payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

EXPLIES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1306	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared:
			5/29/2018 2:07 pm

				37	27/2010 2.	O7 PIII
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed	•		Date: 5/29/2018	Ti me:	2: 07 p
use only	2. [ ] Manually submitted c 3. [ O ] If this is an amende 4. [ F ] Medicare Utilization	d report enter the number o		resubmitted this cost	report	
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended		11.0 this Provider CCN 12.	NPR Date: Contractor's Vendor ( [ O ]If line 5, colum number of times	nn 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 PAOLI HOSPITAL (15-1306) 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
Date

			Title XVIII				
	Cost Center Description		Part A	Part B	HI T	Title XIX	
			2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	159, 012	137, 312	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	43, 201	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10. 00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	202, 213	137, 312	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.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1306 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/25/2018 10:47 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 642 WEST HOSPITAL ROAD PO Box: 1.00 State: IN 2.00 City: PAOLI Zip Code: 47454 County: ORANGE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal IU HEALTH PAOLI 151306 99915 07/01/2001 Ν 0 3.00 1 HOSPI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF LUHP SWING BEDS 157306 99915 7.00 07/01/2001 N 0 N 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 Ν share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 Ν 23 00 3 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d 0ther In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

instructions)

11031 1	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMP		Provider C	°N: 15_1306	Peri od:	u of Form CMS-2 Worksheet S-2		
	THE AND HOSFITAL HEALTH CARE COMP	LEX TOUNTHITCATION DA	IA	Frovider C		From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/25/2018 10:	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1. 00	2. 00	3. 00	4. 00	5. 00	
61. 04	surgery allopathic and/or osteop current cost reporting period. (s	eathic FTEs in the see instructions).						61. 04
51.05	Enter the difference between the and/or general surgery FTEs and primary care and/or general surgent 61.04 minus line 61.03). (see in	the current year's pery FTE counts (line						61. 05
61. 06	Enter the amount of ACA \$5503 avused for cap relief and/or FTEs care or general surgery. (see in	vard that is being that are nonprimary						61. 00
		,	Pro	ogram Name	Program Code		Unweighted Direct GME FTE Count	
	I			1. 00	2. 00	3.00	4.00	
61. 10	specialty, if any, and the number for each new program. (see instr column 1, the program name. Ente program code. Enter in column 3, unweighted count. Enter in colum	er of FTE residents cuctions) Enter in er in column 2, the the IME FTE				0.00	0.00	61. 10
61. 20	FTE unweighted count. Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, Enter in column 2, the program c 3, the IME FTE unweighted count. the direct GME FTE unweighted co	the number of FTE pram. (see the program name. code. Enter in column Enter in column 4,				0.00	0.00	61. 20
							1.00	
62. 00	ACA Provisions Affecting the Hea Enter the number of FTE resident	s that your hospital	trai ned			riod for which	0.00	62. 00
62. 01	during in this cost reporting pe	s that rotated from a riod of HRSA THC pro	n Teachi gram. (s	see instructio		your hospital	0.00	62. 01
	Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this c			N	63.00
63. 00	T TOT YES OF IN TOT HO THE COL	ullil 1. 11 yes, compre	te iiie			uctions)		
63. 00				ss of through	Unwei ghted FTEs	FTEs in	Ratio (col. 1/ (col. 1 + col.	
63. 00				23 04 thi ough	Unwei ghted	FTES in		
63. 00	Seekier FFOA ef 11 AGA D	or ETE David I I I I I I I I I I I I I I I I I I I			Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
63. 00	Section 5504 of the ACA Base Yea			der Settings	Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
	period that begins on or after. Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to re	luly 1, 2009 and befor yes, or your facilit aber of unweighted nor utations occurring in	re June y train n-primar all non	der Settings 30, 2010. ned residents ry care nprovider	Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital  2.00 r is your cost r	(col. 1 + col. 2)) 3.00 reporting	64. 00
64. 00	period that begins on or after of Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your services of the service	July 1, 2009 and before yes, or your facility ber of unweighted nor trations occurring in a number of unweighted our hospital. Enter in	re June ry train n-primar all non l non-pr n column	der Settings 30, 2010. ned residents y care pprovider imary care 1 3 the ratio	Unwei ghted FTEs Nonprovi der Si te 1.00 This base yea	FTES in Hospital  2.00 r is your cost r	(col. 1 + col. 2)) 3.00 reporting	64.00
	period that begins on or after. Enter in column 1, if line 63 is in the base year period, the nun resident FTEs attributable to ro settings. Enter in column 2 the	July 1, 2009 and before yes, or your facility ber of unweighted nor trations occurring in a number of unweighted our hospital. Enter in	re June Ty train The primar The p	der Settings 30, 2010. ned residents y care pprovider imary care 1 3 the ratio	Unwei ghted FTEs Nonprovi der Si te 1.00 This base yea	FTEs in Hospital  2.00 r is your cost r  00 0.00  Unweighted FTEs in	(col. 1 + col. 2)) 3.00 reporting	

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

	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi de		Period: From 01/01/2017	Worksheet S-2	
					To 12/31/2017	Date/Time Pre	
		Program Name	Program Code	Unwei ghted	Unwei ghted	5/25/2018 10: Ratio (col. 3/	
				FTÉs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	поѕрі таі	4))	
<b>45.00</b>	le	1.00	2. 00	3. 00	4.00	5.00	45.00
65. 00	Enter in column 1, if line 63 is yes, or your facility			0.0	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 FTEs	Unweighted FTEs in	Ratio (col. 1/ (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 Set				
66 00	beginning on or after July 1, 20 Enter in column 1 the number of		v care resident	0.0	0.00	0. 000000	66 00
00.00	FTEs attributable to rotations of	occurring in all nonpr	ovider settings.	0.0	0.00	0.000000	00.00
	Enter in column 2 the number of FTEs that trained in your hospit						
	(column 1 divided by (column 1 +	column 2)). (see ins					
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1.00	2.00	Si te 3.00	4.00	5.00	
67. 00	Enter in column 1, the program	1.00	2.00	0.0			67. 00
	name associated with each of						
	name associated with each of your primary care programs in which you trained residents.						
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	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)  Inpatient Psychiatric Facility Fis this facility an Inpatient Psenter "Y" for yes or "N" for no lf line 70 is yes: Column 1: Dic	sychiatric Facility (I o. I the facility have ar	approved GME tea	aching program in	provider? N	0 2.00 3.00	70. 00
	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)  Inpatient Psychiatric Facility FI is this facility an Inpatient Psenter "Y" for yes or "N" for no If line 70 is yes: Column 1: Dic recent cost report filed on or by 42 CFR 412.424(d)(1)(iii)(c)) Co	sychiatric Facility (1 ). I the facility have ar pefore November 15, 20 Dlumn 2: Did this faci	approved GME tea 004? Enter "Y" fo lity train reside	aching program in or yes or "N" for ents in a new teac	provider? N the most no. (see hing		
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71.00	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)  Inpatient Psychiatric Facility FI is this facility an Inpatient Psenter "Y" for yes or "N" for no If line 70 is yes: Column 1: Did recent cost report filed on or the 42 CFR 412.424(d)(1)(iii)(c)) Coprogram in accordance with 42 CFC Column 3: If column 2 is Y, indice instructions) Inpatient Rehabilitation Facility	sychiatric Facility (I b. In the facility have an pefore November 15, 20 Dlumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program ye	approved GME tea 104? Enter "Y" fo lity train reside (D)? Enter "Y" fo ear began during	aching program in or yes or "N" for ents in a new teac or yes or "N" for this cost reportir	provider? N the most no. (see hi ng no. g period.		71.00
71. 00 75. 00	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)  Inpatient Psychiatric Facility FI is this facility an Inpatient Psenter "Y" for yes or "N" for not of the program in accordance with 42 CFC column 3: If column 2 is Y, indi (see instructions)  Inpatient Rehabilitation Facilit Is this facility an Inpatient Resubprovider? Enter "Y" for yes	sychiatric Facility (I b. I the facility have an before November 15, 20 blumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program year ty PPS Phabilitation Facility and "N" for no.	approved GME tea 1004? Enter "Y" fo 11 ity train reside (D)? Enter "Y" fo 10 ear began during 10 (IRF), or does in	aching program in or yes or "N" for ents in a new teac or yes or "N" for this cost reporting it contain an IRF	provi der? N the most no. (see hi ng no. g peri od.		
71. 00 75. 00	your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the program residents at 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)  Inpatient Psychiatric Facility Is this facility an Inpatient Psenter "Y" for yes or "N" for not of the program in accordance with 42 CFC column 3: If column 2 is Y, indi (see instructions)  Inpatient Rehabilitation Facility Is this facility an Inpatient Resubprovider? Enter "Y" for yes If line 75 is yes: Column 1: Dic	sychiatric Facility (I b. d the facility have ar before November 15, 20 plumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program year ty PPS ehabilitation Facility and "N" for no.	approved GME tea 104? Enter "Y" for 11ty train reside (D)? Enter "Y" for 12ar began during (IRF), or does in 11 approved GME tea	aching program in or yes or "N" for ents in a new teac or yes or "N" for this cost reportir it contain an IRF aching program in	provi der? N the most no. (see hi ng no. g peri od.  N		71.00
71. 00 75. 00	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)  Inpatient Psychiatric Facility FI is this facility an Inpatient Psenter "Y" for yes or "N" for not of the program in accordance with 42 CFC column 3: If column 2 is Y, indi (see instructions)  Inpatient Rehabilitation Facilit Is this facility an Inpatient Resubprovider? Enter "Y" for yes	sychiatric Facility (I b. d the facility have an defore November 15, 20 plumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program year ty PPS enabilitation Facility and "N" for no. d the facility have and ling on or before Nove	approved GME tea 1004? Enter "Y" for 11 ity train reside (D)? Enter "Y" for 10 ear began during 11 (IRF), or does in 12 approved GME tea 13 approved GME tea 15 approved GME tea 16 approved GME tea	aching program in or yes or "N" for ents in a new teac or yes or "N" for this cost reporting it contain an IRF aching program in ter "Y" for yes o	provider? N the most no. (see hing no. g period.  N the most r "N" for	0	71. 00
71. 00 75. 00	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)  Inpatient Psychiatric Facility Fister "Y" for yes or "N" for not fine 70 is yes: Column 1: Dic recent cost report filed on or the 42 CFR 412.424(d)(1)(iii)(c)) Coprogram in accordance with 42 CFC Column 3: If column 2 is Y, indice instructions)  Inpatient Rehabilitation Facilit Is this facility an Inpatient Resubprovider? Enter "Y" for yes If line 75 is yes: Column 1: Dic recent cost reporting period ence	sychiatric Facility (ID).  If the facility have an opefore November 15, 20 olumn 2: Did this facility August 12, 424 (d) (1) (iii) cate which program years 12 pps whabilitation Facility and "N" for no. If the facility have and ing on or before Nove train residents in a per "Y" for yes or "N"	approved GME tea 104? Enter "Y" for 11 ity train reside (D)? Enter "Y" for 12 ear began during (IRF), or does in 13 approved GME tea 14 mber 15, 2004? En 15 new teaching profor no. Column 3	aching program in or yes or "N" for ents in a new teac or yes or "N" for this cost reporting it contain an IRF aching program in accordance: If column 2 is Y	provider? N the most no. (see hing no. g period.  N the most r "N" for with 42	0	71. 00

Health Financial Systems  IU HEALTH PAOLI HOSPITAL  HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CCN: 15-1306 From To		wof Form CMS- Worksheet S-2 Part I Date/Time Pre 5/25/2018 10:	epared:			
		1. 00	-			
Long Term Care Hospi tal PPS		1.00				
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting per "Y" for yes and "N" for no.	riod? Enter	N N	80. 00 81. 00			
TEFRA Providers  85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "  86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	85. 00 86. 00				
87.00 Is this hospital an extended neoplastic disease care hospital classified under section		N	87. 00			
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	V	XI X				
THE WORLD CO.	1. 00	2. 00				
Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Υ	90.00			
yes or "N" for no in the applicable column.						
91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00			
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00			
93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93. 00			
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94. 00			
95.00 lf line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	.00   Filine 94 is "Y", enter the reduction percentage in the applicable column. 0.00					
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	97. 00			
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98. 00			
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98. 01			
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Υ	98. 02			
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N	N	98. 03			
for title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N	N	98. 04			
in column 2 for title XIX.  98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	N	Υ	98. 05			
column 2 for title XIX.  98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Υ	98. 06			
Rural Providers  105.00 Does this hospital qualify as a CAH?	Υ		105. 00			
106.00 lf this facility qualifies as a CAH, has it elected the all-inclusive method of payment   for outpatient services? (see instructions)	N N		106. 00			
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost	N		107. 00			
reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42  CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Υ		108. 00			
Physi cal Occupati onal	Speech	Respi ratory				
1.00 2.00  109.00 If this hospital qualifies as a CAH or a cost provider, are N N	3. 00 N	4. 00 N	109. 00			

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 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 applicable.

