: 15-T051	Го 12/31/2017	Date/Time Prep 5/27/2018 9:18	oared: 3 am
		Ti tl	e XIX	Subprovi der -	PPS	
		T	T	IRF	D 11 C 0 1	-
Cost Center Description	All Other Medical	Total Cost (sum of col 1	Total Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
	Education Cost	`	Cost (sum of		(col. 5 ÷ col.	
	Luucati on cost	4)	col. 2, 3 and		7)	
		'/	4)		,,	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	(	196, 889, 625	0.000000	50.00
50. 01   05001   CV   SURGERY	0	0	(	0	0.000000	50. 01
51.00   05100   RECOVERY ROOM	0	0		29, 604, 389		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0		35, 111, 417	0. 000000	52.00
53. 00   05300   ANESTHESI OLOGY	0	0		0	0. 000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	56, 490, 313	0. 000000	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	(	84, 641, 454		55. 00
56. 00   05600   RADI 01 SOTOPE	0	0		0	0. 000000	56. 00
57. 00   05700   CT   SCAN	0	0	1	27, 300, 845	0.000000	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		10, 256, 829		58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	0		69, 622, 027	0.000000	59.00
60. 00   06000   LABORATORY 64. 00   06400   I NTRAVENOUS THERAPY	0		]	127, 697, 749	0. 000000 0. 000000	60. 00 64. 00
65. 00   06500   RESPIRATORY THERAPY			] :	12, 396, 354		64. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY			] /	28, 482, 733		66.00
67. 00   06700   OCCUPATI ONAL THERAPY			] /	20,402,733	0.000000	67. 00
or. or or or or or or or or or or or or or	1	٥	1	7	0.000000	07.00

Heal th   Financial   Systems   IU   HEALTH   BLOOMINGTON   HOSPITAL   In   Lieu of   Form   CMS-2552-10
Component CCN: 15-T051   From 01/01/2017   Part IV Date/Time Prepared: 5/27/2018 9: 18 am
Component CCN: 15-T051   To   12/31/2017   Date/Time Prepared: 5/27/2018 9: 18 am
Cost Center Description
Cost Center Description
To Charges   Charges   Charges   Pass-Through   Costs (col. 8   x col. 10)   x col. 12)
Costs (col. 8   Costs (col. 9   x col. 12)   y col. 12)   y col. 12)   y col. 12)   x col. 12)   y col. 12)
7   x col 10   x col 12
9. 00 10. 00 11. 00 12. 00 13. 00  ANCI LLARY SERVI CE COST CENTERS  50. 00 05000 OPERATI NG ROOM 0. 000000 0 0 0 0 50. 00 50. 01 05001 CV SURGERY 0. 000000 0 0 0 0 50. 01 51. 00 05100 RECOVERY ROOM 0. 000000 0 0 0 0 51. 00
ANCI LLARY   SERVI CE   COST   CENTERS
50. 00         05000         OPERATI NG ROOM         0.000000         0         0         0         0         50. 00           50. 01         05001         CV SURGERY         0.000000         0         0         0         0         0         50. 01           51. 00         05100         RECOVERY ROOM         0.000000         0         0         0         0         0         51. 00
50. 01     05001     CV SURGERY     0.000000     0     0     0     0     50. 01       51. 00     05100     RECOVERY ROOM     0.000000     0     0     0     0     0     51. 00
51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00
52 ON 05200 DELIVERY ROOM & LABOR ROOM   0 0000000 Ol 0 0 0 0 0 52 00
53. 00   05300   ANESTHESI OLOGY   0. 000000   0   0   0   53. 00
54. 00   05400   RADI 0LOGY-DI AGNOSTI C   0. 000000   1, 374   0   0   0   54. 00
55. 00   05500   RADI 0LOGY-THERAPEUTI C   0. 000000   0   0   0   55. 00
56. 00   05600   RADI 0I SOTOPE   0. 000000   0   0   0   56. 00
57. 00   05700   CT SCAN   0. 000000   0   0   0   57. 00
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.000000   0   0   0   58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON   0. 000000   0   0   0   59. 00
60. 00   06000   LABORATORY   0. 000000   5, 514   0   0   0   60. 00
64. 00   06400   I NTRAVENOUS THERAPY   0. 000000   0   0   0   64. 00
65. 00   06500   RESPI RATORY THERAPY   0. 000000   334   0   0   0   65. 00
66. 00   06600   PHYSI CAL THERAPY   0. 000000   80, 957   0   0   0   66. 00
67. 00   06700   0CCUPATI ONAL THERAPY   0. 000000   0   0   0   67. 00
68. 00   06800   SPEECH PATHOLOGY   0. 000000   0   0   0   68. 00
69. 00   06900   ELECTROCARDI OLOGY   0. 000000   0   0   0   69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   0   0   0   0   70. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0.000000   0   0   0   71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   0   0   72.00
73.00   07300   DRUGS CHARGED TO PATIENTS   0.003186   17,928   57   0   0   73.00
73. 01   07302   OP PHARMACY   0. 000000   0   0   0   73. 01
74. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   74. 00
75. 00   07500   ASC (NON-DISTINCT PART)   0. 000000   0   0   0   0   75. 00
75. 01   03550  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0. 000000  0  0  0  0  75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON 0. 000000 0 0 0 0 76. 97
OUTPATIENT SERVICE COST CENTERS
90. 00   09000  CLI NI C   0. 000000  0   0   0   0   0   90. 00
90. 01   09001   OP ONCOLOGY INFUSION CENTER   0. 000000   1, 452   0   0   0   90. 01
90. 02   09002   WOUND CARE CENTER   0. 000000   0   0   0   0   90. 02
90. 03   09003   PAIN CLINIC   0. 000000   0   0   0   0   90. 03
90. 05   09005   OP PSYCH CLINIC   0. 000000   0   0   0   0   90. 05
91.00   09100   EMERGENCY   0.000000   0   0   0   91.00
92. 00   09200  0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 000000  0  0  0  0  92. 00

0. 000000

107, 559

0

57

0

0 94.00 95.00 0 200.00

91. 00 | 09100 | EMERGENCY 92. 00 | 09200 | DSSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 94. 00 | 09500 | AMBULANCE SERVI CES 200. 00 | Total (Lines 50 through 199)

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2017	Worksheet D-1	
			Date/Time Pre 5/27/2018 9:1	pared: 8 am
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1 00	

		Title XVIII	Hospi tal	PPS	o alli
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			44, 456	
2.00	Inpatient days (including private room days, excluding swing-b			44, 456	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(S). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		39, 237	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (	21 of the cost	0	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	on days) at ter becember .	of the cost	U	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
0.00	reporting period		1 -6		0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember 3	i or the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	16, 711	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)		_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI> through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)		
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	0	
16. 00	Nursery days (title V or XIX only)			0	•
	SWING BED ADJUSTMENT			S	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	arter becomber 31 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of the	ne cost	0. 00	20. 00
20.00	reporting period	s after becember 31 of the	le cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			51, 933, 332	1
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)			-	
24. 00	Swing-bed cost applicable to NF type services through December  7 x line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	X TITIE 19)  Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			- [	
26. 00	Total swing-bed cost (see instructions)	(1) 04		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		51, 933, 332	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	1
30.00	Semi-private room charges (excluding swing-bed charges)	line 20)		0. 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ± Average private room per diem charge (line 29 ± line 3)	- ITHE 28)		0.00000	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
34.00	Average per diem private room charge differential (line 32 mir		tions)	0. 00	1
35. 00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	•
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 51, 933, 332	36. 00 37. 00
200	27 minus line 36)	, ,		2 ., ,00, 002	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 168. 20	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		19, 521, 790	1
40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		19, 521, 790	41.00