1.00

N

110. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-1306	Period: From 01/01/ To 12/31/	2017   Part 2017   Date	sheet S-   /Time Pr /2018 10	epared:
		1.00		2. 00	_
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is particular all that apply: "A" for Ambulance services; "B" for addition tele-health services.	t reporting period? Ente umn 1 is Y, enter the cipating in column 2.	N		2.00	111. 00
			1.00 2.0	00 3.00	)
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or 'is yes, enter the method used (A, B, or E only) in column 2. Is a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers; Pub.15-1, chapter 22, §2208.1.  16.00 Is this facility classified as a referral center? Enter "Y" for	If column 2 is "E", ente for long term care (inc ) based on the definitio	r in column Iudes	N	0	115. 00
17.00 s this facility legally-required to carry malpractice insurar		r "N" for	N		117. 00
18.00 is the malpractice insurance a claims-made or occurrence policiclaim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the polic	y is	1		118. 00
	Premi ums	Losses	S Ins	surance	
	1.00	2.00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:	46,	524	0		0 118. 0
		1. 00		2. 00	
18. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedul and amounts contained therein. 19. 00 DO NOT USE THIS LINE		N			118. 02
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in a "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes or lifies for the Outpatien			N	120. 00
21.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices charged to	Y			121. 0
22.00 Does the cost report contain healthcare related taxes as defined for a column 1. If column 1 is the Worksheet A line number where these taxes are included.				5. 00	122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no. If	N			125. 0
yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 on the sis a Medicare certified kidney transplant center, enters and the sister of	er the certification dat	е			126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification date				127. 0
28.00 of this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification date				128. 0
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		in			129. 0
30.00 If this is a Medicare certified pancreas transplant center, endate in column 1 and termination date, if applicable, in colum	mn 2.				130. 0
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum	mn 2.				131. 0
32.00 f this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.					132. 0
33.00 of this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. 34.00 of this is an organ procurement organization (OPO), enter the					133. 0
and termination date, if applicable, in column 2.  All Providers					-
40.00 Are there any related organization or home office costs as det chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye		y s	1	5H059	140. 00

 
 Heal th Financial
 Systems
 IU HEALTH

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE
 COMPLEX I DENTIFICATION DATA
 IU HEALTH PAOLI HOSPITAL Provider CCN: 15-1306

					To		/01/2017 /31/2017	Part I Date/Time Pr	
1.00		2. 00					3. 00	5/25/2018 10	): 47 am
If this facility is part of a chai	n organization, enter		11 throu	uah 143 tl	he name	and		of the	
home office and enter the home off	<u>ice contractor name a</u>	and contracto	or numbe	er.					
141.00 Name: INDIANA UNIVERSITY HEALTH	Contractor's Nam	ne: WISCONSIN SERVICES	PHYSI CI	AN  Contr	ractor's	s Numl	ber: 0810	)1	141. 00
142.00 Street: 340 WEST TENTH STREET	PO Box:								142. 00
143. 00 Ci ty: I NDI ANAPOLI S	State:	I N		Zip C	Code:		4620	)4	143. 00
								1. 00	
144.00 Are provider based physicians' cos	ts included in Worksh	eet A?						Y	144. 00
						1	. 00	2. 00	
<ul> <li>145.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"</li> <li>146.00 Has the cost allocation methodol og Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d</li> </ul>	for yes or "N" for n ude Medicare utiliza for no in column 2. y changed from the pr column 1. (See CMS P	no in column ntion for thi reviously fil	1. If c s cost ed cost	olumn 1 i reportino report?	9		Υ	11/27/2017	145. 00
yes, enter the approval date (IIIII) d	d/yyyy) iii cordiiii 2.								
147 00	!!0 5 ! !!!!!	£ "	NIII C					1.00	147.00
147.00 Was there a change in the statisti 148.00 Was there a change in the order of								Y N	147. 00 148. 00
149.00 Was there a change to the simplifi					for no			l N	148.00
The comment of a sharinge to the orimpitti	sa coot iiiiaiiig motile		t A	Part			tle V	Title XIX	1177.00
			00	2.00			. 00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "									
155.00 Hospi tal			ı	N			N	N	155. 00
156.00 Subprovider - IPF			۱ <u> </u>	N			N	N N	156. 00
157.00 Subprovider - IRF 158.00 SUBPROVIDER			J	N			N	N	157. 00 158. 00
159. 00 SNF			J	N	-		N	N	159. 00
160. OO HOME HEALTH AGENCY		l l	i	N	-		N	N N	160. 00
161. 00 CMHC				N			N	N	161. 00
								1.00	
Multicampus 165.00 s this hospital part of a Multica	mous hospital that ha	is one or mor	- Campii	ese in di	fferent	r CRS	Λe2	N	165. 00
Enter "Y" for yes or "N" for no.	iipus nospi tai that na		c campa	303 111 01		. 000	ns:		103.00
	Name	Count		State	Zip Co	_	CBSA	FTE/Campus	_
1// 00  6	0	1. 00		2. 00	3.00	)	4. 00	5. 00	001// 00
166.00  f   line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0. 0	166. 00
								1.00	
Health Information Technology (HIT						ct			
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	īis "Y") and is a me	aningful use				nter	the	Y	167. 00 0168. 00
168.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	ot a meaningful user, Enter "Y" for yes or	does this p "N" for no.	(see i	nstructio	ons)		·	N	168. 01
169.00 If this provider is a meaningful u transition factor. (see instructio		and is not	a CAH (	line 105	is "N")	), en	ter the	0.0	169. 00
, , , , , , , , , , , , , , , , , , , ,	•						nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR b	eginning date and end	ling date for	the re	porting			. 00 1/2017	2.00	170. 00
						1	. 00	2. 00	
171.00   If line 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, nn 1. If column 1 is	Pt. I, line	2, col	. 6? Ente			N		0171.00

MCRI F32 - 14. 2. 164. 1

	Financial Systems IU HEALTH PACTAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1306	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Pre 5/25/2018 10:	2 epared:
		. '		Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	lfor all NO re	esponses. Ent	er all dates in t	the	
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS					+
	Provider Organization and Operation					+
. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in a		instructions	)		
			Y/N	Date	V/I	-
. 00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2. 00	3. 00	2. (
. 00	yes, enter in column 2 the date of termination and in column	n 3. "V" for	IN IN			2. 0
	voluntary or "I" for involuntary.	2,				
. 00	Is the provider involved in business transactions, including		Υ			3. 0
	contracts, with individuals or entities (e.g., chain home					
	or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			Y/N	Туре	Date	
	<u> </u>		1.00	2. 00	3. 00	
. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cer-	ified Dublic	Y	A		4.0
. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C"		ı ı	A		4.0
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	+
	Approved Educational Activities			11.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider i	s N		6.0
	the legal operator of the program?					
. 00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7.0
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	a during the	N		8.0
. 00	Are costs claimed for Interns and Residents in an approved	graduate medic	cal education	N		9. (
	program in the current cost report? If yes, see instruction					
0. 00	Was an approved Intern and Resident GME program initiated	or renewed in t	the current	N		10.0
1. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I	8 Din an Ann	royod	N		11. (
1.00	Teaching Program on Worksheet A? If yes, see instructions.	a k ili ali App	or oved	IN		11.0
	Troubling Trogram on normanost Tri Tri your ood Tribth dott one.				Y/N	
					1. 00	
	Bad Debts				.,	١
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection;			net roportina	Y N	12. 0 13. 0
3. 00	period? If yes, submit copy.	ourcy change c	during this c	ust reporting	IN	13. (
4. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see in	structions.	N	14. (
	Bed Complement					
5. 00	Did total beds available change from the prior cost reporti				N	15. (
		Y/N	Tt A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
6. 00		N		N		16.0
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see instructions)					
7. 00	1	Υ	04/04/2018	Υ	04/04/2018	17. (
	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)			A.I		1.0
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. (
3. 00	Penort data for additional claims that have been billed	1	1			1
3. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
3. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
8. 00 9. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		19. (

Heal th	Financial Systems IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet S Part II Date/Time P 5/25/2018 1	6-2 Prepared:
			ipti on	Y/N	Y/N	
20. 00	If line 1/ or 17 is use were adjustments made to DCOD		0	1. 00 N	3. 00 N	20. 00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN IN	IN	20.00
		Y/N	Date	Y/N	Date	
	III	1. 00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost re	porting period?	N	24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reportir	ng period? If	yes, submit	N	27. 00
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	reporti ng	N	28. 00		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	eserve Fund)	Υ	29. 00		
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	, see	N	30. 00		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	, see	N	31. 00
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provi der-ba	sed physi ci ans?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exilphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based	Υ	35. 00
	priysicians durring the cost reporting perrod? IT yes, see In	ISTI UCTI OIIS.		Y/N	Date	
				1. 00	2. 00	
24 00	Home Office Costs			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		27, 00
36. 00 37. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr	epared by the	home office?	Y		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off			N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
	i nstructi ons.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41. 00
42. 00		INDIANA UNIVER	SITY HEALTH			42. 00
43. 00		317-962-1093		RUTTER@I UHEALTI	H. ORG	43. 00
	report preparer in columns 1 and 2, respectively.			l		

Heal th	Financial Systems IU HEALTH PA	OLI HOSPITA	AL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi d	ler CCN:	15-1306	Period: From 01/01/2017	Worksheet S-2 Part II	!
					To 12/31/2017		pared: 47 am
			3. 00				
	Cost Report Preparer Contact Information	_					
41.00	Enter the first name, last name and the title/position	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 the cost						43.00
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1306

				T-	o 12/31/2017	Date/Time Prep 5/25/2018 10:4	
			<b>'</b>			I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	10, 440. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)						2.00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider						2. 00 3. 00
4. 00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		25	9, 125	10, 440. 00	0	7. 00
7.00	beds) (see instructions)		20	7, 120	10, 110.00	Ü	7.00
8.00	INTENSIVE CARE UNIT	31, 00	0	0	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		25	9, 125	10, 440. 00	0	14.00
15. 00	CAH visits					0	15.00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE	101 00					21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00 24. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	30. 00					24. 00
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	25			O	27. 00
28. 00	Observation Bed Days		20			0	28. 00
29. 00	Ambul ance Trips					_	29. 00
30. 00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1306

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Period: Worksheet S-3 From 01/01/2017 Part I

18.00

19.00

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21.00

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28. 00 29. 00

30.00

31.00

32.00

32.01

33.00

33.01

0.00

0.00

0.00

131.45

12/31/2017 Date/Time Prepared: 5/25/2018 10:47 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 6.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 149 435 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) 229 2 00 33 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 84 0 5.00 84 85 Hospital Adults & Peds. Swing Bed NF 6.00 Ω 6.00 7.00 Total Adults and Peds. (exclude observation 233 604 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 0 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 179 13.00 14.00 Total (see instructions) 233 11 783 0.00 131.45 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00

0

0

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18.00

19.00

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25. 00 26. 00

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32.01

33.00

SUBPROVI DER

HOSPI CE

CMHC - CMHC

NURSING FACILITY

OTHER LONG TERM CARE

HOME HEALTH AGENCY

RURAL HEALTH CLINIC

Observation Bed Days

LTCH non-covered days

Ambul ance Trips

SKILLED NURSING FACILITY

HOSPICE (non-distinct part)

Total (sum of lines 14-26)

Employee discount days - IRF

AMBULATORY SURGICAL CENTER (D. P.)

FEDERALLY QUALIFIED HEALTH CENTER

Employee discount days (see instruction)

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

outpatient days (see instructions)

33.01 LTCH site neutral days and discharges

					12/31/2017	5/25/2018 10:	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	49	8	287	1. 00
0.00	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			4.1	445		
2.00	HMO and other (see instructions)			11	115		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF						6. 00 7. 00
	Total Adults and Peds. (exclude observation beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00	0	40		207	13.00
14. 00 15. 00	Total (see instructions)	0. 00	0	49	8	287	14. 00 15. 00
16. 00	CAH visits						
17. 00	SUBPROVI DER - I PF   SUBPROVI DER - I RF						16. 00 17. 00
18. 00	SUBPROVI DER - TRF						18.00
19. 00	1						19.00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0.00					22.00
23. 00		0.00					23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00		0.00					27. 00
28. 00	,	0.00					28.00
29. 00	1						29.00
	Employee discount days (see instruction)						30.00
31. 00							31.00
32. 00	1 . 3						32.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			О			33. 00
	LTCH site neutral days and discharges			o			33. 01
	1	1	ı	١	'		

Heal th	Financial Systems IU HEALTH PAOLI HO	Λςρι ται		In lie	eu of Form CMS-2	2552_10
		Provi der CCI	N: 15-1306	Peri od:	Worksheet S-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 10:	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	ided by lin	e 202 column	1 8)	0. 362260	1. 00
2.00	Net revenue from Medicaid				3, 646, 265	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 00
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental line 4 is no, then enter DSH and/or supplemental payments from the payments of the supplemental payments from the payments of the supplemental payments.			ni d?	Y	4. 00 5. 00
6.00	Medicaid charges	om wearcard	l		15, 257, 032	
7. 00	Medicaid cost (line 1 times line 6)				5, 527, 012	1
8.00	Difference between net revenue and costs for Medicaid program (	line 7 minu	s sum of lir	nes 2 and 5; if	1, 880, 747	
	< zero then enter zero)		,			
9. 00	Children's Health Insurance Program (CHIP) (see instructions for Net revenue from stand-alone CHIP	r each line	)		0	9.00
10. 00	Stand-alone CHIP charges					
11. 00	Stand-alone CHIP cost (line 1 times line 10)				Ö	
12.00	Difference between net revenue and costs for stand-alone CHIP (	line 11 min	us line 9; i	f < zero then	0	12.00
	enter zero)					
13. 00	Other state or local government indigent care program (see insti Net revenue from state or local indigent care program (Not incl				0	13.00
14. 00	Charges for patients covered under state or local indigent care				0	
	10)	1 3 1				
15. 00	State or local indigent care program cost (line 1 times line 14)				0	
16. 00	Difference between net revenue and costs for state or local ind	igent care	program (lir	ne 15 minus line	0	16. 00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHII	P and state	/local indig	jent care program	ns (see	
17. 00	instructions for each line) Private grants, donations, or endowment income restricted to ful	nding chari	ty care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of h				0	1
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent c	are programs	(sum of lines	1, 880, 747	19. 00
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	patients 2.00	+ col . 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20. 00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility	1, 737, 4	139, 635	1, 877, 051	20. 00
21. 00	Cost of patients approved for charity care and uninsured discoulinstructions)	nts (see	629, 39	139, 635	769, 031	21. 00
22. 00	Payments received from patients for amounts previously written charity care	off as	26, 21	0	26, 213	22. 00
23. 00	Cost of charity care (line 21 minus line 22)		603, 18	139, 635	742, 818	23. 00
					1. 00	
24. 00	Does the amount on line 20 column 2, include charges for patient		nd a Length	of stay limit	N	24. 00
25. 00	imposed on patients covered by Medicaid or other indigent care     If line 24 is yes, enter the charges for patient days beyond the	program? e indigent	care program	n's length of	0	25. 00
26 00	stay limit  Total bad debt expense for the entire hospital complex (see ins	tructions)			2, 955, 432	26. 00
27. 00	1		ructions)		728, 809	ı
27. 01	•	•			1, 121, 244	1
28. 00	Non-Medicare bad debt expense (see instructions)				1, 834, 188	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructions)		1, 056, 888	
	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			1, 799, 706 3, 680, 453	
	1. Sta. a Stillbar Sea and arresimperisated care cost (11116 17 prus 111	55)			1 5,000,400	1 01.00