OMPUT	Financial Systems I ATION OF INPATIENT OPERATING COST	U HEALTH BLOOMIN	Provi der CC		Peri od:	w of Form CMS-2 Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/27/2018 9:1	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days ÷	Program Cost (col. 3 x col. 4)	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42. (
2 00	Intensive Care Type Inpatient Hospital Units		2 000	1 040 0	0 1.045	2 (21 220	12
3. 00 4. 00	INTENSIVE CARE UNIT	7, 022, 399 5, 698, 504	3, 800 3, 296	1, 848. 0 1, 728. 9			
5. 00	BURN INTENSIVE CARE UNIT	5, 696, 304	3, 290	1, 720. 9	1, 393	2, 734, 170	45.
	SURGICAL INTENSIVE CARE UNIT						46.
	NEONATAL INTENSIVE CARE UNIT	4, 559, 270	2, 791	1, 633. 5	6 0	0	47.
	Cost Center Description						
2 00	10		1: 000)			1.00	10
3. 00 9. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			26)		33, 732, 513 59, 639, 793	
7. 00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46) (S	see mstructro	15)		39, 039, 193	49.
0. 00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D. sum	of Parts I and	2, 154, 045	50.
			•				
1. 00	Pass through costs applicable to Program inp	atient ancillary	, services (fr	om Wkst. D, s	um of Parts II	1, 467, 142	51.
2 00	and IV)	EO and E1)				2 / 24 407	E 2
2. 00 3. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non phys	sician anosth	otist and	3, 621, 187 56, 018, 606	
J. UU	medical education costs (line 49 minus line	J 1	ateu, non-pny:	ar Crair antesth	ctist, and	30, 010, 000	55.
	TARGET AMOUNT AND LIMIT COMPUTATION						1
4. 00							54.
5. 00						0.00	
5. 00	Target amount (line 54 x line 55)				50)	0	
7. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (li	ne 56 minus	line 53)	0	57.
3. 00 9. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period o	andina 1006 u	ndated and co	mnounded by the	0 0. 00	
7. 00	market basket	portring period e	sharing 1990, up	suated and co	iipourided by the	0.00	37.
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the ma	arket basket		0.00	60.
1. 00	If line 53/54 is less than the lower of line					0	61.
	which operating costs (line 53) are less that		s (lines 54 x o	60), or 1% of	the target		
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.
	.00 Allowable Inpatient cost plus incentive payment (see instructions)				_	63.	
	PROGRAM INPATIENT ROUTINE SWING BED COST	(000 1110 11 01	, , , , , , , , , , , , , , , , , , , ,				
4. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	mber 31 of the	cost reporti	ng period (See	0	64.
- 00	instructions) (title XVIII only)		04 6 11				,-
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 or the co	ost reporting	period (See	0	65.
instructions)(title XVIII only) 66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For			0	66.			
CAH (see instructions)							
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period			0	67.			
(line 12 x line 19)				,,			
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)			0	68.			
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER N						1
0. 00	Skilled nursing facility/other nursing facil						70.
1. 00	Adjusted general inpatient routine service of		ne 70 ÷ line 2	2)			71.
2.00	Program routine service cost (line 9 x line		(line 14 v li	25)			72.
3. 00 4. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	5	•	ne 35)			73. 74.
5. 00	Capital -related cost allocated to inpatient	•	,	orksheet B. P	art II. column		75.
	26, line 45)	2 2 3. 2. 30	Ç . 2 <b></b> .				-
6. 00	Per diem capital-related costs (line 75 ÷ li						76.
7.00	Program capital -related costs (line 9 x line						77.
3. 00 9. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider records	s)			78. 79.
). 00	Total Program routine service costs for comp			*	us line 79)		80.
. 00	Inpatient routine service cost per diem limi			( 70 min	,,		81
2. 00	Inpatient routine service cost limitation (I		1				82
3. 00	Reasonable inpatient routine service costs (	see instructions	s)				83.
1.00	Program inpatient ancillary services (see in						84
	Utilization review - physician compensation						85.
υ. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86.
7. 00	Total observation bed days (see instructions					5, 219	87.
7.00	,	•					
8. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 168. 20	88.

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/27/2018 9:1	
		Title	XVIII	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	4, 462, 924	51, 933, 332	0. 08593	6, 096, 836	523, 938	90.00
91.00 Nursing School cost	0	51, 933, 332	0.00000	0 6, 096, 836	0	91.00
92.00 Allied health cost	0	51, 933, 332	0.00000	0 6, 096, 836	0	92.00
93.00 All other Medical Education	0	51, 933, 332	0. 00000	6, 096, 836	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-T051	To 12/31/2017	Date/Time Prepared: 5/27/2018 9:18 am
	Title XVIII	Subprovider -	PPS

		litie xviii	I RF	PPS	
	Cost Center Description		TIM	1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 761	1. 00
2.00	Inpatient days (including private room days, excluding swing-		2, 761	2.00	
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). II you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 761	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	ili days) trii ougii beceilibei	31 Of the Cost	o l	7.00
8. 00	Total swing-bed NF type inpatient days (including private rool reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	g swing-bed and	1, 627	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private r	room days) after	О	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, el Swing-bed NF type inpatient days applicable to titles V or XI.		te room days)	0	12. 00
13. 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
14. 00	after December 31 of the cost reporting period (if calendar y. Medically necessary private room days applicable to the Progr.	ear, enter O on this lir	ne)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	alli (excruding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			Ö	
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	9			18. 00
19. 00	reporting period  Medicaid rate for swing-bed NF services applicable to services		19. 00		
	reporting period	G			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period		the cost		20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December		ing period (line	2, 888, 609 0	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	ng period (line 6	0	23. 00
	x line 18)	•		0	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	·		-	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	g period (line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)	(1) 04 1 11 0()		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		2, 888, 609	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	!: 22) ( !+		0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		LI UIIS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	ne 31 <i>)</i>		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 888, 609	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UCTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 046. 22	38. 00
38.00	Program general inpatient routine service cost per diem (see			1, 702, 200	
40. 00	Medically necessary private room cost applicable to the Program			1, 702, 200	
	Total Program general inpatient routine service cost (line 39			1, 702, 200	

	Financial Systems IL ATION OF INPATIENT OPERATING COST	J HEALTH BLOOMIN	NGTON HOSPITAL		In Lie	eu of Form CMS-2 Worksheet D-1	
COMPU	ATTON OF INPATTENT OPERATING COST			CCN: 15-0051 CCN: 15-T051	From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
			Ti tl e	xVIII	Subprovi der -	5/27/2018 9: 1 PPS	8 am
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost		col . 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00 0	3.00	4. 00 00 0	5.00	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	ol	0	0.0	00 0	0	43.00
44. 00	CORONARY CARE UNIT	0	0	1		0	1
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	О	O	0. (	00 0	0	46. 00 47. 00
	Cost Center Description			•		1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	, line 200)			1, 722, 043	48. 00
49. 00				ons)		3, 424, 243	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine :	services (from	n Wkst. D, sur	n of Parts I and	237, 184	50. 00
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	68, 940	51.00
52. 00	Total Program excludable cost (sum of lines !					306, 124	1
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-phy	sician anesth	netist, and	3, 118, 119	53.00
54. 00						0	54.00
55.00	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	rget amount (l	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	· ·			,	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	porting period	ending 1996, ι	ipdated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see i				3		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				62.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost			cost roporti	ng pariod (Saa	1 0	64. 00
65. 00	instructions)(title XVIII only)					0	
	instructions) (title XVIII only)			·			
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)						66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after Do	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU	•				0	69. 00
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service c	cost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine /U ÷ line	۷)			71. 00
73. 00	Medically necessary private room cost applica	abĺe to Program	•	,			73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i	•	,		Part II, column		74. 00 75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ lin						76. 00
77. 00 78. 00							77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		rovi der record	ls)			79. 00
80.00	Total Program routine service costs for compa		ost limitation	ı (line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (s	see instruction					83. 00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2017	D 1 (T' D	
		Component (	CN: 15-1051	To 12/31/2017	Date/Time Prep 5/27/2018 9:18	
-		Title	XVIII	Subprovi der -	PPS	<u>J alli</u>
				IRF		
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	402, 502	2, 888, 609	0. 13934	1 0	0	90.00
91.00 Nursing School cost	0	2, 888, 609	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	2, 888, 609	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 888, 609	0. 00000	0	0	93.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2017	Worksheet D-1	
		To 12/31/2017	Date/Time Pre 5/27/2018 9:1	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1 00			44.457	1 1 00

	Title XIX   Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	44, 456	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	44, 456	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	39, 237	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	589	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	3, 616	
16. 00	Nursery days (title V or XIX only)	1, 808	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	51, 933, 332	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19)   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
27.00	X line 20)	0	24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 51, 933, 332	26. 00 27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		20. 22
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	51, 933, 332	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 168. 20	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	688, 070	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	688, 070	41.00

	<u> </u>	U HEALTH BLOOMI		N 45 0054		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2017		
				1	To 12/31/2017	Date/Time Pre 5/27/2018 9:1	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Inpatient Days	Average Per	Program Days	Program Cost (col. 3 x col.	
		impatrent cost	ripati cirt bays	col . 2)		4)	
42.00	MUDSEDY (+i+lo V & VIV only)	1. 00 1, 995, 710	2. 00 3, 616	3.00	4. 00 1 1, 808	5. 00 997, 853	42. 00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		3, 010	551. 91	1, 000	997, 653	42.00
43. 00	INTENSIVE CARE UNIT	7, 022, 399		1, 848. 00			1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	5, 698, 504	3, 296	1, 728. 92	2 0	0	44. 00 45. 00
46. 00	4						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT  Cost Center Description	4, 559, 270	2, 791	1, 633. 56	218	356, 116	47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			`		1, 450, 570	•
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instruction	ns)		4, 170, 825	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	212, 977	50. 00
51. 00		ationt ancillar	v sarvicas (fr	om Wket D ei	ım of Darte II	70, 938	51.00
31.00	and IV)	atrent anerra	y services (iii	ли <b>ж</b> кэт. Б, эс	01 141 (3 11	70,730	31.00
52.00	Total Program excludable cost (sum of lines					283, 915	ł
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		nated, non-phys	sician anestne	etist, and	3, 886, 910	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (li	ne 56 minus I	ine 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, uj	odated and con	pounded by the		1
	market basket					0.00	,,,,,,,
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				he amount by	0.00	ı
	which operating costs (line 53) are less tha	n expected cost					
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of the	cost reportir	na neriod (See	I 0	64. 00
04.00	instructions)(title XVIII only)	Ü		·			04.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the co	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 21 o	f the cost ror	porting ported	0	67. 00
67.00	(line 12 x line 19)	le costs till ough	December 31 0	the cost rep	orting period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repor	rting period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N		•			I	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	,		•			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)		,			72. 00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv			ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•		orksheet B, Pa	rt II, column		75. 00
74 00	26, line 45)	no 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
	Inpatient routine service cost (line 74 minu						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				ıs line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		75710			81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		13)				84. 00
85.00	Utilization review - physician compensation						85.00
86. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rougn 85)				86. 00
87. 00	Total observation bed days (see instructions	5)				5, 219	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 168. 20 6, 096, 836	
57.00	10000. Vali on Doa Cool (11110 of A 11116 oo) (36					1 0,070,030	1 57.00

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/27/2018 9:1	
		Ti tl	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	4, 462, 924	51, 933, 332	0. 08593	6, 096, 836	523, 938	90.00
91.00 Nursing School cost	0	51, 933, 332	0.00000	6, 096, 836	0	91.00
92.00 Allied health cost	0	51, 933, 332	0.00000	6, 096, 836	0	92.00
93.00 All other Medical Education	0	51, 933, 332	0. 000000	6, 096, 836	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0051	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-T051	To 12/31/2017	Date/Time Prepared: 5/27/2018 9:18 am
	Title XIX	Subprovi der -	PPS

		II the XIX	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 761	1.00
2.00	Inpatient days (including private room days, excluding swing-b			2, 761	2. 00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 761	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period			_	
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period	, .,		_	
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (evoluding	swing_bed_and	14	9. 00
7. 00	newborn days)	the rrogram (excluding	3Wi rig-bed and	14	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10.00
44 00	through December 31 of the cost reporting period (see instruct				44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (Including private ro nter 0 on this line)	om days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
	through December 31 of the cost reporting period	3 .	,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	· · · · · · · · · · · · · · · · · · ·	,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	iii (excluding swing-bed d	lays)	-	15. 00
16. 00	Nursery days (title V or XIX only)				16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	e cost	0.00	20. 00
20.00	reporting period	arter becember 31 or th	le cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			2, 888, 609	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	neriod (line 6	0	23. 00
23.00	x line 18)	or the cost reporting	perrou (rine o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
25 00	7 x line 19)	of the east manageting	noried (line 0	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		2, 888, 609	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed cha	r ges)	0	28. 00 29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 20) (	. ,	0.00	
34. 00	Average per diem private room charge differential (line 32 mir		ions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	2, 888, 609	37. 00
37.00	27 minus line 36)				500
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 04/ 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 046. 22 14, 647	
40. 00	Medically necessary private room cost applicable to the Progra			14, 047	40. 00
	Total Program general inpatient routine service cost (line 39	•		14, 647	
				'	

Heal th	Financial Systems II	J HEALTH BLOOMING	GTON HOSPITAL		In Li∈	eu of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Peri od: From 01/01/2017	Worksheet D-1		
			Component C	e XIX	To 12/31/2017	Date/Time Pre 5/27/2018 9:1 PPS		
					Subprovi der -			
	Cost Center Description	Total Inpatient Costlr	Total npatient Daysl	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4.00	5. 00	42.00	
42.00	Intensive Care Type Inpatient Hospital Units	UU	0	0.0	0	0	42. 00	
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0. 0 0. 0		l .		
45. 00	BURN INTENSIVE CARE UNIT	O <sub>1</sub>	o <sub>l</sub>	0.0	0	J	45. 00	
46.00	•	o	0	0.0	00 0	0	46.00	
47.00	NEONATAL INTENSIVE CARE UNIT   Cost Center Description	UU	U <sub>I</sub>	0.0	0	0	47. 00	
40.00	Drogram i proti est escillary comi co cost (Mike	-+ D 2 and 2	line 200)			1.00	40.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ns)		40, 073 54, 720	48. 00 49. 00	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inputers	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	2, 041	50. 00	
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fro	om Wkst. D, s	um of Parts II	1, 612	51.00	
52. 00	and IV)  Total Program excludable cost (sum of lines!	50 and 51)				3, 653	52. 00	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phys	sician anesth	etist, and	51, 067	53. 00	
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION	·					54. 00	
55. 00	Program discharges Target amount per discharge						55. 00	
	Target amount (line 54 x line 55)	na cost and tan		no E/ minuo	line E2)	0		
57. 00 58. 00	Difference between adjusted inpatient operations payment (see instructions)	ng cost and targ	get amount (11	ne 56 minus	11 ne 53)	0		
59. 00	Lesser of lines 53/54 or 55 from the cost re	oorting period e	ndi ng 1996, up	odated and co	mpounded by the	0.00	59. 00	
60. 00	market basket 0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
61. 00								
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				0	62. 00	
63. 00	Allowable Inpatient cost plus incentive payments	ent (see instruc	tions)				63. 00	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	ber 31 of the	cost reporti	ng period (See	0	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	r 31 of the co	ost reporting	period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 65	5)(title XVII	I only). For	0	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through [	December 31 of	the cost re	porting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of t	the cost repo	rting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil	· · · · · · · · · · · · · · · · · · ·					70. 00	
71. 00	Adjusted general inpatient routine service co	ost per diem (lin		` ,			71. 00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 v lir	ne 35)			72. 00 73. 00	
74. 00	Total Program general inpatient routine servi		•	ie 33)			74. 00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service (	costs (from Wo	orksheet B, F	art II, column		75. 00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line	•					76. 00 77. 00	
78. 00	,						78. 00	
79.00	Aggregate charges to beneficiaries for excess				1., 20)		79. 00	
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		st limitation	(iine /8 mir	us line /9)		80. 00 81. 00	
82. 00	Inpatient routine service cost limitation (I	ne 9 x line 81)					82. 00	
83. 00 84. 00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:		)				83. 00 84. 00	
85. 00			s)				85. 00	
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00	
87. 00	Total observation bed days (see instructions)	)				0		
88.00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	line 2)			l e	88. 00 89. 00	
07.00	Tobaci vation bed cost (Time of A Time ob) (Set					1 0	1 07.00	

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	Subprovi der – I RF	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	402, 502	2, 888, 609	0. 13934	1 0	0	90.00
91.00 Nursing School cost	0	2, 888, 609	0. 00000	0	0	91.00
92.00 Allied health cost	0	2, 888, 609	0. 00000	0	0	92.00
93.00 All other Medical Education	0	2, 888, 609	0. 00000	0	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0051	Peri od:	Worksheet D-3	