	Financial Systems	IU HEALTH PAOL				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co	CN: 15-1306   F	Period: From 01/01/2017	Worksheet A	
					To 12/31/2017	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	5/25/2018 10: Recl assi fi ed	47 am
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	(		544, 027	1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0	(	808, 471	808, 471 0	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	59, 613	241, 876	301, 489	1, 324, 113	1, 625, 602	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	586, 756	7, 307, 919			7, 702, 404	5. 00
7.00	00700 OPERATION OF PLANT	378, 055	1, 158, 377	1, 536, 432		862, 381	7.00
7. 01 8. 00	00701 UTILITIES 00800 LAUNDRY & LINEN SERVICE	0	70, 014	70, 014	374, 502	374, 502 70, 014	1
9. 00	00900 HOUSEKEEPING	198, 612	135, 873			265, 298	1
10. 00	01000 DI ETARY	180, 459	155, 558	336, 017		99, 421	1
11.00	01100 CAFETERI A	0	0	1	100, 07 1	168, 094	1
13. 00 13. 01	01300 NURSI NG ADMI NI STRATI ON 01301 HOUSE SUPERVI SORS	544, 783 383, 700	257, 840 86, 936			568, 898 411, 869	1
	01400 CENTRAL SERVICES & SUPPLY	0	-799			324, 219	ł
15. 00	01500 PHARMACY	209, 886	1, 640, 633			493, 440	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	16, 367			12, 134	1
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0 340, 995	0 68, 217	409, 212		0 372, 047	
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	340, 773	00, 217	407, 212	2 -37, 103	372,047	19.00
30. 00	03000 ADULTS & PEDIATRICS	1, 045, 551	488, 616	1, 534, 167	-459, 626	1, 074, 541	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	(	0	0	31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	39, 600	18, 481	58, 081	57, 614	115, 695	43. 00
50. 00	05000 OPERATING ROOM	457, 693	390, 328	848, 021	-310, 066	537, 955	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	34, 743	0	1		52, 246	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	704, 530	1, 027, 657			1, 138, 159	
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	87, 471 66, 814	952, 927 43, 295			1, 035, 053 86, 716	1
65. 00	06500 RESPIRATORY THERAPY	295, 638	150, 734			339, 662	1
66. 00	06600 PHYSI CAL THERAPY	565, 673	316, 151			611, 737	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	78, 726	78, 726	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	(	11, 745 1, 347, 407	11, 745 1, 347, 407	1
73. 00	07301 DRUGS CHARGED TO PATTENTS	0	0		0 1, 347, 407	1, 347, 407	1
74. 00	07400 RENAL DIALYSIS	0	0	(	o	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	(	0	0	75. 00
75. 01 76. 97	07501 CARDI AC REHAB 07697 CARDI AC REHABI LI TATI ON	0 64, 935	0 30, 769	95, 70 <sup>4</sup>	0 1 -14, 681	0 81, 023	75. 01 76. 97
70. 97	OUTPATIENT SERVICE COST CENTERS	04, 935	30, 769	95, 702	-14,001	61,023	10.91
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	88. 00
89. 00		0	0	(		0	
	09000 CLI NI C 09100 EMERGENCY	23, 386 1, 222, 463	38, 321 1, 504, 083				90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 222, 403	1, 504, 083	2, 720, 540	-373, 373	2, 333, 173	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0	(			95. 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(	0	0	101. 00
113. 00	11300 I NTEREST EXPENSE		0		o	0	113. 00
118.00		7, 491, 356	16, 100, 173				
	NONREI MBURSABLE COST CENTERS					_	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC	0	0 728				190. 00 190. 01
	2 19002 OUTREACH	126, 189	69, 199			169, 639	
190. 03	19003 FOUNDATION	0	3, 137				190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	(	-		190. 04
	19005 PAOLI FAMILY PRACTICE 19006 OTHER PROPERTY	0	6, 326 7, 320				190. 05 190. 06
	19000 OTHER PROPERTY		7, 320 O	7, 320			191.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	o	0	Č	1	0	192. 00
	19300 NONPAI D WORKERS	0	0	(00.004.15	0		193. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	7, 617, 545	16, 186, 883	23, 804, 428	3  0	23, 804, 428	<sub>1</sub> 200.00

| Peri od: | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/25/2018 10: 47 am

				5/25/2018 10: 4	47 am
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FIXT	139, 376		·	1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	-141, 776	666, 695	,	2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-327, 362	1, 298, 240	·	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 343, 144	5, 359, 260		5. 00
7.00	00700 OPERATION OF PLANT	0	862, 381		7. 00
7. 01	00701 UTI LI TI ES	0	374, 502		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	70, 014		8. 00
9.00	00900 HOUSEKEEPI NG	-74	265, 224		9. 00
10.00	01000 DI ETARY	0	99, 421		10. 00
11. 00	01100 CAFETERI A	-49, 340		1	11. 00
13. 00	01300 NURSI NG ADMINI STRATI ON	-252	568, 646	1	13. 00
13. 01	01301 HOUSE SUPERVI SORS	0	411, 869		13. 01
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	324, 219	1	14. 00
15. 00	01500 PHARMACY	0	493, 440	·	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-5, 384	6, 750	1	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	l .	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	-98, 119	273, 928		19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T			
30. 00	03000 ADULTS & PEDI ATRI CS	-109	1, 074, 432	·	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0		31. 00
43. 00	04300 NURSERY	0	115, 695		43. 00
	ANCILLARY SERVICE COST CENTERS	T			
50. 00	05000 OPERATING ROOM	-1, 000	536, 955		50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	52, 246		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 138, 159	·	54. 00
60.00	06000 LABORATORY	-413	1, 034, 640		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	86, 716		64. 00
65.00	06500 RESPI RATORY THERAPY	0	339, 662		65. 00
66. 00	06600 PHYSI CAL THERAPY	-13, 800	597, 937		66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	78, 726		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 745		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	805	1, 348, 212		73. 00
73. 01	07301 DRUGS CHARGED TO PATIENTS	0	0		73. 01
74.00	07400 RENAL DIALYSIS	0	0		74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
75. 01	07501 CARDI AC REHAB	0	0		75. 01
76. 97	07697 CARDIAC REHABILITATION	0	81, 023		76. 97
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00	09000 CLI NI C	0	60, 897		90. 00
91. 00	09100 EMERGENCY	-74, 832	2, 278, 341		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES	0			95. 00
101.00	10100 HOME HEALTH AGENCY	0	0		101. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0		113. 00
118.00	9 /	-2, 915, 424	20, 712, 132		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19001 VISITING SPECIALTY CLINIC	0	11		190. 01
	19002 OUTREACH	0	169, 639		190. 02
190.03	3 19003 FOUNDATION	0	3, 137		190. 03
190. 04	19004 SPRING VALLEY FAMILY PRACTICE	0	0		190. 04
190. 0	19005 PAOLI FAMILY PRACTICE	0	4, 069		190. 05
190.00	19006 OTHER PROPERTY	0	16		190. 06
191.00	19100 RESEARCH	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	19300 NONPALD WORKERS	0	0		193. 00
200.00		-2, 915, 424	20, 889, 004		200. 00
	<u> </u>		,	·	

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/25/2018 10:47 am

					5/25/2018 10:	:47 am_
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS					
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 324, 916		1. 00
2.00		0.00	0	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	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		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	•	0		19. 00
	0		0	1, 324, 916		-
	B - BILLABLE DRUGS		_			
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	1, 347, 407		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
	0		0	1, 347, 407		-
4 00	C - BILLABLE SUPPLIES	74 00	ما	70.70/		4 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	78, 726		1. 00
2 00	PATI ENTS	0.00		0		2 00
2.00		0.00	0	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		9. 00
	D - CAPITAL RELATED COSTS		0	78, 726		-
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	374, 447		1 00
2. 00	CAP REL COSTS-BLDG & FIXT	2.00	0	808, 471		1. 00 2. 00
3.00	CAF REL COSTS-WVBEL EQUIP	0.00	0	008, 471		3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	o	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	o	0		7. 00
8. 00		0.00	o	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	0		13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	0	0		18.00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	0		20.00
21. 00		0.00	0	0		21.00
21.00		0.00	0	0		21.00
23. 00		0.00	0	0		23. 00
23. 00 24. 00		0.00		0		24. 00
∠4. ∪∪			+		4	24.00
	E IMPLANT CURRETE		0	1, 182, 918	<u> </u>	-
1 00	E - IMPLANT SUPPLIES IMPL. DEV. CHARGED TO	72. 00	ما	11 74		1 00
1. 00		72.00	0	11, 745		1.00
	PATI ENTS	+				
	F - LEASE EXPENSE		U	11, 745		1
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	169, 580		1.00
1.00	0	— — <del>···</del> • • •	<del> </del>	169, 580		1.00
	1-	ı	વ	,	1	1

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 | Peri od: | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/25/2018 10: 47 am Provider CCN: 15-1306

					<u>5/25/2018 10:47 am</u>
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
-	G - NON-BILLABLE DRUGS				
1.00	PHARMACY	15. 00	0	36, 533	1. 00
2.00		0.00	0	0	2. 00
3.00		0.00	o	Ö	3. 00
4. 00		0.00	ő	ő	4. 00
5.00		0.00	o	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
12.00		0.00	0	0	12. 00
13.00		0.00	0	0	13. 00
				36, 533	
	H - NON-BILLABE MED SUPPLIES			· ·	
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	328, 544	1.00
2.00		0.00	ol	0	2. 00
3.00		0.00	o	Ö	3. 00
4. 00		0.00	o	0	4. 00
		0.00	0		· · · · · · · · · · · · · · · · · · ·
5.00			0	0	5. 00
6.00		0.00	-1	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
12.00		0.00	0	0	12. 00
13.00		0.00	0	0	13. 00
14.00		0.00	o	0	14. 00
15. 00		0.00	0	0	15. 00
16. 00		0.00	Ō	Ö	16. 00
17. 00		0.00	ol	Ö	17. 00
18. 00		0.00	o	ő	18. 00
19. 00		0.00	0	0	19. 00
		0.00	o o	0	
20. 00			0		20. 00
	0		U	328, 544	
4 00	I - COO/CNO	- aal	457.000	ما	
1.00	ADMI NI STRATI VE & GENERAL		15 <u>7, 8</u> 02	0	1.00
	0		157, 802	0	
	J - UTILITIES				
1.00	UTILITIES		0	374, 502	1.00
	0		0	374, 502	
	L - OBSTETRICS				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	11, 976	5, 527	1.00
2. 00	NURSERY	43. 00	62, 007	12, 914	2. 00
	0	— — <del>···</del>	73, 983	18, 441	2.00
	M - CAFETERIA		. 5, .50	.5, .11	 
1.00	CAFETERI A	11. 00	113, 392	54, 702	1. 00
1.00	O				1.00
E00 00	Crand Tatal, Ingrasass		113, 392	54, 702	F00 00
500.00	Grand Total: Increases		345, 177	4, 928, 014	500. 00

RECLASSI FI CATIONS

Provider CCN: 15-1306

Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Ti me Prepared:

5/25/2018 10:47 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL 5.00 61, 636 1.00 0 0 2.00 OPERATION OF PLANT 7.00 59, 395 2.00 HOUSEKEEPI NG 9.00 0 63.840 0 3.00 3.00 4.00 DI ETARY 10.00 0 59, 137 0 4.00 NURSING ADMINISTRATION o 73, 776 0 5.00 13.00 5.00 0 6.00 HOUSE SUPERVISORS 13.01 58. 767 0 6.00 0 0 PHARMACY 7.00 15.00 29,039 7.00 8.00 NONPHYSICIAN ANESTHETISTS 19.00 0 14, 181 0 8.00 o 0 9.00 ADULTS & PEDIATRICS 30.00 261, 371 9.00 10 00 OPERATING ROOM 50 00 0 0 10 00 94 034 RADI OLOGY-DI AGNOSTI C 0 11.00 54.00 0 133, 164 11.00 12.00 LABORATORY 60.00 o 477 0 12.00 13.00 INTRAVENOUS THERAPY 64.00 0 13, 778 0 13.00 RESPIRATORY THERAPY 0 0 14 00 65.00 44.862 14 00 106, 686 0 15.00 PHYSICAL THERAPY 66.00 0 15.00 10, 992 16.00 CARDIAC REHABILITATION 76. 97 o 0 16.00 17.00 CLINIC 90.00 0 810 0 17.00 0 **IEMERGENCY** 213, 758 91 00 0 18.00 18.00 19.00 OUTREACH 190.02 25, 213 0 19.00 1, 324, 916 B - BILLABLE DRUGS 1.00 PHARMACY 15.00 1, 338, 819 0 1.00 2.00 RADI OLOGY-DI AGNOSTI C 0 54.00 5,862 2.00 3.00 LABORATORY 60.00 2, 586 0 3.00 4.00 OUTREACH 190.02 140 0 4.00 1, 347, 407 BILLABLE SUPPLIES ADMINISTRATIVE & GENERAL 0 1.00 5.00 1.00 CENTRAL SERVICES & SUPPLY 2 00 14.00 0 793 0 2 00 3.00 ADULTS & PEDIATRICS 30.00 0 884 0 3.00 4.00 NURSERY 43.00 0 49 0 4.00 0 0 5.00 OPERATING ROOM 50.00 68.736 5.00 RADI OLOGY-DI AGNOSTI C 0 6.00 54.00 0 2, 472 6.00 65.00 7.00 RESPIRATORY THERAPY 0 204 0 7.00 0 8.00 PHYSICAL THERAPY 66.00 0 328 8.00 **EMERGENCY** 0 9.00 9.00 91.00 5.258 0 78, 726 D - CAPITAL RELATED COSTS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 803 1.00 0 2.00 ADMINISTRATIVE & GENERAL 5.00 116,030 2.00 3.00 OPERATION OF PLANT 7.00 0 239, 940 0 3.00 HOUSEKEEPI NG 0 0 4.00 9.00 201 4.00 5.00 DI ETARY 0 8.012 0 10.00 5.00 NURSING ADMINISTRATION 0 0 6.00 13.00 1, 975 6.00 7.00 CENTRAL SERVICES & SUPPLY 14.00 o 2, 693 0 7.00 8.00 PHARMACY 15.00 0 9, 328 0 8.00 MEDICAL RECORDS & LIBRARY 0 0 9.00 16.00 4, 230 9.00 0 10.00 NONPHYSICIAN ANESTHETISTS 19.00 0 18, 897 10.00 11.00 ADULTS & PEDIATRICS 30.00 0 65, 321 0 11.00 0 0 12 00 NURSERY 43 00 1 300 12 00 0 OPERATING ROOM 0 13.00 50.00 73, 300 13.00 14.00 RADI OLOGY-DI AGNOSTI C 54.00 0 403, 411 0 14.00 0 0 15.00 LABORATORY 60.00 1,563 15.00 0 0 INTRAVENOUS THERAPY 64 00 16.00 16 00 1.628 17.00 RESPIRATORY THERAPY 65.00 0 29, 798 0 17.00 PHYSICAL THERAPY 66.00 o 155, 753 0 18.00 18.00 0 19.00 CARDIAC REHABILITATION 76.97 0 2,554 19.00 0 0 20 00 EMERGENCY 91 00 35,606 20 00 21.00 VISITING SPECIALTY CLINIC 190.01 0 717 0 21.00 190.02 o 308 0 22.00 OUTREACH 22.00 PAOLI FAMILY PRACTICE o 0 23.00 190.05 2.257 23.00 OTHER PROPERTY 24.00 190.06 0 7, 293 0 24.00 O 1, 182, 918 - IMPLANT SUPPLIES 1.00 OPERATING ROOM 50.00 0 11, 745 0 1.00 11, 745 - LEASE EXPENSE 1.00 ADMINISTRATIVE & GENERAL 5.00 169, 580 1.00 0 10 169, 580 G - NON-BILLABLE DRUGS 1.00 ADMINISTRATIVE & GENERAL 5.00 0 0 1.00 DI ETARY 0 105 2.00 10.00 0 2.00

40

0

3.00

3.00

CENTRAL SERVICES & SUPPLY

14.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1306 

						0 12/31/201/ Date/IIM 5/25/201	e Prepared: 8 10:47 am_
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
4.00	NONPHYSICIAN ANESTHETISTS	19. 00	0	19	l .		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	2, 610			5. 00
6.00	NURSERY	43. 00	0	252	0		6. 00
7.00	OPERATING ROOM	50.00	0	3, 690	0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	20, 715	l .		8. 00
9.00	LABORATORY	60.00	0	61	0		9. 00
10.00	I NTRAVENOUS THERAPY	64. 00	0	781	0		10. 00
11. 00	RESPIRATORY THERAPY	65. 00	0	42	0		11. 00
12.00	PHYSI CAL THERAPY	66. 00	0	101	0		12. 00
13.00	EMERGENCY	<u>91.</u> 00	0	<u>8, 1</u> 14			13. 00
	0		0	36, 533			
	H - NON-BILLABE MED SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 822			1. 00
2.00	OPERATION OF PLANT	7. 00	0	214	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	5, 146	0		3. 00
4.00	DI ETARY	10.00	0	1, 248	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	172	0		5. 00
6.00	PHARMACY	15. 00	0	16, 426	0		6. 00
7.00	MEDICAL RECORDS & LIBRARY	16. 00	0	3	0		7. 00
8.00	NONPHYSICIAN ANESTHETISTS	19. 00	0	4, 068	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	37, 016	o		9. 00
10.00	NURSERY	43.00	0	15, 706	o		10.00
11.00	OPERATING ROOM	50.00	0	58, 561	o		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	28, 404	0		12. 00
13.00	LABORATORY	60.00	0	658	0		13. 00
14.00	INTRAVENOUS THERAPY	64. 00	О	7, 206	o		14. 00
15.00	RESPIRATORY THERAPY	65.00	O	31, 804	o		15. 00
16.00	PHYSI CAL THERAPY	66.00	o	7, 219	o		16. 00
17.00	CARDIAC REHABILITATION	76. 97	o	1, 135	o		17. 00
18.00	EMERGENCY	91.00	o	110, 637	o		18. 00
19.00	OUTREACH	190. 02	o	88	o		19. 00
20.00	OTHER PROPERTY	190. 06	o	11	o		20. 00
	0 = = = = =			328, 544			
	I - COO/CNO						
1.00	NURSING ADMINISTRATION	13. 00	157, 802	0	0		1. 00
	0		157, 802				
	J - UTILITIES						
1.00	OPERATION OF PLANT	7. 00	0	374, 502	0		1. 00
	0 — — — — —			374, 502			
	L - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	73, 983	18, 441	0		1. 00
2.00		0.00	0	0	o		2. 00
	0 — — — — —		73, 983				
	M - CAFETERIA		,				
1.00	DI ETARY	10.00	113, 392	54, 702	0		1. 00
	0 — — — — —		113, 392	54, 702			
500.00	Grand Total: Decreases		345, 177	4, 928, 014			500.00
	•	'	. !		'		į

| Period: | Worksheet A-7 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:

				To	12/31/2017	Date/Time Prep	
				Acqui si ti ons		5/25/2018 10: 2	47 am
		Begi nni ng	Purchases	Donation	Total	Disposals and	
		Bal ances	rui chases	Donation	iotai	Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	3. 00	4. 00	5.00	
1.00	Land	148, 000	O	0	0	0	1. 00
2.00	Land Improvements	438, 464	Ö	0	0	ا م	2. 00
3.00	Buildings and Fixtures	4, 741, 722	Ö	0	0	ا م	3. 00
4. 00	Building Improvements	877, 722	731, 335	0	731, 335	192, 930	4. 00
5. 00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	10, 065, 053	1, 213, 166	0	1, 213, 166	628, 759	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	16, 270, 961	1, 944, 501	0	1, 944, 501	821, 689	8. 00
9.00	Reconciling Items	o	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	16, 270, 961	1, 944, 501	0	1, 944, 501	821, 689	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	148, 000	0				1. 00
2.00	Land Improvements	438, 464	0				2. 00
3.00	Buildings and Fixtures	4, 741, 722	0				3. 00
4.00	Building Improvements	1, 416, 127	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	10, 649, 460	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	17, 393, 773	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	17, 393, 773	0			ļ	10. 00

Heal th	Financial Systems	IU HEALTH PAOI	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CCN: 15-1306	Peri od:	Worksheet A-7	
					From 01/01/2017 To 12/31/2017		nared·
						5/25/2018 10:	
			S	SUMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9. 00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	(	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	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) (sun	m			
		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	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	(	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o	(	ol			2. 00
3.00	Total (sum of lines 1-2)	o	(	o			3. 00
		. '					•

Provider CCN: 15-1306	Heal th	Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description	RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider C		From 01/01/2017	Part III Date/Time Prep	
Leases   For Ratio   Instructions			COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS   1.00   2.00   3.00   4.00   5.00		Cost Center Description	Gross Assets				Insurance	
Description   Capital Cost Center Description   Descript				Leases				
PART       - RECONCILIATION OF CAPITAL COSTS CENTERS					V			
1.00   CAP REL COSTS-BLDG & FIXT   6,744,314   0   6,744,314   0.387743   0   1.00			1.00	2.00		4. 00	5. 00	
2. 00   CAP REL COSTS-MVBLE EQUIP   10, 649, 460   0   10, 649, 460   0   17, 393, 774   1, 000000   0   3, 00		PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		1			
17, 393, 774   0   17, 393, 774   1.000000   0   3.00	1.00				6, 744, 31	4 0. 387743	0	1.00
ALLOCATION OF OTHER CAPITAL   SUMMARY OF CAPITAL	2.00	CAP REL COSTS-MVBLE EQUIP	10, 649, 460	0	10, 649, 46			2.00
Taxes	3.00	Total (sum of lines 1-2)						3. 00
Capital -Relate   Cols. 5   through 7			ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
A Costs   through 7)		Cost Center Description				Depreciation	Lease	
CAP REL COSTS-BLDG & FIXT   O   O   O   O   O   O   O   O   O								
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00		DART LLL DESCRIPTION OF CARLEY COOTS OF		7.00	8.00	9. 00	10.00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 666, 695 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 1, 182, 918 167, 180 3.00 SUMMARY OF CAPITAL  Cost Center Description Interest Insurance (see instructions) Capital -Relate of Costs (see instructions) 11.00 12.00 13.00 14.00 15.00  PART III - RECONCILIATION OF CAPITAL COSTS CENTERS  1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 683, 403 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 666, 695 2.00	4 00					544 000	4/7 400	1 00
3.00   Total (sum of lines 1-2)			1	· -	(			
Cost Center Description			1					
Cost Center Description	3.00	Total (Sull of Titles 1-2)	0	<u> </u>	IMMADY OF CADI		107, 180	3.00
instructions   instructions   Capital -Relate   d Costs (see   through 14)				30	JIVIIVIART OF CAPT	TAL		
d Costs (see instructions)   11.00   12.00   13.00   14.00   15.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
Instructions		·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
11.00   12.00   13.00   14.00   15.00							through 14)	
PART       - RECONCILIATION OF CAPITAL COSTS CENTERS								
1. 00     CAP REL COSTS-BLDG & FIXT     0     0     0     683, 403     1. 00       2. 00     CAP REL COSTS-MVBLE EQUIP     0     0     0     0     666, 695     2. 00				12. 00	13. 00	14. 00	15. 00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 666, 695 2.00					1	_		
				1	1			
3.00     10   0   0   0   1,350,098   3.00			0	1	1		·	
	3.00	Total (Sum OT Tines 1-2)	0	1 0	ין	U  0	1, 350, 098	3.00