I NPATI EN	T ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0051	Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre	nared:
				10 12/31/2017	5/27/2018 9:1	8 am
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
ΙN	PATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03	000 ADULTS & PEDIATRICS			37, 599, 241		30. 00
	100 INTENSIVE CARE UNIT			8, 077, 619		31. 00
	200 CORONARY CARE UNIT			6, 289, 725		32. 00
	1060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
	100 SUBPROVI DER - I RF			0		41. 00
	.200  SUBPROVI DER .300  NURSERY			0		42. 00 43. 00
	CILLARY SERVICE COST CENTERS					43.00
	OOO OPERATING ROOM		0. 0927	29 38, 694, 485	3, 588, 101	50.00
	001 CV SURGERY		0.0000		0,000,101	50. 01
	100 RECOVERY ROOM		0. 2050		796, 685	
	200 DELIVERY ROOM & LABOR ROOM		0. 2221		7, 349	52.00
53.00 05	300 ANESTHESI OLOGY		0.0000	00	0	53. 00
	A400 RADI OLOGY-DI AGNOSTI C		0. 1373	7, 927, 450	1, 088, 962	54. 00
	500 RADI OLOGY-THERAPEUTI C		0. 0791		169, 787	55. 00
	600 RADI OI SOTOPE		0.0000		0	56. 00
	7700 CT SCAN		0. 0623		253, 232	57. 00
	800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1043		112, 791	58. 00
	900 CARDI AC CATHETERI ZATI ON		0.05048		556, 124	
	1000 LABORATORY 1400 I NTRAVENOUS THERAPY		0. 1324 0. 0000		2, 585, 700 0	64. 00
	500 RESPIRATORY THERAPY		0. 29659		1, 436, 760	65. 00
	600 PHYSI CAL THERAPY		0. 43034		1, 669, 254	66.00
	700 OCCUPATIONAL THERAPY		0. 00000		0	67. 00
	800 SPEECH PATHOLOGY		0.0000		0	68. 00
69.00 06	900 ELECTROCARDI OLOGY		0. 0844!	5, 580, 994	471, 354	69. 00
	000 ELECTROENCEPHALOGRAPHY		0. 1181!		107, 097	70. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2538		2, 564, 876	
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 25428		8, 223, 693	
	300 DRUGS CHARGED TO PATIENTS		0. 2204:		7, 435, 231	73. 00
	302 OP PHARMACY 400 RENAL DIALYSIS		0. 00000 0. 40118		0 752, 334	73. 01 74. 00
	500 ASC (NON-DISTINCT PART)		0. 00000		752, 554	75.00
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		ĺ	75. 00
	697 CARDI AC REHABI LI TATI ON		0. 39918		83, 218	76. 97
	TPATIENT SERVICE COST CENTERS		,		,	
	000 CLI NI C		0. 9269	10, 356	9, 599	90. 00
	OO1 OP ONCOLOGY INFUSION CENTER		0. 1811:	548, 523	99, 359	90. 01
	0002 WOUND CARE CENTER		0. 3657		2, 591	90. 02
	PAIN CLINIC		0. 2901			90. 03
	005 OP PSYCH CLINIC		1. 0038		1, 982	90. 05
	1100 EMERGENCY		0. 11958			91.00
	200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 2566	1, 332, 410	341, 991	92. 00
	1400 HOME PROGRAM DIALYSIS		0.0000	00 0	0	94. 00
	1500 AMBULANCE SERVI CES		0.0000	,5		95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			195, 225, 136	33, 732, 513	
201. 00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)			195, 225, 136		202. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL		In lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO		Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017		pared:
	Ti tl e	XVIII	Subprovi der - I RF	PPS	<u> </u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LAIDATI FAIT DOUTLAIG CEDIULOG COCT CENTEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		T			20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT			0		30.00
32. 00   03200 CORONARY CARE UNIT				•	32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT					35. 00
41. 00   04100   SUBPROVI DER -   RF			2, 771, 174		41. 00
42. 00   04200   SUBPROVI DER			2, 771, 174		42. 00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					10.00
50. 00 05000 OPERATING ROOM		0. 09272	9 52, 268	4, 847	50.00
50. 01   05001 CV SURGERY		0.00000		0	1
51. 00   05100   RECOVERY ROOM		0. 20508		2, 411	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 22214		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000	00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13736	91, 388	12, 554	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C		0. 07913	2, 067	164	55. 00
56. 00   05600   RADI 0I SOTOPE		0.00000	00	0	56. 00
57. 00  05700   CT   SCAN		0. 06237			1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 10431			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON		0. 05048		0	
60. 00 06000 LABORATORY		0. 13244			1
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		11 040	
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY		0. 29659 0. 43034			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 43034			1
68. 00 06800 SPEECH PATHOLOGY		0. 00000		0	
69. 00   06900   ELECTROCARDI OLOGY		0. 08445		_	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 11815			1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-S	0. 25381			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 25428			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 22043			1
73. 01 07302 OP PHARMACY		0.00000		0	1
74. 00   07400   RENAL DI ALYSI S		0. 40118	70, 073	28, 112	74. 00
75.00 07500 ASC (NON-DISTINCT PART)		0. 00000	00	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 00000			
76. 97 O7697 CARDIAC REHABILITATION		0. 39918	34 279	111	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C		0. 92694		511	
90. 01 09001 OP ONCOLOGY INFUSION CENTER		0. 18113			
90. 02 09002 WOUND CARE CENTER		0. 36574	3 0	0	90. 02

90.03

90. 05

91.00

92.00

94.00

95.00

200. 00

201.00

202. 00

0

0

2, 490

3, 791

1, 722, 043

0

20, 825

14, 770

4, 944, 293

4, 944, 293

0. 290143

1.003876

0. 119589

0. 256671

0.000000

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

OTHER REIMBURSABLE COST CENTERS

09005 OP PSYCH CLINIC

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

09003 PAIN CLINIC

09100 EMERGENCY

90.03

90.05

91.00

92.00

200.00

201.00

202.00

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL		In Lieu of Form CMS-2552-10
LAIDATI ENT. ANGLI LADVI CEDVI CE COCT. ADDODTI CAMENT		D ' I OON 45 0054	D . I	W I I I D 0

Health Financial Systems IU HEALTH BLOOMING	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0051	Peri od:	Worksheet D-3	
			From 01/01/2017		
			To 12/31/2017	Date/Time Pre	
				5/27/2018 9:1	<u>8 am</u>
	liti	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 959, 964		30.00
31. 00   03100   NTENSI VE CARE UNI T			1, 050, 585		31. 00
32. 00 03200 CORONARY CARE UNIT			63, 817		32. 00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT			1, 265, 943		35.00
41. 00   04100   SUBPROVI DER -   RF			59, 325		41.00
			37, 323		42.00
			000 044		
43. 00   04300   NURSERY			202, 944		43. 00
ANCI LLARY SERVI CE COST CENTERS		T			
50.00   05000   OPERATING ROOM		0. 09272		47, 873	50. 00
50. 01   05001   CV   SURGERY		0.00000		0	50. 01
51. 00   05100   RECOVERY ROOM		0. 20508	71, 650	14, 694	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM		0. 22214	506, 858	112, 593	52.00
53. 00   05300   ANESTHESI OLOGY		0.00000	0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13736		37, 295	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 07913		4, 331	
56. 00   05600   RADI OI SOTOPE		0.00000		0	56.00
57. 00   05700   CT   SCAN		0. 06237		10, 406	
				5, 027	58.00
		0. 10431		· ·	
59. 00   05900   CARDI AC CATHETERI ZATI ON		0. 05048		8, 422	
60. 00   06000   LABORATORY		0. 13244		179, 858	
64.00   06400   I NTRAVENOUS THERAPY		0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 29659		169, 992	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 43034	9 217, 956	93, 797	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67. 00
68. 00  06800 SPEECH PATHOLOGY		0.00000	0 0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0. 08445	187, 429	15, 830	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 11815	90, 620	10, 708	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25381	3 351, 053	89, 102	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 25428		77, 507	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 22043		474, 746	73. 00
73. 01   07302   OP   PHARMACY		0.00000		0	73. 01
74. 00 07400 RENAL DI ALYSI S		0. 40118		25, 048	
75. 00   07500   ASC (NON-DISTINCT PART)		0. 00000		25, 040	75.00
		0.00000		0	75. 00
		1			
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 39918	10, 004	3, 993	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 92694		0	90.00
90.01 09001 OP ONCOLOGY INFUSION CENTER		0. 18113		6, 468	
90. 02   09002   WOUND CARE CENTER		0. 36574	3 0	0	90. 02
90. 03  09003 PAIN CLINIC		0. 29014	3 0	0	90. 03
90. 05   09005   OP PSYCH CLINIC		1. 00387	6 346	347	90. 05
91. 00   09100   EMERGENCY		0. 11958	478, 263	57, 195	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 25667	20, 798	5, 338	92.00
OTHER REIMBURSABLE COST CENTERS				2, 200	1
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		0.00000			95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1	7, 647, 034	1, 450, 570	
201.00 Less PBP Clinic Laboratory Services-Program only charges	c (line 41)	1	7,047,034	1, 450, 570	200.00
	5 (11116 01)		7 447 024		
202.00   Net charges (line 200 minus line 201)		I	7, 647, 034		202. 00

Heal th	Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0051	Peri od:	Worksheet D-3	
		Component (	CCN: 15-T051	From 01/01/2017 To 12/31/2017		pared: 8 am
		Ti tl	e XIX	Subprovider - IRF	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			0		30.00
31. 00	03100 INTENSIVE CARE UNIT			0		31.00
32. 00	03200 CORONARY CARE UNIT			0		32.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
41. 00	04100 SUBPROVI DER - I RF			62, 325		41.00
42. 00	04200 SUBPROVI DER			02, 320		42.00
43. 00	04300 NURSERY			Ö		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 09272	29 0	0	50.00
50. 01	05001 CV SURGERY		0.00000	00	0	50. 01
51.00	05100 RECOVERY ROOM		0. 20508	37 O	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 22214	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY		0.00000		-	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 13736			
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 07913		1	55. 00
56. 00	05600 RADI OI SOTOPE		0.00000			56. 00
57. 00	05700 CT SCAN		0. 06237		0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 10431		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 05048		0	59.00
60.00	06000 LABORATORY		0. 13244			
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		0. 00000 0. 29659		1	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 43034			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 00000		34, 840	67.00
68. 00	06800 SPEECH PATHOLOGY		0.00000			68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 08445			69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 11815		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25381		· -	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 25428		l ol	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 22043		3, 952	
73. 01	07302 OP PHARMACY		0. 00000		0	73. 01
74.00	07400 RENAL DIALYSIS		0. 40118	31 0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)		0. 00000	00	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000	00	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 39918	34 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS					

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	From 01/01/2017	Worksheet E Part A Date/Time Prepared: 5/27/2018 9:18 am

			10 12/31/2017	5/27/2018 9:1	
		Title XVIII	Hospi tal	PPS	
	DART A LABORT FUT HOODITH OFFINIORS INVESTIGATION			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see				1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ing on or after October	1 (see	11, 515, 206	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			1, 059, 644	2.00
2. 01	Outlier reconciliation amount	l ana)		0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ions)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	rting period (see instru	ctions)	243. 59	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	t recent cost reporting	period ending on	0.00	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet	the criteria for an add-	on to the cap	0.00	6. 00
7 00	for new programs in accordance with 42 CFR 413.79(e)	undon 40 CED \$410 105(5)	(1) (i v) (D) (1)	0. 00	7. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00	7. 00
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0.00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (	see	0.00	9. 00
10.00	instructions) FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	ds	0.00	10. 00 11. 00
11. 00 12. 00	FTE count for residents in dental and podiatric programs.  Current year allowable FTE (see instructions)				12. 00
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sep	tember 30, 1997,	0.00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18. 00	Adjusted rolling average FTE count	34. 3		0.00	
19. 00	Current year resident to bed ratio (line 18 divided by line 4)	).		0.000000	
20.00	Prior year resident to bed ratio (see instructions)	•		0. 000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
22.00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$ .		FR 412. 105	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	24 (see	0.00	
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	)		0	28. 01
29.00	Total IME payment ( sum of lines 22 and 28)	•		0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0) Disproportionate Share Adjustment	1)		0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	6. 01	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	and Coo motivo	,	26. 08	
32. 00	Sum of lines 30 and 31			32. 09	
33. 00	Allowable disproportionate share percentage (see instructions)	)		15. 69	
	Disproportionate share adjustment (see instructions)	,		1, 661, 383	
	, , , ,		!	,,	

111 41-	Figure in Contains	TON HOODI TAI	1-1:-	£ F CMC 3	NEE 2 4 0
	Financial Systems IU HEALTH BLOOMING ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0051	Peri od:	u of Form CMS-2 Worksheet E	2552-10
ONLOGE	ATTOW OF RETWINDORSEMENT SETTLEMENT	Trovider cent. 13 dos1	From 01/01/2017	Part A	
			To 12/31/2017	Date/Time Prep 5/27/2018 9:18	
		Title XVIII	Hospi tal	PPS	<u> </u>
			Prior to 10/1		
	Unanama and Cara Adi water at		1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		5, 977, 483, 147	6, 766, 695, 164	35. 00
35. 01	Factor 3 (see instructions)		0. 000341021	0. 000340737	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (see	2, 038, 445	2, 305, 667	35. 02
25 02	instructions)		1 504 (45	F01 1FF	25 02
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amo Total uncompensated care (sum of columns 1 and 2 on line 35.0	,	1, 524, 645 2, 105, 800	581, 155	35. 03 36. 00
30. 00	Additional payment for high percentage of ESRD beneficiary di				30.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40. 00
	652, 682, 683, 684 and 685 (see instructions)	00 /01 /05 /			
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	583, 684 an 685. (see	0		41. 00
41. 01		DRGs 652, 682, 683, 684	0		41. 01
	an 685. (see instructions)				
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)	32, 683, 684 an 685. (see	0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 00
00	days)	2,	0.00000		
45.00	Average weekly cost for dialysis treatments (see instructions		0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	mall rural bosnitals	47, 182, 031		47. 00 48. 00
46.00	only. (see instructions)	siliari Turai Hospitars	0		46.00
	, (and ) . (and )			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions			47, 182, 031	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.			3, 756, 753 0	50. 00 51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			0	52. 00
53. 00	Nursing and Allied Health Managed Care payment	, .		0	53. 00
54.00	Special add-on payments for new technologies			0	54.00
54. 01	Islet isolation add-on payment	->		0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	•		0	55. 00
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I		arough 35)	0	56. 00 57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		n ough oo).	107, 462	58. 00
59. 00	Total (sum of amounts on lines 49 through 58)	,		51, 046, 246	59. 00
60.00	Primary payer payments			32, 532	60. 00
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		51, 013, 714	
62.00	Deductibles billed to program beneficiaries			4, 312, 476	62.00
63.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			48, 692 138, 856	
65. 00	Adjusted reimbursable bad debts (see instructions)			90, 256	
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		126, 118	66. 00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			46, 742, 802	67. 00
68. 00	Credits received from manufacturers for replaced devices for			0	68. 00
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instructions	5)	0	69. 00
70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see i	nstructions)	0	70. 00 70. 50
70. 87	Demonstration payment adjustment amount before sequestration	ration, adjustment (see i	nstructrons)	Ö	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 2 246	70. 92 70. 93
70. 93	HRR adjustment amount (see instructions)			2, 240	
	Recovery of accelerated depreciation			0	
			·		

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0051	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/27/2018 9:1	
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3	ŕ			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			46, 745, 048	71. 00
71. 01	Sequestration adjustment (see instructions)	ŕ			934, 901	71. 01

Demonstration payment adjustment amount after sequestration

74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and

90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)

Protested amounts (nonallowable cost report items) in accordance with

Tentative settlement (for contractor use only)

CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

72.00 | Interim payments

73)

73.00

75.00

92, 027

45, 718, 120

0

802, 844 75. 00

71. 01 71.02

72.00

73.00

74.00

90.00

90.00  Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instructions)		0	93. 00
94.00 The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00 Time value of money for operating expenses (see instructions)		0	95. 00
96.00 Time value of money for capital related expenses (see instructions)		0	96.00
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current	5-year demonst	ration	
peri od)			
204.00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00 Reserved for future use			210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
(line 212 minus line 213) (see instructions)			

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0051

							5/27/2018 9: 1	8 am
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		0.00	1. 00
1.00	payments	1.00		Ŭ			J	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	30, 839, 998	0	30, 839, 998		30, 839, 998	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	11, 515, 206	0		11, 515, 206	11, 515, 206	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4	1. 03	0	0	C		0	1. 03
1. 04	BPCI occurring prior to October 1 DRG for Federal specific operating payment for Model 4	1. 04	0	0		0	0	1. 04
2. 00	BPCI occurring on or after October 1 Outlier payments for	2. 00	1, 059, 644	O	820, 532	239, 112	1, 059, 644	2. 00
	discharges (see instructions)	2.02		0				
2. 01	Outlier payments for discharges for Model 4 BPCI Operating outlier	2. 02 2. 01	0	0			0	2. 01 3. 00
4. 00	reconciliation Managed care simulated	3. 00	0	0	C	o	0	4. 00
	payments							
5. 00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
0.00	A, line 21 (see instructions)	21.00	0.00000	0.00000	0.00000	0.00000		0.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	C	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	C	0	0	6. 01
7 00	Indirect Medical Education Adju					0.000000		7 00
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		0	7.00
8. 00	IME adjustment (see instructions)	28. 00	0	U	С	, 0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	C	0	0	8. 01
9. 00	<pre>instructions) Total IME payment (sum of lines 6 and 8)</pre>	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	C	0	0	9. 01
	8. 01)							
10.00	Disproportionate Share Adjustme		0.15(0	0.15/0	0.15/0	0.15(0		10.00
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1569	0. 1569	0. 1569	0. 1569		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	1, 661, 383	0	1, 209, 699	451, 684	1, 661, 383	11. 00
11. 01	Uncompensated care payments	36.00	2, 105, 800	0	1, 524, 645	581, 155	2, 105, 800	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	ש beneticiary ו ה	di scharges 0	C	ol	0	12. 00
12.00	(see instructions)	40.00		U		,		12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	47, 182, 031 0	0	34, 394, 874 C	12, 787, 157 0	47, 182, 031 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	47, 182, 031	0	34, 394, 874	12, 787, 157	47, 182, 031	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	3, 756, 753	0	2, 739, 396	1, 017, 357	3, 756, 753	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54. 00	0	O	C	О	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	C	0	0	17. 01 17. 02