2. 00 In CO 3. 00 In (CO 3. 00 In (CO 4. 00 Tr di 5. 00 Re ex 6. 00 Re su 7. 00 Te st 21 8. 00 Te (CO 9. 00 Pr ad 11. 00 Sa (CC 12. 00 Re tr 13. 00 La 14. 00 Ca	nvestment income - CAP REL DSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL DSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of xpenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter	Basi s/Code (2) 1.00 B  A-8-2 A-8-1	Amount 2.00 -2,400	Expense Classification on To/From Which the Amount is to To/Fr	o be Adjusted	Wkst. A-7 Ref. 5.00 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00   In CO CO   CO   In CO CO   CO   CO   CO   CO   CO   CO	nvestment income - CAP REL DSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL DSTS-WNBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of expenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service	1.00 B	Amount  2.00  -2,400  0  0  0  0  0  0  -2,198,217	Cost Center 3.00  CAP REL COSTS-BLDG & FIXT  CAP REL COSTS-MVBLE EQUIP	Li ne # 4. 00 1. 00 2. 00 0. 0	5.00 10 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00   In CO CO CO   CO CO CO CO CO CO CO CO CO CO CO CO CO	nvestment income - CAP REL DSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL DSTS-WNBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of expenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service	1.00 B	2. 00 -2, 400 0 0 0 0 0 0 0 0 0 0 0 0	3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	4. 00 1. 00 2. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	5.00 10 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 In CO 3. 00 In (CO 4. 00 Ir di 5. 00 Re ex 6. 00 Re su 7. 00 Te st 21 8. 00 Te (CO 9. 00 Pa 10. 00 Pr ad 11. 00 Sa (CO 12. 00 Re 13. 00 La 14. 00 Ca	nvestment income - CAP REL DSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL DSTS-WNBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of expenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service	1.00 B	2. 00 -2, 400 0 0 0 0 0 0 0 0 0 0 0 0	3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	4. 00 1. 00 2. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	5.00 10 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 In CO 3. 00 In (CO 4. 00 Ir di 5. 00 Re ex 6. 00 Re su 7. 00 Te st 21 8. 00 Te (CO 9. 00 Pa 10. 00 Pr ad 11. 00 Sa (CO 12. 00 Re 13. 00 La 14. 00 Ca	nvestment income - CAP REL DSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL DSTS-WNBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of expenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service	1.00 B	2. 00 -2, 400 0 0 0 0 0 0 0 0 0 0 0 0	3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	4. 00 1. 00 2. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	5.00 10 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 In CO 3. 00 In (CO 4. 00 Ir di 5. 00 Re ex 6. 00 Re su 7. 00 Te st 21 8. 00 Te (CO 9. 00 Pa 10. 00 Pr ad 11. 00 Sa (CO 12. 00 Re 13. 00 La 14. 00 Ca	nvestment income - CAP REL DSTS-BLDG & FIXT (chapter 2) nvestment income - CAP REL DSTS-WNBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of expenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service	1.00 B	2. 00 -2, 400 0 0 0 0 0 0 0 0 0 0 0 0	3.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	4. 00 1. 00 2. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	5.00 10 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 In CO 3. 00 In (CO 4. 00 Ir di 5. 00 Re ex 6. 00 Re su 7. 00 Te st 21 8. 00 Te (CO 9. 00 Pa 10. 00 Pr ad 11. 00 Sa (CO 12. 00 Re 13. 00 La 14. 00 Ca	OSTS-BLDG & FIXT (chapter 2) hvestment income - CAP REL OSTS-WMBLE EQUIP (chapter 2) hvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of kpenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) el ated organization ransactions (chapter 10) aundry and linen service	B A-8-2	-2, 400 0 0 0 0 0 0 0 -2, 198, 217	CAP REL COSTS-BLDG & FIXT  CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00 0. 00 0. 00 0. 00 0. 00 0. 00	10 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 In CO 3. 00 In (CO 4. 00 Ir di 5. 00 Re ex 6. 00 Re su 7. 00 Te st 21 8. 00 Te (CO 9. 00 Pa 10. 00 Pr ad 11. 00 Sa (CO 12. 00 Re 13. 00 La 14. 00 Ca	OSTS-BLDG & FIXT (chapter 2) hvestment income - CAP REL OSTS-WMBLE EQUIP (chapter 2) hvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of kpenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) el ated organization ransactions (chapter 10) aundry and linen service	A-8-2	0 0 0 0 0 0 0 -2, 198, 217	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00   In CO   3. 00   In (C   4. 00   Tr   6. 00   Re   ex   6. 00   Te   5. 10   C   7. 00   Pa   10. 00   Pr   ad   11. 00   Sa   (C   12. 00   Re   13. 00   La   14. 00   Ca	nvestment income - CAP REL OSTS-MVBLE EQUIP (chapter 2) nvestment income - other chapter 2) rade, quantity, and time iscounts (chapter 8) efunds and rebates of xpenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0 0 0 0 0 0 -2, 198, 217		0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3.00   In (c) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	nvestment income - other chapter 2) rade, quantity, and time is scounts (chapter 8) efunds and rebates of expenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) euundry and linen service		0		0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
4. 00	chapter 2) rade, quantity, and time scounts (chapter 8) efunds and rebates of xpenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
4. 00 Tr di 5. 00 Re ex 6. 00 Re su 7. 00 Te st 21 8. 00 Te (c 9. 00 Pa 10. 00 Pr ad 11. 00 Sa (c 12. 00 Re tr 13. 00 La 14. 00 Ca	rade, quantity, and time iscounts (chapter 8) efunds and rebates of xpenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00
5. 00 Re ex 6. 00 Re su 7. 00 Te st 21 8. 00 Cc 12. 00 Re re ta 21 8. 00 Cc 12. 00 0	iscounts (chapter 8) efunds and rebates of xpenses (chapter 8) ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00
6. 00 Re su 7. 00 Te st 21 8. 00 Pe ad 11. 00 Sa (c 12. 00 Re tr 13. 00 La 14. 00 Ca	ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0. 00 0. 00 0. 00 0. 00	0 0 0 0	6. 00 7. 00 8. 00 9. 00
6. 00 Re su 7. 00 Te st 21 8. 00 Te (C 9. 00 Pa 10. 00 Pa 11. 00 Sa (C 12. 00 Re tr 13. 00 La 14. 00 Ca	ental of provider space by uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0. 00 0. 00 0. 00	0 0 0	7. 00 8. 00 9. 00
7. 00 Te st 21 8. 00 Te (c 9. 00 Pa ad, 11. 00 Sa (c 12. 00 Re tr 13. 00 La 14. 00 Ca	uppliers (chapter 8) elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0. 00 0. 00 0. 00	0 0 0	7. 00 8. 00 9. 00
7. 00 Te st 21 8. 00 Te (c 9. 00 Pa ad (c 11. 00 Sa (c 12. 00 Re tr 13. 00 La 14. 00 Ca	elephone services (pay tations excluded) (chapter 1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0. 00 0. 00	0 0 0	8. 00 9. 00
8. 00 Te (c) 9. 00 Pr ad 11. 00 Sa (c) 12. 00 Re 11. 00 Ca	1) elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0.00	0	9. 00
8.00 Te (c	elevision and radio service chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0.00	0	9. 00
9. 00 Pa 10. 00 Pr ad 11. 00 Sa (c 12. 00 Re tr 13. 00 La 14. 00 Ca	chapter 21) arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0.00	0	9. 00
9. 00 Pa 10. 00 Pr ad 11. 00 Sa (c 12. 00 Re tr 13. 00 La 14. 00 Ca	arking lot (chapter 21) rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0			0	
10. 00 Pr ad 11. 00 Sa (c 12. 00 Re tr 13. 00 La 14. 00 Ca	rovider-based physician djustment ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service		0		0. 00		10. 00
11. 00 Sa (c 12. 00 Re tr 13. 00 La 14. 00 Ca	ale of scrap, waste, etc. chapter 23) elated organization ransactions (chapter 10) aundry and linen service	A-8-1			0. 00	0	
12.00 Re tr 13.00 La 14.00 Ca	chapter 23) elated organization ransactions (chapter 10) aundry and linen service	A-8-1			0.00	U	1 11 00
12. 00 Re tr 13. 00 La 14. 00 Ca	elated organization ransactions (chapter 10) aundry and linen service	A-8-1	1, 623, 888	ļ.			11. 00
13.00 La 14.00 Ca	aundry and linen service					0	12. 00
14.00 Ca							
	afeteria-employees and quests!		0		0.00	0	
The COLL IDe	ental of quarters to employee		0		0. 00 0. 00	0	14. 00 15. 00
	nd others		U		0.00	U	15.00
1	ale of medical and surgical		0		0.00	0	16. 00
	upplies to other than						
	atients		0		0.00	0	17 00
	ale of drugs to other than atients		U		0. 00	0	17. 00
	ale of medical records and		0		0.00	0	18. 00
1	ostracts						
	ursing and allied health		0		0. 00	0	19. 00
	ducation (tuition, fees, boks, etc.)						
	ending machines		0		0.00	0	20. 00
21. 00 In	ncome from imposition of		0		0.00	0	21. 00
	nterest, finance or penalty						
	narges (chapter 21) nterest expense on Medicare		0		0. 00	0	22. 00
	verpayments and borrowings to		U		0.00	U	22.00
	epay Medicare overpayments						
	djustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	nerapy costs in excess of imitation (chapter 14)						
	djustment for physical	A-8-3	O	PHYSI CAL THERAPY	66.00		24. 00
th	nerapy costs in excess of		J		33.00		= 50
	mitation (chapter 14)						
	tilization review - nysicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	chapter 21)						
	epreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
1	OSTS-BLDG & FIXT						
	epreciation - CAP REL OSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
1	DSTS-MVBLE EQUIP on-physician Anesthetist		Ω	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
1	nysicians' assistant		0		0.00	0	29.00
30. 00 Ad	djustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	nerapy costs in excess of						
	imitation (chapter 14) ospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	nstructions)		O	ADDETO & LETATINGS	30.00		30. 77
31. 00 Ad	djustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	athology costs in excess of						
	imitation (chapter 14) AH HIT Adjustment for	Α	_141 776	CAP REL COSTS-MVBLE EQUIP	2.00	9	32. 00
	epreciation and Interest	-	171,770	S NEE SOSTO WIVELE EQUIT	2.00	7	52.00
	SCELLANEOUS INCOME	В	-104, 295	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

Period: Worksheet A-8 From 01/01/2017 To 12/31/2017 Date/Time Prep

				To	o 12/31/2017	Date/Time Prep 5/25/2018 10:4	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 01	MI SCELLANEOUS I NCOME	В		CAFETERI A	11. 00	-	33. 01
33. 02	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00		33. 02
33. 03	MI SCELLANEOUS I NCOME	В	•	MEDICAL RECORDS & LIBRARY	16. 00		33. 03
33. 04	MI SCELLANEOUS I NCOME	В	•	OPERATING ROOM	50.00		33. 04
33.06		В	•	PHYSI CAL THERAPY	66. 00	-	33. 06
33. 07	MI SCELLANEOUS I NCOME	В		DRUGS CHARGED TO PATIENTS	73. 00	-	33. 07
33. 08	MI SCELLANEOUS I NCOME	В	-435	EMERGENCY	91. 00	-	33. 08
33. 09	UNWONTED SITUATIONS	В	-2, 240	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	<b>4</b>	A	-501, 809	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11	TO ADJUST BUDGET TO ACTUAL	A	-4, 241	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	ACCRUED PTO	A	-54, 718	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 12
33. 13	BENEFI TS	Α	-1, 393, 934	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 13
33. 14	CRNA	A	-98, 119	NONPHYSICIAN ANESTHETISTS	19. 00	0	33. 14
33. 15	MARKETI NG	A	-895	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	MARKETI NG	A	-121	NURSING ADMINISTRATION	13. 00	0	33. 16
33. 17	MARKETI NG	A	-109	ADULTS & PEDIATRICS	30.00	-	33. 17
33. 18	RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5. 00		33. 18
33. 19	CONTRI BUTI ON EXPENSE	A	-2, 614	ADMINISTRATIVE & GENERAL	5. 00	-	33. 19
33. 20	TELEPHONE EQUIPMENT	A		HOUSEKEEPI NG	9. 00	0	33. 20
50.00	TOTAL (sum of lines 1 thru 49)		-2, 915, 424				50.00
	(Transfer to Worksheet A,						
	column 6. line 200.)						

column 6, line 200.)
(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> 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: 15-1306

Peri od: Worksheet A-8-1 From 01/01/2017

002	00010			To 12/31/2017	Date/Time Pre 5/25/2018 10:	
	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	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	141, 776	0	1.00
2.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1, 248, 569	127, 279	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4, 482, 939	5, 515, 110	3.00
3. 01	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	103, 620	0	3. 01
3.02	7. 00	OPERATION OF PLANT	SHARED EMPLOYEES	33, 953	33, 953	3. 02
3.03	10.00	DI ETARY	SHARED EMPLOYEES	8, 979	8, 979	3. 03
3.04	13. 00	NURSING ADMINISTRATION	SHARED EMPLOYEES	118, 886	118, 886	3. 04
3.05	15. 00	PHARMACY	SHARED EMPLOYEES	209, 748	209, 748	3. 05
3.08	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	5, 475	5, 475	3. 08
3.09	60.00	LABORATORY	SHARED EMPLOYEES	969, 653	969, 653	3. 09
3. 10	65. 00	RESPI RATORY THERAPY	SHARED EMPLOYEES	15, 289	15, 289	3. 10
3. 11	76. 97	CARDIAC REHABILITATION	SHARED EMPLOYEES	6,000	6, 000	3. 11
3. 12	90.00	CLINIC	SHARED EMPLOYEES	39, 306	39, 306	3. 12
4.00	91. 00	EMERGENCY	SIP ER ALLOCATION	2, 298, 030	1, 008, 657	4.00
5.00	TOTALS (sum of lines 1-4).			9, 682, 223	8, 058, 335	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

·			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
 B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	O. OO I U HEALTH BLOOM O. C	0	6. 00
7. 00	В	0.00 IU HEALTH 100.0	0	7.00
8. 00	С	0.00 IUH SIP 0.0	0	8.00
9. 00		0.00	0	9.00
10. 00		0.00	0	10.00
100.00 G	6. Other (financial or			100.00
n	on-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.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

							<u>5/25/2018 10:</u>	_47 am
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
			ENTS REQUIRED AS A RES	SULT OF TRAN	NSACTIONS WITH RELATED	ORGANIZATIONS OR C	CLAI MED	
	HOME OFFICE CO							
1.00	141, 776							1. 00
2.00	1, 121, 290							2. 00
3.00	-1, 032, 171							3. 00
3. 01	103, 620	0						3. 01
3.02	0	0						3. 02
3.03	0	0						3. 03
3.04	0	0						3. 04
3.05	0	0						3. 05
3.08	0	0						3. 08
3. 09	0	0						3. 09
3. 10	0	0						3. 10
3. 11	0	0						3. 11
3. 12	0	0						3. 12
4.00	1, 289, 373	0						4. 00
5.00	1, 623, 888							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.

 	del dina di La di di La di da di La	
Rel ated Organi zati on(s)		
and/or Home Office		
41147 01 1101110 0111100		
Type of Business		
1,500 01 240111000		
6. 00		
 B INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
 B. THIERREDATIONSHIT TO RELAT	ED ONOTHER PARTIES.	

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.

	Comorre diago. El el C 711111	
6.00	HOSPI TAL	6.00
7.00	HOME OFFICE	7.00
8.00	PHYSICIAN GROUP	8.00
9.00		9.00
10.00		10.00
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.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider}.$
- 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: 15-1306

					-	To 12/31/2017	7 Date/Time Pre 5/25/2018 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
				·			Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	834, 034				0	1. 00
2.00		EMERGENCY	2, 044, 907	1, 363, 770	681, 137	C		
3.00	60.00	LABORATORY	413	413	0	C	0	3. 00
4.00	0.00		0	0	0	C	0	4. 00
5.00	0.00		0	0	0	C	0	5. 00
6.00	0.00		0	0	0	C	0	6. 00
7.00	0.00		0	0	0	C	0	7. 00
8.00	0.00		0	0	0	C	0	8. 00
9.00	0.00		0	0	0	C	0	9. 00
10.00	0.00		0	0	0	C	0	10. 00
200.00			2, 879, 354				0	
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8.00	9. 00	Educati on	12 13. 00	14.00	
1. 00	1.00	2. 00 ADMI NI STRATI VE & GENERAL	8.00		12. 00		14.00	1. 00
2. 00	•	EMERGENCY					1	
3. 00	•	LABORATORY						
4. 00	0.00	4			_			
5.00	0.00			0				
6. 00	0.00			0				
7. 00	0.00			0				
8. 00	0.00			0				
9. 00	0.00		0	0			ol o	
10. 00	0.00		0	0			ol o	
200.00	0.00		l o	Ö	Ö	l c	ol o	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADMINISTRATIVE & GENERAL	0					1.00
2. 00		EMERGENCY	0			.,,		2. 00
3.00		LABORATORY	0		_			3.00
4.00	0.00		0	0		C	1	4. 00
5.00	0.00		0	0	_	C	)	5. 00
6.00	0.00		0	0	_		2	6. 00
7.00	0.00		0		_	C	2	7. 00
8.00	0.00			0	_			8. 00
9.00	0. 00 0. 00		0	0		C		9. 00 10. 00
10. 00 200. 00	0.00			1	_	2, 198, 217	,	200.00
200.00	I	I	1	1	'I U	2, 190, 217		200.00

Health Financial Systems		IU HEALTH PAOLI HOSPITAL In Lieu of Form					2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CO	CCN: 15-1306   Peri od: From 01/01/2 To 12/31/2		Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REI	ATED_COSTS		5/25/2018 10:	4 / am
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A			DEFARTMENT		
		col . 7)					
	OFNEDAL CEDILLOS COCT OFNEDO	0	1. 00	2. 00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT	683, 403	683, 403				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	666, 695	003, 403	666, 695			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 298, 240	3, 674		1, 305, 916		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 359, 260	44, 220		128, 650	5, 580, 297	5. 00
7.00	00700 OPERATION OF PLANT	862, 381	50, 545	1	65, 323 0	1, 033, 306	7.00
7. 01 8. 00	00701   UTILITIES   00800   LAUNDRY & LINEN SERVICE	374, 502 70, 014	0 3, 488	0 3, 800	0	374, 502 77, 302	7. 01 8. 00
9. 00	00900 HOUSEKEEPI NG	265, 224	9, 384		34, 318	319, 147	9. 00
10.00	01000 DI ETARY	99, 421	19, 197	20, 911	11, 588	151, 117	10. 00
11.00	01100 CAFETERI A	118, 754	11, 686			162, 762	
13. 00 13. 01	01300   NURSI NG   ADMI NI STRATI ON   01301   HOUSE   SUPERVI SORS	568, 646 411, 869	8, 477 0	9, 233 0	66, 865 66, 298	653, 221 478, 167	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	324, 219	23, 837		00, 270	374, 020	
15. 00	01500 PHARMACY	493, 440			36, 266	558, 105	
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 750	14, 535		0	37, 117	
17. 00 19. 00	01700 SOCI AL SERVI CE	0	0		0	222.040	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	273, 928	0	0	58, 920	332, 848	19. 00
30.00	03000 ADULTS & PEDI ATRI CS	1, 074, 432	88, 544	96, 447	167, 874	1, 427, 297	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
43. 00	04300 NURSERY	115, 695	2, 907	3, 166	17, 556	139, 324	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	536, 955	70, 080	76, 334	79, 083	762, 452	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	52, 246	4, 151		8, 072	68, 991	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 138, 159	67, 836			1, 401, 619	
60.00	06000 LABORATORY	1, 034, 640	21, 430		15, 114	1, 094, 526	
64. 00 65. 00	06400   I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	86, 716 339, 662	5, 232 3, 302		11, 545 51, 082	109, 192 397, 643	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	597, 937	65, 033			831, 549	66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	78, 726	0	0	0	78, 726	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 745	0	0	0	11, 745	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 DRUGS CHARGED TO PATIENTS	1, 348, 212 0	0	0	0	1, 348, 212 0	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	07501 CARDI AC REHAB	0	0	0	0	0	75. 01
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	81, 023	8, 267	9, 005	11, 220	109, 515	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	О	0	
90.00	09000 CLI NI C	60, 897	1, 105			67, 246	
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT PART	2, 278, 341	46, 801	50, 978	211, 229	2, 587, 349 0	1
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
	09500 AMBULANCE SERVI CES	0	0		0	0	95. 00
101. 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118. 00		20, 712, 132	587, 324	639, 743	1, 284, 112	20, 567, 297	
	NONREI MBURSABLE COST CENTERS		3317321	55.75	., = = .,=		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19001   VISITING SPECIALTY CLINIC   19002   OUTREACH	110 (20	23, 372	25, 457	0		190. 01
	19003 FOUNDATION	169, 639 3, 137	10, 500 1, 372		21, 804	201, 943	190. 02
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	o		190. 04
190. 05	19005 PAOLI FAMILY PRACTICE	4, 069	27, 906		0	31, 975	190. 05
	19006 OTHER PROPERTY	16	32, 929	0	0		190.06
	19100  RESEARCH   19200  PHYSI CLANS'   PRI VATE   OFFI CES	0	0	0	0		191. 00 192. 00
	19300 NONPAID WORKERS		0	0			193. 00
200.00	Cross Foot Adjustments					0	200. 00
201.00		20,000,004	0	0	1 205 014		201.00
202.00	TOTAL (sum lines 118 through 201)	20, 889, 004	683, 403	666, 695	1, 305, 916	20, 889, 004	J2U2. UU

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2017	Part
To 12/31/2017	Date/Time Prepared:
5/25/2018	10: 47 am

				'	0 12/31/201/	5/25/2018 10:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	
	·	& GENERAL	PLANT		LINEN SERVICE		
		5. 00	7. 00	7. 01	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS			Г		Г	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5 500 007					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 580, 297	4 400 0/5				5. 00
7.00	00700 OPERATION OF PLANT	376, 659	1, 409, 965				7. 00
7. 01	00701 UTI LI TI ES	136, 513	14 504	511, 015			7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	28, 178	11, 504	3, 261		l	8.00
9.00	00900 HOUSEKEEPI NG	116, 335	30, 946			475, 201	9.00
10.00	01000 DI ETARY	55, 085	63, 310			20, 252	1
11. 00	01100 CAFETERI A	59, 330	38, 538			12, 328	1
13.00	01300 NURSI NG ADMINI STRATI ON	238, 111	27, 955	7, 925	0	8, 942	1
13. 01	01301 HOUSE SUPERVI SORS	174, 300	70 (10	22.20		0	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	136, 337	78, 610			0	
15. 00	01500 PHARMACY	203, 439	44, 827	12, 709		0	
16.00	01600 MEDICAL RECORDS & LIBRARY	13, 530	47, 933	1		15, 333	1
17. 00	01700 SOCIAL SERVICE	121 220	0		_	0	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	121, 329	0		) 0	0	19. 00
20.00	03000 ADULTS & PEDIATRICS	520, 275	202 000	02 704	25 245	93, 409	30.00
30. 00 31. 00	03100 I NTENSI VE CARE UNI T	520, 275	292, 009	82, 786	25, 245	93, 409	1
43. 00	04300 NURSERY	50, 786	9, 587	2 710	0	1	1
43.00	ANCI LLARY SERVI CE COST CENTERS	30, 760	9, 307	2, 718	0	3,007	43.00
50. 00	05000 OPERATING ROOM	277, 927	231, 115	65, 523	10, 261	73, 930	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	25, 148	13, 690			4, 379	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	510, 915	223, 714			71, 562	1
60.00	06000 LABORATORY	398, 974	70, 673			22, 607	1
	i i						1
64. 00	06400 I NTRAVENOUS THERAPY	39, 802	17, 256			5, 520	1
65. 00	06500 RESPI RATORY THERAPY	144, 948	10, 890			3, 484	1
66. 00	06600 PHYSI CAL THERAPY	303, 115	7, 631	60, 804	7, 182		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 697	0		0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 281	0	(	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	491, 448	0	(	0	0	
73. 01	07301 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	
74. 00	07400 RENAL DI ALYSI S	0	0		0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	(	0	0	
75. 01	07501 CARDI AC REHAB	0	0	(	0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	39, 920	27, 264	7, 730	) 0	8, 721	76. 97
	OUTPATIENT SERVICE COST CENTERS			_		_	
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90.00	09000 CLI NI C	24, 512	3, 643			1, 165	1
91. 00	09100 EMERGENCY	943, 135	154, 345	43, 758	54, 715	49, 372	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	0	0				
101.00	10100 HOME HEALTH AGENCY	0	0		0	0	101. 00
112 0	SPECIAL PURPOSE COST CENTERS			I	I	Γ	112 00
	0 11300 INTEREST EXPENSE	F 4/2 020	1 405 440	457.000	120 245	4/2 /77	113. 00
118. 00		5, 463, 029	1, 405, 440	457, 092	120, 245	462, 677	1118.00
100 0	NONREIMBURSABLE COST CENTERS 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						100 00
		17 003	0			l .	190.00
	1 19001 VISITING SPECIALTY CLINIC	17, 803	0	21, 852	0		
	2 19002 OUTREACH	73, 612	4 525	1 200			190. 02
	3 19003 FOUNDATION	2, 189	4, 525	1, 283			190. 03
	1 19004 SPRING VALLEY FAMILY PRACTICE	0	0			•	190. 04
	5 19005 PAOLI FAMILY PRACTICE	11, 655	0	00.700		<b>l</b>	190. 05
	19006 OTHER PROPERTY	12, 009	0	30, 788	0	l	190. 06
	0 19100 RESEARCH	0	0	[	<u>0</u>		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		1		192. 00
	19300 NONPALD WORKERS	0	0		0 ار	0	193. 00
200.00							200. 00
201.00		0	0		0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	5, 580, 297	1, 409, 965	511, 015	120, 245	475, 201	J202. 00

			To	12/31/2017	Date/Time Pre 5/25/2018 10:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	HOUSE SUPERVI SORS	CENTRAL SERVI CES & SUPPLY	T diii
	10.00	11. 00	13. 00	13. 01	14.00	
GENERAL SERVICE COST CENTERS   1.00						1. 00 2. 00 4. 00 5. 00 7. 00
7. 01   00701   UTI LITIES 8. 00   00800   LAUNDRY & LINEN SERVICE 9. 00   00900   HOUSEKEEPING 10. 00   01000   DI ETARY 11. 00   01100   CAFETERIA 13. 00   01300   NURSING ADMINISTRATION	307, 713 0 0	283, 884 18, 898				7. 01 8. 00 9. 00 10. 00 11. 00 13. 00
13. 01   01301   HOUSE SUPERVI SORS 14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	0 0 0	13, 266 0 10, 816 0	0 0 1, 259 0	665, 733 0 877 0	611, 254 23, 706 4 0	13. 01 14. 00 15. 00 16. 00 17. 00
17. 00   01700   SOCIAL SERVICE 19. 00   01900   NONPHYSICIAN ANESTHETISTS   I NPATIENT ROUTINE SERVICE COST CENTERS	0	5, 359	0	0	5, 822	17.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100   NTENSI VE CARE UNI T	307, 713	48, 001 0	409, 817 0	285, 671 0	54, 988 0	30. 00 31. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	1, 934	17, 494	12, 194	22, 670	43. 00
50. 00   05000   0PERATING ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM 54. 00   05400   RADIOLOGY-DIAGNOSTIC 60. 00   06000   LABORATORY	0 0	18, 063 3, 628 31, 099 34, 588	32, 820 1, 445	74, 295 22, 878 1, 007	93, 817 0 40, 867 1, 653	50. 00 52. 00 54. 00 60. 00
64. 00   06400   INTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	0	2, 288 13, 523 21, 218	20, 699 0	14, 428 0 0	10, 315 45, 515 10, 333	64. 00 65. 00 66. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS 73. 00   07300   DRUGS CHARGED TO PATIENTS 73. 01   07301   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS 75. 00   07500   ASC (NON-DISTINCT PART) 75. 01   07501   CARDIAC REHAB	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	112, 666 16, 808 0 0 0 0	71. 00 72. 00 73. 00 73. 01 74. 00 75. 00 75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATIENT SERVI CE COST CENTERS	0	2, 107	10, 489	7, 312	1, 624	76. 97
88. 00   08800   RURAL HEALTH CLINIC 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC 91. 00   09100   EMERGENCY	0 0 0 0	0 0 0 54, 328	0 0 0 354, 446	0 0 0 247, 071	0 0 0 170, 323	88. 00 89. 00 90. 00 91. 00
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES	0	0	0	ol	0	92. 00 95. 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	Ö	0		ا		101. 00
113.00 11300   INTEREST EXPENSE 118.00   SUBTOTALS (SUM OF LINES 1 through 117)	307, 713	279, 116	955, 052	665, 733	611, 111	113. 00 118. 00
NONREI MBURSABLE COST CENTERS  190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  190.01 19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 00 190. 01
190. 02 19002 OUTREACH 190. 03 19003 FOUNDATI ON	0	4, 768 0	0	0	127	190. 02 190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 05 19005 PAOLI FAMILY PRACTICE	0	0	0	0	0	190. 04 190. 05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	190. 06 191. 00 192. 00
193. 00   19300   NONPAID WORKERS 200. 00   Cross Foot Adjustments	0	0	0	0		192.00 193.00 200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 307, 713	0 283, 884	0 955, 052	0 665, 733	0 611, 254	201. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/201