Hear th	Financial Systems		) HEALTH BLOOMI	NGTON HOSPITAL		<u>In Lie</u>	U OT FORM CMS-2	2552-10
LOW VC	DLUME CALCULATION EXHIBIT 4			Provi der Co		Period: From 01/01/2017	Worksheet E Part A Exhibi	 † 4
						o 12/31/2017	Date/Time Pre 5/27/2018 9:1	pared:
				Title	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	T	0	1. 00	2. 00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	(	0	0	18. 00
19. 00				0	37, 134, 270	13, 804, 514	50, 938, 784	19 00
171.00	COBTOTAL	W/S L, line	(Amounts from		077 10 17 27 0	10,001,011	00/700/701	171.00
			L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	3, 434, 826	0	2, 497, 118	937, 708	3, 434, 826	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	91, 107	0	74, 472	16, 635	91, 107	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	(	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	(	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0672	0. 0672	0. 0672	0. 0672		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	230, 820	0	167, 806	63, 014	230, 820	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	3, 756, 753	0	2, 739, 396	1, 017, 357	3, 756, 753	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 000000	0. 000000	0	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment	70. 97				0	0	29. 00
400.00	(transfer amount to Wkst. E, Pt. A, line)							100.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 15-0051

Peri od:

Part A Exhibit 5

From 01/01/2017 Date/Time Prepared: 12/31/2017 5/27/2018 9:18 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 30, 839, 998 1.01 1.01 30, 839, 998 30, 839, 998 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 11, 515, 206 11, 515, 206 11, 515, 206 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 1, 059, 644 820, 532 239, 112 1, 059, 644 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 O 2.01 **BPCI** Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0. 1569 0.1569 10.00 0.1569 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1,661,383 1, 209, 699 451, 684 1, 661, 383 11.00 instructions) 2, 105, 800 11.01 Uncompensated care payments 36.00 1, 524, 645 581, 155 2, 105, 800 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see 12 00 46 00 0 0 instructions) 13.00 Subtotal (see instructions) 47.00 47, 182, 031 34, 394, 874 12, 787, 157 47, 182, 031 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 47, 182, 031 34, 394, 874 12, 787, 157 47, 182, 031 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 3, 756, 753 2, 739, 396 1, 017, 357 3, 756, 753 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 17.00 0 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 amount (see instructions) 19.00 SUBTOTAL 37, 134, 270 13, 804, 514 50, 938, 784 19. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider CO		Period: From 01/01/2017 To 12/31/2017		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier 20.01 Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	3, 434, 826 0	2, 497, 11	8 937, 708 0 0	3, 434, 826 0	20. 00
21.00 Capital DRG outlier payments	2.00	91, 107	74, 47	٥		21.00
21.01   Model 4 BPCI Capital DRG outlier payments	2. 01	0	, ., .,	0 0	0	
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0.0000	_	22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0672	0. 067	2 0.0672		24. 00
25.00 Disproportionate share adjustment (see instructions)	11.00	230, 820	167, 80	63, 014	230, 820	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	3, 756, 753	2, 739, 39	6 1, 017, 357	3, 756, 753	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1. 00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	
30.00 HVBP payment adjustment (see instructions)	70. 93	2, 246	3, 64	8 -1, 402	2, 246	30. 00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	0		0 0	0	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0	0	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.	1	N				100. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/27/2018 9:18 am

		10 12/31/201	/ Date/Time Pre 5/27/2018 9:1	
		Title XVIII Hospital	PPS	o alli
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1	
1.00	Medical and other services (see instructions)	ti ana)	42, 678	1
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction opps payments)	tions)	34, 243, 997 33, 265, 831	1
4.00	Outlier payment (see instructions)		282, 897	1
4. 01	Outlier reconciliation amount (see instructions)		0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)	0.000	5. 00
6.00	Line 2 times line 5		0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	1
8.00	Transitional corridor payment (see instructions)		0	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, COI. 13, II ne 200	83, 040	ı
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		42, 678	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES		42,070	11.00
	Reasonabl e charges			1
12.00	Ancillary service charges		191, 535	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13)		191, 535	14. 00
15 00	Customary charges  Aggregate amount actually collected from patients liable for patients liable for patients.	nayment for services on a charge basis	T 0	15. 00
15. 00 16. 00	Amounts that would have been realized from patients liable for		0	
10.00	had such payment been made in accordance with 42 CFR §413.13(			10.00
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)		191, 535	18. 00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds line 11) (see	148, 857	19. 00
20.00	instructions)	: £ l: 11 l: 10) /		20.00
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	ry IT ITHE IT exceeds ITHE 18) (See	0	20.00
21. 00	Lesser of cost or charges (see instructions)		42, 678	21. 00
22. 00	Interns and residents (see instructions)		0	1
23. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		33, 631, 768	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		215	25.00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	r CAH see instructions)	215 6, 010, 671	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]		27, 663, 560	
	instructions)		,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)	0	1
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29)		27, 663, 560	ı
32.00	Primary payer payments Subtotal (line 30 minus line 31)		6, 098 27, 657, 462	1
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)	27,007,102	02.00
33.00		,	0	33. 00
34.00	Allowable bad debts (see instructions)		680, 490	1
35. 00	Adjusted reimbursable bad debts (see instructions)		442, 319	
36.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)	674, 573	1
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R		28, 099, 781 -84	1
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instructions)	125, 348	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	
40.00	Subtotal (see instructions)		28, 099, 865	1
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration		561, 997	1
41. 00	Interim payments		27, 534, 749	1
42. 00	Tentative settlement (for contractors use only)		0	1
43.00	Balance due provider/program (see instructions)		3, 119	43. 00
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, chapter 1,	10, 838	1
	§115. 2			
00.00	TO BE COMPLETED BY CONTRACTOR		1 ^	00 00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)		0 0	1
91.00	The rate used to calculate the Time Value of Money		0.00	
93. 00	Time Value of Money (see instructions)		0.00	1
94. 00	Total (sum of lines 91 and 93)		0	

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15	5-0051 Peri od: From 01/01/2017	Worksheet E
	Component CCN: 1	15-T051 To 12/31/2017	
	Title XVII	II Subprovider -	PPS

		Title XVIII	Subprovi der – I RF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)	h!>		15	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	(i ons)		0	2. 00 3. 00
4. 00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction 2 times line 5	ctions)		0. 000	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9. 00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 15	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			13	11.00
	Reasonable charges				
12.00	Ancillary service charges	no (0)			12.00
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii Total reasonable charges (sum of lines 12 and 13)	ne 69)		0 69	13. 00 14. 00
11.00	Customary charges			0,	11.00
15. 00	Aggregate amount actually collected from patients liable for p			0	15. 00
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(6)		n a chargebasis	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)			69	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	54	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete onl instructions)</pre>	y if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			15	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	15	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, li</pre>	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	116 30)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			15	30. 00
31.00	1 3 1 3 1 3			0	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	`FS)		15	32. 00
33. 00		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33. 00
34.00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	ructions)		0 15	36. 00 37. 00
	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		_	39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	and dovices (see instruc	tions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	Led devices (see Ilistiac	tions)	0	39. 99
40. 00	Subtotal (see instructions)			15	40. 00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	, , , ,			0	40. 02
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			14 0	41. 00 42. 00
43. 00	Balance due provider/program (see instructions)			1	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
	The rate used to calculate the Time Value of Money				91.00
93. 00				0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/27/2018 9:18 am Health Financial Systems IU HEAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0051

Title XVIII	
1.00	
1.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.5,683,820   27,433,349   27,433,349   27,534,749   27,534	
1.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.00   2.00   3.00   4.5,683,820   27,433,349   27,433,349   27,534,749   27,534	
1.00	
Interim payments payable on individual bills, either submitted or to be submitted or the submitted or to be submitted or the	1. 00
Submitted for to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	2. 00
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 payment. If none, write "NONE" or enter a zero. (1)	2.00
## Tite "NONE" or enter a zero	
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   ADJUSTMENTS TO PROVIDER   O6/27/2017   34,300   O6/27/2017   101,400   O3.02   O3.03   O3.04   O3.05	
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 3.04 3.05 8.50 8.51 3.50 3.51 3.52 3.53 3.54 3.59 3.59 3.59 3.59 3.59 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR  5.01 5.01 TENTATI VE TO PROVI DER  TENTATI VE TO PROGRAM  O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00
for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  3.01 ADJUSTMENTS TO PROVIDER  ADJUSTMENTS TO PROVIDER  O6/27/2017 34, 300 O6/27/2017 101, 400 0 3.03 3.04 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00
payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	
Program to Provider	
3. 01 3. 02 3. 03 3. 03 3. 04 3. 05 8-rovider to Program  ADJUSTMENTS TO PROVIDER  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
3. 02 3. 03 3. 04 3. 05 Provider to Program  3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR  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 PROGRAM  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 01
3. 03 3. 04 3. 05 3. 05 Provider to Program  3. 50 ADJUSTMENTS TO PROGRAM  3. 51 3. 52 3. 53 3. 54 3. 59 4. 00  Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR  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 FENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  O	3. 02
3.04   0   0   0   0   0   0   0   0   0	3. 02
3.05	3. 03
Provider to Program   3.50   ADJUSTMENTS TO PROGRAM   0   0   0   0   0   0   0   0   0	3. 04
3.50   3.51   3.52   3.52   3.53   3.54   3.55   3.554   3.554   3.554   3.555   3.5	3. 03
3.51	2 50
3. 52   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 50
3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  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  TENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 51
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   34,300   101,400   3.50-3.98)   45,718,120   27,534,749   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR   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	3. 52
3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   45,718,120   27,534,749   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR   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   TENTATIVE TO PROVIDER   0   0   0   0   0   0   0   0   0	3. 53
3. 50-3. 98)  4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  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  TENTATIVE TO PROVIDER  5. 50 Provider to Program  TENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  O O O O O O O O O O O O O O O O O O O	3. 54
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  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  5.50 Provider to Program  TENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  O O O O O O O O O O O O O O O O O O O	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  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  O O O O Frovider to Program  TENTATIVE TO PROGRAM  TENTATIVE TO PROGRAM  O O O O O O O O O O O O O O O O O O O	
appropriate   TO BE COMPLETED BY CONTRACTOR	4. 00
TO BE COMPLETED BY CONTRACTOR  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 0 0 0  Provider to Program  5.50 TENTATIVE TO PROGRAM  0 0 0  0 0  0 0  0 0  0 0  0 0  0 0	
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	
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	F 00
write "NONE" or enter a zero. (1) Program to Provider  5. 01 5. 02 5. 03 Provider to Program  TENTATI VE TO PROGRAM  TENTATI VE TO PROGRAM  O	5. 00
Program to Provider	
5. 01 TENTATI VE TO PROVI DER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
5. 02	F 04
5. 03 Provi der to Program  5. 50 Tentati ve to Program  Tentati ve to Program  0 0 0  0 0  0 0  0 0  0 0  0 0  0 0	5. 01
Provi der to Program  5. 50 TENTATI VE TO PROGRAM  0 0 0 0	5. 02
5.50 TENTATI VE TO PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 03
5.51 0 0	F F6
	5. 50
5. 52	5. 51
	5. 52
5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0	5. 99
5. 50-5. 98)	, _
6.00 Determined net settlement amount (balance due) based on	6. 00
the cost report. (1)	, -
6.01   SETTLEMENT TO PROVIDER   92,027   3,119	6. 01
6.02   SETTLEMENT TO PROGRAM 0 0	6. 02
7.00 Total Medicare program liability (see instructions) 45,810,147 27,537,868	7. 00
Contractor NPR Date	
Number (Mo/Day/Yr)	
0 1.00 2.00	
8.00 Name of Contractor	8. 00

Component CCN: 15-T051

Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 734, 464		14	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02 3. 03					0	3. 02 3. 03
3. 03					0	3. 03
3. 05					Ö	3. 05
	Provider to Program		-	1	-	
3.50	ADJUSTMENTS TO PROGRAM		C	)	0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 54 3. 99
3. 77	3. 50-3. 98)			,	U	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 734, 464	ļ	14	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider			1		
5. 01	TENTATI VE TO PROVI DER		C	)	0	5. 01
5.02			C		0	5. 02
5. 03			C	)	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			\	0	
5. 50	TENTATIVE TO PROGRAM				0	5. 50 5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		ĺ		Ö	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)				. ا	/ 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		11, 436	<u>'</u>	1 0	6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)		2, 723, 028		15	
			2,720,020	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
	Tu.	(	)	1. 00	2. 00	
8.00	Name of Contractor			[		8. 00

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAL	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0051	Peri od:	Worksheet E-1	
			From 01/01/2017 To 12/31/2017		narodi
			10 12/31/2017	5/27/2018 9:1	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12		1	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		1	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20		1	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	1	7. 00
	line 168	33		1	
8.00	Calculation of the HIT incentive payment (see instructions)			1	8. 00
9.00	Sequestration adjustment amount (see instructions)			1	9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		1	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)			1	31. 00
	Balance due provider (line 8 (or line 10) minus line 30 and L	ine 31) (see instruction	(2)	1	32 00

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

30. 00 31. 00 32. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0051	Peri od:	Worksheet E-3
		From 01/01/2017	
	Component CCN: 15-T051	To 12/31/2017	Date/Time Prepared:
			5/27/2018 9:18 am
	Title XVIII	Subprovi der -	PPS
		IDE	

		II the XVIII	I RF	PP3	
				1. 00	
4 00	PART III - MEDICARE PART A SERVICES - IRF PPS			0.404.074	4 00
1.00	Net Federal PPS Payment (see instructions)			2, 434, 064	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0200	2.00
3. 00 4. 00	Inpatient Rehabilitation LIP Payments (see instructions)			101, 744 267, 405	3. 00 4. 00
5.00	Outlier Payments Unweighted intern and resident FTE count in the most recent of	ast reporting period or	nding on or prior	0.00	5. 00
5.00	to November 15, 2004 (see instructions)	ost reporting period er	iding on or prior	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count	t for residents that wer	re displaced by	0. 00	5. 01
	program or hospital closure, that would not be counted without		'		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	, , ,			
6.00	New Teaching program adjustment. (see instructions)			0. 00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	period of a "new	0.00	7. 00
	teaching program" (see instructions)				
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth p	period of a "new	0. 00	8. 00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)			7. 564384	
11.00	Teaching Adjustment Factor (see instructions)			0. 000000	
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			2, 803, 213	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0	15.00
16.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0 002 212	16.00
17. 00 18. 00	Subtotal (see instructions)			2, 803, 213	18. 00
19. 00	Primary payer payments Subtotal (line 17 less line 18).			0 2, 803, 213	
20. 00	Deductibles			2, 803, 213	
21. 00	Subtotal (line 19 minus line 20)			2, 778, 237	21.00
22. 00	Coi nsurance			2, 778, 237	
23. 00	Subtotal (line 21 minus line 22)			2, 775, 934	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		81	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	des) (see thisti deti dhis)		53	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		81	26. 00
27. 00	Subtotal (sum of lines 23 and 25)			2, 775, 987	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	28. 00
29. 00	Other pass through costs (see instructions)	,		2, 613	29. 00
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32. 00	Total amount payable to the provider (see instructions)			2, 778, 600	32.00
32. 01	Sequestration adjustment (see instructions)			55, 572	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			2, 734, 464	33. 00
34.00	Tentative settlement (for contractor use only)			0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.0)	•		-11, 436	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub. 15-2,	chapter 1,	3, 651	36. 00
	§115. 2				
EO 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4			267, 405	50 00
	Outlier reconciliation adjustment amount (see instructions)			267, 405	50. 00 51. 00
52. 00	The rate used to calculate the Time Value of Money				52. 00
	Time Value of Money (see instructions)				53. 00
55.00	Time value of money (see first detrois)		1	١	33.00