			T	o 12/31/2017	Date/Time Pre 5/25/2018 10:	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	Subtotal	77 (1111
		RECORDS &		ANESTHETI STS		
	15.00	LI BRARY	17.00	10.00	24.00	
GENERAL SERVICE COST CENTERS	15.00	16. 00	17. 00	19. 00	24. 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
7. 01  00701   UTI LI TI ES						7. 01
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG ADMI NI STRATI ON						11. 00 13. 00
13. 01   01301   HOUSE SUPERVI SORS						13. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY						14. 00
15. 00 01500 PHARMACY	855, 738					15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	127, 506				16. 00
17.00 01700 SOCIAL SERVICE	o	0	0			17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	12	0	0	465, 370		19. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	1, 614	9, 955	0		3, 558, 780	30. 00
31. 00   03100   INTENSIVE CARE UNIT	0	0	0		0	31.00
43. 00 O4300 NURSERY	156	612	0	0	260, 542	43. 00
ANCILLARY SERVICE COST CENTERS  50. 00   O5000   OPERATING ROOM	2, 282	14, 981	0	465, 370	2, 196, 599	50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	2, 202	2, 464			180, 940	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 810	20, 808		_	2, 399, 051	54.00
60. 00   06000   LABORATORY	38	15, 185		o	1, 658, 280	60.00
64. 00 06400 I NTRAVENOUS THERAPY	483	2, 700	0	O	227, 575	64. 00
65. 00 06500 RESPI RATORY THERAPY	26	1, 721	0	0	620, 838	65. 00
66. 00 06600 PHYSI CAL THERAPY	62	4, 077	0	0	1, 314, 577	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	815	0	0	220, 904	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	252	0	0	33, 086	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	833, 237	13, 992	0	0	2, 686, 889	73. 00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 01
74. 00   07400   RENAL DIALYSIS 75. 00   07500   ASC (NON-DISTINCT PART)	0	0	0	0	0	74. 00 75. 00
75. 00   07500 ASC (NON-DISTINCT PART)  75. 01   07501   CARDI AC REHAB	0	0			0	75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	5, 018	480	ĺ		220, 180	76. 97
OUTPATIENT SERVICE COST CENTERS	0,0.0			<u> </u>	2207 100	70.77
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLINIC	0	87	0	0	97, 686	90. 00
91. 00   09100   EMERGENCY	0	39, 377	0	0	4, 698, 219	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES	0	0	0	ol	0	95. 00
101. 00 10100 HOME HEALTH AGENCY	0	0				101. 00
SPECIAL PURPOSE COST CENTERS	9			<u> </u>		101.00
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	855, 738	127, 506	0	465, 370	20, 374, 146	118. 00
NONREI MBURSABLE COST CENTERS	, ,					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	_		190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	0	0	0	-	88, 495	
190. 02 19002  OUTREACH 190. 03 19003  FOUNDATI ON	0	0	0	0	291, 527	
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	15, 448	190. 03
190.05 19005 PAOLI FAMILY PRACTICE		0	0	0		190. 04
190. 06 19006 OTHER PROPERTY		0				190. 05
191. 00 19100 RESEARCH		0	l	l ő		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0	Ö	o		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	o		193. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	855, 738	127, 506	0	465, 370	20, 889, 004	202. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1306 Peri od: Worksheet B From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/25/2018 10:47 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 UTI LI TI ES 7. 01 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01301 HOUSE SUPERVI SORS 13.01 13.01 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17 00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 3, 558, 780 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31 00 04300 NURSERY 43.00 0 260, 542 43.00 ANCILLARY SERVICE COST CENTERS 2, 196, 599 50.00 05000 OPERATING ROOM 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000 52 00 180, 940 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 399, 051 54.00 54.00 60.00 06000 LABORATORY 1, 658, 280 60.00 06400 I NTRAVENOUS THERAPY 227, 575 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 620, 838 65.00 66.00 06600 PHYSI CAL THERAPY 1, 314, 577 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 220, 904 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72.00 33, 086 72.00 73 00 2, 686, 889 73 00 07301 DRUGS CHARGED TO PATIENTS 73.01 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 07501 CARDI AC REHAB 75.01 75.01 07697 CARDIAC REHABILITATION 76.97 0 220, 180 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88 00 88 00 0 Ω 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 97, 686 90.00 0 09100 EMERGENCY 91.00 91.00 4, 698, 219 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 n 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 20, 374, 146 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 190.01 19001 VISITING SPECIALTY CLINIC 0000000000000 88, 495 190.01 190. 02 19002 OUTREACH 291, 527 190. 02 190. 03 19003 FOUNDATION 15, 448 190.03 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 04 190.05 19005 PAOLI FAMILY PRACTICE 43,630 190.05 190.06 19006 OTHER PROPERTY 75, 758 190 06 191. 00 19100 RESEARCH 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 0 193. 00 19300 NONPALD WORKERS 0 193. 00 200.00 Cross Foot Adjustments 200. 00 0 201.00 Negative Cost Centers 201.00 C

20, 889, 004

202.00

TOTAL (sum lines 118 through 201)

202.00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1306

					To	12/31/2017	Date/Time Pre 5/25/2018 10:	
				CAPITAL RELATED COSTS			3/23/2018 10.	47 alli
Coot Conton Description			D:+1	DIDC 0 FLVT	MVDLE FOULD	Culababal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1.00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	U	1.00	2.00	ZA	4.00	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP	0	2 474	4 000	7 /7/	7 /7/	2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0	3, 674 44, 220		7, 676 92, 387	7, 676 756	4. 00 5. 00
7. 00	1	OPERATION OF PLANT	0	50, 545		105, 602	384	7. 00
7. 01	1	UTI LI TI ES	0	0		O	0	
8.00	1	LAUNDRY & LINEN SERVICE	0	3, 488		7, 288	0	1
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	9, 384 19, 197		19, 605 40, 108	202 68	9. 00 10. 00
11. 00	1	CAFETERI A	0	11, 686		24, 415	115	1
13.00	1	NURSING ADMINISTRATION	0	8, 477	9, 233	17, 710	393	•
13. 01	1	HOUSE SUPERVI SORS	0	0		0	390	•
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	0	23, 837 13, 593		49, 801 28, 399	0 213	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	Ö	14, 535		30, 367	0	•
17. 00	01700	SOCIAL SERVICE	0	0		O	0	
19. 00		NONPHYSI CLAN ANESTHETI STS	0	0	0	0	346	19. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	88, 544	96, 447	184, 991	987	30. 00
31. 00	1	INTENSIVE CARE UNIT	Ö	00,011		0	0	31.00
43.00		NURSERY	0	2, 907	3, 166	6, 073	103	43. 00
FO 00		LARY SERVICE COST CENTERS	0	70.000	7/ 224	144 414	445	FO 00
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	70, 080 4, 151	76, 334 4, 522	146, 414 8, 673	465 47	50. 00 52. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	0	67, 836		141, 726	716	1
60.00		LABORATORY	0	21, 430		44, 772	89	60. 00
64.00		I NTRAVENOUS THERAPY	0	5, 232		10, 931	68	ł
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	3, 302 65, 033		6, 899 135, 871	300 575	ł
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 73. 01	1	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0	0	0	0	73. 01 74. 00
75. 00		ASC (NON-DISTINCT PART)	0	Ö	0	ō	0	75. 00
75. 01		CARDI AC REHAB	0	0	0	0	0	75. 01
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	0	8, 267	9, 005	17, 272	66	76. 97
88. 00		RURAL HEALTH CLINIC	0	О	0	ol	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0		o	0	•
90.00		CLINIC	0	1, 105		2, 308	24	•
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	46, 801	50, 978	97, 779 0	1, 241	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS				<u></u>		72.00
		AMBULANCE SERVICES	0			0		95. 00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113.00		INTEREST EXPENSE						113. 00
118.00	)	SUBTOTALS (SUM OF LINES 1 through 117)	0	587, 324	639, 743	1, 227, 067	7, 548	118. 00
400.00		I MBURSABLE COST CENTERS				ما		1.00.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN VISITING SPECIALTY CLINIC	0	0 23, 372		48, 829		190. 00 190. 01
		OUTREACH	0	10, 500		10, 500		190. 02
	1	FOUNDATI ON	0	1, 372	1, 495	2, 867		190. 03
		SPRING VALLEY FAMILY PRACTICE	0	0 27 00/		0		190. 04
		PAOLI FAMILY PRACTICE OTHER PROPERTY	0	27, 906 32, 929		27, 906 32, 929		190. 05 190. 06
		RESEARCH		0	l	0		191. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	O	0	o	0	192. 00
		NONPAID WORKERS	0	0	0	0	0	193. 00
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers		0	٥	0	n	200. 00 201. 00
202.00	1	TOTAL (sum lines 118 through 201)	0	683, 403	666, 695	1, 350, 098		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: | 5/25/2018 10: 47 am

						5/25/2018 10:	47 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	PLANT		LINEN SERVICE		
	1	5. 00	7. 00	7. 01	8. 00	9. 00	
	GENERAL SERVI CE COST CENTERS	1		T	T		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	93, 143					5. 00
7. 00	00700 OPERATION OF PLANT	6, 287	112, 273				7. 00
7. 01	00701 UTI LI TI ES	2, 278	0	2, 278			7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	470	916	15	8, 689		8. 00
9.00	00900 HOUSEKEEPI NG	1, 942	2, 464	39	0	24, 252	9. 00
10.00	01000 DI ETARY	919	5, 041	80	0	1, 034	10. 00
11. 00	01100 CAFETERI A	990	3, 069	49	0	629	11. 00
13.00	01300 NURSING ADMINISTRATION	3, 974	2, 226	35	0	456	13. 00
13. 01	01301 HOUSE SUPERVI SORS	2, 909	O	0	0	0	13. 01
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 276	6, 260	99	0	0	14. 00
15. 00	01500 PHARMACY	3, 396	3, 570	1	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	226	3, 817	1	0	783	1
17. 00	01700 SOCIAL SERVICE	0	0,017	1	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	2, 025	Ö		0	0	19.00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2,023		<u>,                                     </u>	<u> </u>		17.00
30. 00	03000 ADULTS & PEDIATRICS	8, 684	23, 252	369	1, 824	4, 767	30.00
31. 00	03100   NTENSIVE CARE UNIT	0,004	23, 232	1		4, 707	31.00
			-				
43. 00	04300 NURSERY	848	763	12	0	157	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	4 (00	40.400		744	0.770	F0 00
50.00	05000 OPERATING ROOM	4, 639	18, 403			3, 773	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	420	1, 090			223	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 527	17, 814			3, 652	
60.00	06000 LABORATORY	6, 659	5, 628		0	1, 154	
64. 00	06400 I NTRAVENOUS THERAPY	664	1, 374		0	282	64. 00
65. 00	06500 RESPI RATORY THERAPY	2, 419	867		0	178	65. 00
66.00	06600 PHYSI CAL THERAPY	5, 059	608	271	519	3, 501	66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	479	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	71	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 203	0	0	0	0	73. 00
73. 01	07301 DRUGS CHARGED TO PATIENTS	0	O	0	0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	0	) 0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
75. 01	07501 CARDI AC REHAB	0	0	o	0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	666	2, 171			445	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	000	2, 171	J	<u> </u>	773	70. 77
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	1
		409	290	1	0		
90.00	09000   CLI NI C   09100   EMERGENCY	1			2 055	59 2, 520	90.00
91.00		15, 746	12, 290	195	3, 955	2, 520	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	0			0	95. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS			T	T		
	11300 INTEREST EXPENSE						113. 00
118.00		91, 185	111, 913	2, 038	8, 689	23, 613	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	1 19001 VISITING SPECIALTY CLINIC	297	0	97	0	0	190. 01
190. 02	2 19002 OUTREACH	1, 229	0	0	0	565	190. 02
190.03	3 19003 FOUNDATION	37	360	) 6	0	74	190. 03
190.04	1 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190. 04
	19005 PAOLI FAMILY PRACTICE	195	0	0	o	0	190. 05
	19006 OTHER PROPERTY	200	l o	137	o		190. 06
	19100 RESEARCH	0	l a	) 0	o		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	n		l ol		192. 00
	19300 NONPALD WORKERS	0	n	م ا	n		193. 00
200.00						O	200.00
200.00		0	_		0	0	201.00
201.00		93, 143	112, 273	2, 278	8, 689		202.00
202. U	TOTAL (Sum TITIES TTO CITIOUGH 201)	1 73, 143	112,2/3	7 2,2/0	0,009	24, 232	1202.00

Provider CCN: 15-1306

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2017 | Part II |
| To | 12/31/2017 | Date/Time | Prepared: | 5/25/2018 | 10: 47 am |

				''	3 12/31/2017	5/25/2018 10:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	HOUSE	CENTRAL	
				ADMI NI STRATI ON	SUPERVI SORS	SERVI CES & SUPPLY	
		10.00	11. 00	13.00	13. 01	14. 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
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 UTI LI TI ES						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	47 250					9.00
10. 00 11. 00	01100 CAFETERI A	47, 250	29, 267				10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON		1, 948	26, 742			13.00
13. 00	01301 HOUSE SUPERVI SORS		1, 368		4, 667		13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	o o	1, 555	o o	1, 007	58, 436	14. 00
15. 00	01500 PHARMACY	o	1, 115	35	6	2, 266	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	o	0	0	0	0	16.00
17. 00	01700 SOCIAL SERVICE	O	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	552	0	0	557	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	47, 250	4, 949	11, 475	2, 004	5, 257	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
43.00	04300 NURSERY	0	199	490	85	2, 167	43. 00
	ANCILLARY SERVICE COST CENTERS		1.0/0		=04	0.040	
50.00	05000 OPERATING ROOM	0	1, 862		521	8, 969	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	374	919	160	0	52.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	3, 206 3, 566	40	7	3, 907 158	54. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY		236	580	101	986	64.00
65. 00	06500 RESPIRATORY THERAPY		1, 394	0	0	4, 351	65.00
66. 00	06600 PHYSI CAL THERAPY		2, 187	0	0	988	66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	2, 107	0	0	10, 771	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0	o o	Ö	1, 607	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0	Ō	O	0	73. 00
73. 01	07301 DRUGS CHARGED TO PATIENTS	o	0	0	0	0	73. 01
74.00	07400 RENAL DIALYSIS	O	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	07501 CARDI AC REHAB	0	0	0	0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	217	294	51	155	76. 97
	OUTPATIENT SERVICE COST CENTERS			T	_1		
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	U E (0)	9. 925	1 722	14 202	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	U	5, 602	9, 925	1, 732	16, 283	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	L					72.00
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	o	0	Ō	O		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	47, 250	28, 775	26, 742	4, 667	58, 422	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19001 VISITING SPECIALTY CLINIC	0	0		0		190. 01
	19002 OUTREACH	0	492		0		190. 02
	3 19003 FOUNDATION	0	0	0	0		190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
	19005 PAOLI FAMILY PRACTICE	0	0		0		190. 05
	19006 OTHER PROPERTY 19100 RESEARCH	0	0	0	0		190. 06 191. 00
	19100  RESEARCH   19200  PHYSI CLANS'   PRI VATE   OFFI CES		0		0		191.00
	19200 PHYSICIANS PRIVATE OFFICES		0	0	0		192.00
200.00			U		١	U	200.00
201.00		n	n	n	n	n	201.00
202.00	1 1 0	47, 250	29, 267	26, 742	4, 667		202. 00
			• •				