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

Provider CCN: 15-0051 Period From 0

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/27/2018 9:18 am

Offi y)					5/27/2018 9:1	8 am
		General Fund		Endowment Fund	Plant Fund	
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS				1	
1.00	Cash on hand in banks	237, 700, 073		_	_	
2. 00 3. 00	Temporary investments Notes receivable	0	0	_	0	2. 00 3. 00
4. 00	Accounts recei vable	58, 068, 667	1	0	0	
5.00	Other recei vable	-9, 073, 522		0	o o	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	0	Ö	Ō	Ō	6. 00
7.00	Inventory	5, 212, 018	0	0	0	
8.00	Prepai d expenses	2, 032, 886	0	0	0	
9.00	Other current assets	0	0	_	0	1
10.00	Due from other funds	000 040 100	0	_	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	293, 940, 122	2 0	0	0	11. 00
12. 00	Land	19, 741, 447	'l o	0	0	12. 00
13. 00	Land improvements	2, 058, 207		_	_	13. 00
14.00	Accumulated depreciation	-1, 833, 882	1	0	0	14. 00
15.00	Bui I di ngs	166, 616, 930	0	0	0	15. 00
16. 00	Accumulated depreciation	-128, 727, 516	1	0	0	16. 00
17. 00	Leasehold improvements	7, 148, 073		_	0	17. 00
18. 00	Accumulated depreciation	-5, 380, 299	1	_	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	0	0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks	481, 181	0	0	0	20.00
22. 00	Accumulated depreciation	401, 101		0	0	22. 00
23. 00	Major movable equipment	171, 960, 464	Ö	o o	ő	23. 00
24. 00	Accumulated depreciation	-151, 358, 183	1	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	_	0	28. 00
29. 00 30. 00	Mi nor equi pment-nondepreci abl e	90 704 422	0	_	0	29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	80, 706, 422	.[ 0	0	0	30.00
31. 00	Investments	25, 395, 219	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	165, 931, 925			0	34. 00
35. 00	Total other assets (sum of lines 31-34)	191, 327, 144	1	_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	565, 973, 688	8 0	0	0	36. 00
37. 00	Accounts payable	14, 847, 880	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	11, 915, 310	1	0	_	38.00
39. 00	Payrol I taxes payable	0	Ö	Ō	ō	
40.00	Notes and Loans payable (short term)	1, 690, 000	0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41. 00
42. 00	Accel erated payments	0	)	_	_	42. 00
43. 00	Due to other funds	0 (27 022	0	0	0	43. 00
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	2, 627, 022 31, 080, 212	1	_	0	1
45.00	LONG TERM LIABILITIES	31,000,212	.[ 0	0	0	45.00
46. 00	Mortgage payable	1 0	0	0	0	46. 00
47.00	Notes payable	0	0	0	l .	
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	25, 534, 564		_	_	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	25, 534, 564			_	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	56, 614, 776	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS  General fund balance	509, 358, 912	1		I	52.00
53. 00	Specific purpose fund	307, 330, 712				53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
EO 00	replacement, and expansion	E00 350 010	,	_	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	509, 358, 912 565, 973, 688		0	0	
00.00	[59]	303, 773, 000	,			00.00
	1 * /	ı	1	ļ	1	1

| Period: | Worksheet G-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0051

					То	12/31/2017	Date/Time Pre 5/27/2018 9:1	
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	
	I	1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		406, 296, 380			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		103, 062, 528 509, 358, 908			0		2. 00 3. 00
4. 00	ROUNDING	4	509, 358, 908		0	U	0	4. 00
5. 00	ROUNDING	0			0		0	5. 00
6. 00		0			0		Ö	6. 00
7. 00		l o			Ö		Ö	7. 00
8.00		O			0		0	8. 00
9.00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		4			0		10.00
11. 00	Subtotal (line 3 plus line 10)		509, 358, 912			0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13. 00		0			0		0	13. 00
14.00		0			0		0	14.00
15. 00		0			0		0	15. 00
16. 00 17. 00		0			0		0	16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	U	0		U	0	Ŭ	17. 00
19. 00	Fund balance at end of period per balance		509, 358, 912			0		19. 00
171.00	sheet (line 11 minus line 18)		007,000,712			· ·		. ,
		Endowment Fund	PI ant	Fund				
			7.00	0.00				
1 00	Fund halanasa at haginning of namind	6.00	7. 00	8. 00	0			1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			U			1. 00 2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4. 00	ROUNDI NG		0		٦			4. 00
5. 00			0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10. 00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13. 00 14. 00			0					13. 00 14. 00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)	o	3		0			18. 00
19. 00	Fund balance at end of period per balance	o			0			19. 00
	sheet (line 11 minus line 18)							

Health Financial Systems 100 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0051

		1	0 12/31/201/	5/27/2018 9:1	
	Cost Center Description	I npati ent	Outpati ent	Total	o diii
	3331 331131 23331 pt 311	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2.22	
	General Inpatient Routine Services				
1.00	Hospi tal	91, 586, 844		91, 586, 844	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	4, 669, 026		4, 669, 026	3. 00
4.00	SUBPROVI DER			0	4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				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)	96, 255, 870	)	96, 255, 870	10. 00
	Intensive Care Type Inpatient Hospital Services	·			
11.00	INTENSIVE CARE UNIT	16, 263, 677	'	16, 263, 677	11. 00
12.00	CORONARY CARE UNIT	12, 692, 647	'	12, 692, 647	12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14. 00
15.00	NEONATAL INTENSIVE CARE UNIT	12, 115, 793	3	12, 115, 793	15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	s 41, 072, 117	'	41, 072, 117	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	137, 327, 987		137, 327, 987	17. 00
18. 00	Ancillary services	433, 045, 847			18. 00
19. 00	Outpati ent servi ces	27, 478, 451	137, 471, 990	164, 950, 441	19. 00
20.00	RURAL HEALTH CLINIC	(	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	(	0	"	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES	122, 075	42, 827, 467	42, 949, 542	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		0		25. 00
26. 00	HOSPI CE		1	0	26. 00
27. 00	OTHER NRCC				27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to We	kst. 597, 974, 360	790, 803, 065	1, 388, 777, 425	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		200 010 001	ı	
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		333, 818, 024		29. 00
30.00	ADD (SPECIFY)	(			30.00
31.00		(			31.00
32.00		(			32.00
33. 00		(			33. 00
34. 00		(			34.00
35. 00	T + 1 11111 ( C 11 20 05)		)		35. 00
36.00	Total additions (sum of lines 30-35)		U		36.00
37. 00	DEDUCT (SPECIFY)		1		37. 00
38. 00					38. 00 39. 00
39. 00					
40.00					40.00
41.00	Total doductions (sum of lines 27 41)		<u></u>		41. 00 42. 00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ancfor	333, 818, 024		42.00
43.00	to Wkst. G-3, line 4)	31131 61	333, 010, 024		43.00
	TO MASE. O S, TITLE 4)	1	I	I	I

	Financial Systems IU HEALTH BLOOMING			u of Form CMS-2	
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0051	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	narad.
			10 12/31/201/	5/27/2018 9:1	
				0,27,2010 711	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		1, 388, 777, 425	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	nts		986, 159, 001	2. 00
3.00	Net patient revenues (line 1 minus line 2)			402, 618, 424	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		333, 818, 024	4.00
5.00	Net income from service to patients (line 3 minus line 4)			68, 800, 400	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	n services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10. 00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00				0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	MI SCELLANEOUS I NCOME			34, 262, 128	
25. 00	Total other income (sum of lines 6-24)			34, 262, 128	
26. 00	Total (line 5 plus line 25)			103, 062, 528	
	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28.00

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

103, 062, 528 29. 00

28. 00

CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0051	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre	pared:
				5/27/2018 9: 1	8 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			3, 434, 826	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			91, 107	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost r	reporting period (see ins	tructions)	136. 62	
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)	<del></del>	1! 1!	0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			0	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)		E, part A line	6. 01	7.00
3. 00				26. 08	
9. 00				32. 09	
10. 00	Allowable disproportionate share percentage (see instruction	ns)		6. 72	
11.00	Disproportionate share adjustment (see instructions)			230, 820	
12. 00	Total prospective capital payments (see instructions)			3, 756, 753	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2. 00	Program inpatient ancillary capital cost (see instructions)			0	
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00	Capital cost payment factor (see instructions)			0	•
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00
5. 00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	
7.00	Adjustment to capital minimum payment level for extraordinar	ry circumstances (line 2	x line 6)	0	7.00
3.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as appl		l !: O)	0	9.00
10.00	Current year comparison of capital minimum payment level to			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over	capital payment (from pr	ror year	0	11.00

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

0 12.00

0 13.00

0 14.00

0 15.00

0 16.00

0 17.00

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

13.00

14.00