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1306

Period: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

5/25/2018 10:47 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN Subtotal **ANESTHETI STS** RECORDS & LI BRARY 15. 00 17.00 19. 00 24.00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 UTI LI TI ES 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 13.01 01301 HOUSE SUPERVI SORS 13.01 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 39.057 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 35, 254 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 3, 481 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 74 2, 753 0 298, 636 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 04300 NURSERY 11,073 43.00 43.00 169 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 104 4, 143 0 193, 310 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 681 0 12,825 52.00 0 0 54 00 05400 RADI OLOGY-DI AGNOSTI C 585 5 755 187, 647 54 00 06000 LABORATORY 0 60.00 4, 200 66, 317 60.00 64.00 06400 I NTRAVENOUS THERAPY 22 747 0 16, 013 64.00 0 65.00 06500 RESPIRATORY THERAPY 476 16, 899 65.00 06600 PHYSI CAL THERAPY 0 150, 709 66.00 3 1, 127 66.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 225 11, 475 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 70 1, 748 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 38 029 3 870 0 50, 102 73 00 07301 DRUGS CHARGED TO PATIENTS 0 73.01 0 C 0 73.01 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 07501 CARDI AC REHAB 0 0 75 01 C 75 01 0 07697 CARDIAC REHABILITATION 76.97 229 133 0 21, 733 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC Э 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 0 89 00 C 0 0 90.00 09000 CLI NI C 0 24 3, 119 90.00 91.00 09100 EMERGENCY 0 10.881 0 178, 149 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 39,057 35, 254 0 1, 219, 755 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 190. 01 19001 VISITING SPECIALTY CLINIC C 49, 223 190. 01 190. 02 19002 OUTREACH 0 0 12, 926 190. 02 0 190. 03 19003 FOUNDATI ON 0 3, 344 190. 03 0 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 190. 04 0 190.05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 28, 101 190. 05 190. 06 19006 OTHER PROPERTY 33, 268 190. 06 0 0 0 191.00 0 191. 00 19100 RESEARCH 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 C 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 3, 481 3, 481 200. 00 Negative Cost Centers 0 0 201, 00 201.00 202.00 TOTAL (sum lines 118 through 201) 39.057 35, 254 3.481 1, 350, 098 202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1306 Peri od: Worksheet B From 01/01/2017 Part II Date/Time Prepared: 12/31/2017 5/25/2018 10:47 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 UTI LI TI ES 7. 01 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01301 HOUSE SUPERVI SORS 13.01 13.01 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17 00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 298, 636 30.00 03100 INTENSIVE CARE UNIT 0 31 00 31.00 04300 NURSERY 43.00 0 11,073 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 193, 310 50.00 000000000000000 05200 DELIVERY ROOM & LABOR ROOM 52 00 12, 825 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 187, 647 54.00 60.00 06000 LABORATORY 60.00 66, 317 06400 I NTRAVENOUS THERAPY 16, 013 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 16, 899 65.00 66.00 06600 PHYSI CAL THERAPY 150, 709 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 11, 475 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72.00 1, 748 72.00 73 00 50, 102 73 00 07301 DRUGS CHARGED TO PATIENTS 73.01 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 07501 CARDI AC REHAB 75.01 75.01 07697 CARDIAC REHABILITATION 76.97 0 21, 733 76.97 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 Ω 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 3, 119 90.00 0 09100 EMERGENCY 178, 149 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 219, 755 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 Ω 190.00 190.01 19001 VISITING SPECIALTY CLINIC 49, 223 0000000000000 190.01 190. 02 19002 OUTREACH 12, 926 190. 02 190. 03 19003 FOUNDATI ON 3, 344 190.03 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 04 190.05 19005 PAOLI FAMILY PRACTICE 28, 101 190.05 190.06 19006 OTHER PROPERTY 190 06 33, 268 191. 00 19100 RESEARCH 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 0 193. 00 19300 NONPALD WORKERS Ω 193. 00 200.00 Cross Foot Adjustments 200. 00 3, 481 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 1, 350, 098 202.00

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1306 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/25/2018 10:47 am CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 58 774 2.00 00200 CAP REL COSTS-MVBLE EQUIP 52, 639 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 316 316 7, 557, 932 4.00 00500 ADMINISTRATIVE & GENERAL 15, 308, 707 5 00 3 803 3 803 744 558 -5, 580, 297 5 00 7.00 00700 OPERATION OF PLANT 4, 347 4, 347 378, 055 0 1, 033, 306 7.00 7.01 00701 UTI LI TI ES 374, 502 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 300 300 0 77, 302 8.00 0 0 319, 147 00900 HOUSEKEEPI NG 198, 612 9 00 807 807 9 00 10.00 01000 DI ETARY 1,651 1,651 67,067 0 151, 117 10.00 01100 CAFETERI A 1,005 1, 005 113, 392 11.00 0 162, 762 11.00 01300 NURSING ADMINISTRATION 386, 981 653, 221 13.00 13.00 729 729 01301 HOUSE SUPERVI SORS 478, 167 13.01 383, 700 13 01 0 14.00 01400 CENTRAL SERVICES & SUPPLY 2,050 2,050 374,020 14.00 01500 PHARMACY 15.00 1, 169 1, 169 209, 886 558, 105 15.00 0 01600 MEDICAL RECORDS & LIBRARY 1, 250 1, 250 0 37, 117 16, 00 16,00 17 00 01700 SOCIAL SERVICE 0 0 0 Ω 17 00 01900 NONPHYSICIAN ANESTHETISTS 340, 995 332, 848 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 7,615 7, 615 0 1, 427, 297 30.00 971, 568 31.00 03100 INTENSIVE CARE UNIT 0 Λ 31.00 139, 324 04300 NURSERY 0 43.00 43.00 250 250 101,607 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 6,027 6,027 457, 693 0 762, 452 05200 DELIVERY ROOM & LABOR ROOM 52.00 357 357 46, 719 0 68, 991 52.00 05400 RADI OLOGY-DI AGNOSTI C 1, 401, 619 54.00 5,834 5, 834 704, 530 0 54.00 60.00 06000 LABORATORY 1.843 1.843 87, 471 1, 094, 526 60.00 06400 I NTRAVENOUS THERAPY 109, 192 64.00 450 450 66, 814 64.00 06500 RESPIRATORY THERAPY 284 284 295, 638 0 397, 643 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 5, 593 5, 593 565, 673 0 831, 549 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 78, 726 71 00 0 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 11, 745 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 0 1, 348, 212 73.00 07301 DRUGS CHARGED TO PATIENTS 0 73.01 73.01 0 0 0 ol 07400 RENAL DIALYSIS 0 0 74.00 Ω 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 C 0 0 0 75.00 75. 01 07501 CARDI AC REHAB 0 0 0 0 75.01 109, 515 07697 CARDIAC REHABILITATION 0 76 97 711 711 64, 935 76 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 O 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 89.00 0 90 00 09000 CLINIC 95 95 23 386 0 67, 246 90 00 91.00 09100 EMERGENCY 4,025 4,025 1, 222, 463 0 2, 587, 349 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00

118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	50, 511	50, 511	7, 431, 743	-5, 580, 297	14, 987, 000 118. 00			
NONREI MBURSABLE COST CENTERS									
190. 00 1900	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00			
190. 01 1900	01 VISITING SPECIALTY CLINIC	2, 010	2, 010	0	0	48, 840 190. 01			
190. 02 1900	02 OUTREACH	903	0	126, 189	0	201, 943 190. 02			
190. 03 1900	3 FOUNDATI ON	118	118	0	0	6, 004 190. 03			
190. 04 1900	04 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0 190. 04			
190. 05 1900	D5 PAOLI FAMILY PRACTICE	2, 400	0	0	0	31, 975 190. 05			
190. 06 1900	06 OTHER PROPERTY	2, 832	0	0	0	32, 945 190. 06			
191. 00 1910	00 RESEARCH	0	0	0	0	0 191. 00			
192. 00 1920	00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00			
193. 00 1930	NONPALD WORKERS	0	0	0	0	0 193. 00			
200. 00	Cross Foot Adjustments					200. 00			
201. 00	Negative Cost Centers					201. 00			
202. 00	Cost to be allocated (per Wkst. B,	683, 403	666, 695	1, 305, 916		5, 580, 297 202. 00			
	Part I)								
203. 00	Unit cost multiplier (Wkst. B, Part I)	11. 627641	12. 665419	0. 172787		0. 364518 203. 00			
204.00	Cost to be allocated (per Wkst. B,			7, 676		93, 143 204. 00			
	Part II)								

Heal th Financ	cial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATI	ION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 10:	
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1. 00	2. 00	4. 00	5A	5. 00	
	Unit cost multiplier (Wkst. B, Part II)			0. 00101	6	0. 006084	205. 00
	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Ti me Prepared: Provider CCN: 15-1306

				Т	o 12/31/2017	Date/Time Pre 5/25/2018 10:	pared: 47 am
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		,		LAUNDRY)			
	GENERAL SERVICE COST CENTERS	7. 00	7. 01	8.00	9. 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						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	24 740					5. 00 7. 00
7. 00 7. 01	00700 OPERATION OF PLANT	36, 769 0					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	300		12, 808			8. 00
9.00	00900 HOUSEKEEPI NG	807	807	0	38, 740		9.00
10.00	01000 DI ETARY	1, 651	1, 651	0	1, 651	3, 774	
11.00	01100 CAFETERI A	1, 005		0	1, 005	0	1
13. 00 13. 01	01300 NURSI NG ADMI NI STRATI ON 01301 HOUSE SUPERVI SORS	729		0	729	0	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	2,050		0	0	0	
15. 00	01500 PHARMACY	1, 169		0	0	0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 250	1, 250	0	1, 250	0	
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	7, 615	7, 615	2, 689	7, 615	3, 774	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	7,019		2,007	0	0	
43.00	04300 NURSERY	250	250	0	250	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6, 027	6, 027	1, 093	6, 027	0	
52.00	O5200   DELIVERY ROOM & LABOR ROOM   O5400   RADIOLOGY-DIAGNOSTIC	357	357	326		0	
54. 00 60. 00	06000 LABORATORY	5, 834 1, 843	5, 834 1, 843	2, 107 0	5, 834 1, 843	0	
64. 00	06400 I NTRAVENOUS THERAPY	450			450	0	•
65. 00	06500 RESPI RATORY THERAPY	284	284	0	284	0	
66. 00	06600 PHYSI CAL THERAPY	199	5, 593	765	5, 593	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1	0	0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73. 00	07301 DRUGS CHARGED TO PATTENTS	0	0	1 0	0	0	
74. 00	07400 RENAL DIALYSIS	0	0	Ö	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	07501 CARDI AC REHAB	0	0	0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	711	711	0	711	0	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	T 0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		-	0	
90.00	09000 CLINIC	95	95	Ō	95	0	
91.00	09100 EMERGENCY	4, 025	4, 025	5, 828	4, 025	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS		1 0		0	0	05 00
	09500  AMBULANCE SERVICES  10100  HOME HEALTH AGENCY		0		0		95.00
101.00	SPECIAL PURPOSE COST CENTERS						101.00
113.00	11300 INTEREST EXPENSE						113. 00
118.00		36, 651	42, 045	12, 808	37, 719	3, 774	118. 00
100.00	NONREI MBURSABLE COST CENTERS						1100 00
	1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN   1900  VISITING SPECIALTY CLINIC	0	1	0	_		190. 00 190. 01
	19002 OUTREACH			0	_		190. 02
	19003 FOUNDATION	118	118	Ō			190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
	19005 PAOLI FAMILY PRACTICE	0	0	0	0		190. 05
	19006 OTHER PROPERTY	0	2, 832	0	0		190. 06
	19100 RESEARCH  19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		191. 00 192. 00
	19300 NONPALD WORKERS		0	0	0		193. 00
200.00			_	_	_		200.00
201.00							201.00
202.00		1, 409, 965	511, 015	120, 245	475, 201	307, 713	202. 00
202.01	Part I)	20 24/5/2	10 071500	0.200272	10 0//417	01 504077	202 00
203. 00 204. 00		38. 346569 112, 273				81. 534976 47, 250	
204. UC	Part II)	112,2/3	2,2/8	0, 089	24, 252	47,250	204.00
205.00		3. 053469	0. 048463	0. 678404	0. 626020	12. 519873	205. 00
							1
206. 00	NAHE adjustment amount to be allocated	1	i				206.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				rom 01/01/2017		
			1	o 12/31/2017	Date/Time Pre	pared:
					5/25/2018 10:	<u>47 am</u>
Cost Center Description	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	(SQUARE FEET)	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)		(POUNDS OF			
			LAUNDRY)			
	7. 00	7. 01	8. 00	9. 00	10.00	
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Constraint   Con	Health Financial Systems		IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Centrer Description		L BASIS		Provi der Co			Worksheet B-1	
CONTITUE								
BISS   BISS   BISS   BISS   BISS   BISS	Cost Center Desc	cription		ADMI NI STRATI ON	SUPERVI SORS (DI RECT NRSI NG	SERVI CES & SUPPLY	PHARMACY (COSTED	4/ am
The color of the					HRS)			
SARREME SERVICE COST CENTERS  1.00 DOTO CAP MEE COSTS-SELVE & FIXE  2.00 DOTO CAP MEE COSTS-SELVE & FIXE  2.00 DOTO CAP MEE COSTS-SELVE & FIXE  3.00 DOTO CAP MEE COSTS-SELVE & FIXE  3.00 DOTO CAP MEE COSTS-SELVE & FIXE  3.00 DOTO CAP MEE COSTS-SELVE & FIXE  4.00 DOTO CAP MEE COSTS-SELVE & FIXE  5.00 DOTO CAP MEE SELVE &			11. 00		13. 01		15. 00	
2.00	GENERAL SERVICE COST (	CENTERS						
13.01   13.01   HOUSE SUPERVISORS   10.298   0   81.945   13.01   13.01   14.00   1400 (CENTRAL SERVICES & SUPPLY   0   0   0   0   0   0   12.510   15.00   17.00	2.00 00200 CAP REL COSTS-M\ 4.00 00400 EMPLOYEE BENEFIT 5.00 00500 ADMINISTRATIVE & 7.00 00700 OPERATION OF PLA 7.01 00701 UTILITIES 8.00 00800 LAUNDRY & LINEN 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA	/BLE EQUIP 'S DEPARTMENT		81 945				2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00
15.00   01500   PHANNACY   15.00   0.00				0.,,,,0				
16.00   16.00   16.00   16.00   16.00   17.0	14.00 01400 CENTRAL SERVICES		0	0	0	427, 117	1 202 701	14. 00
17.00   01700   MONHYMYSICIAN ANESTHETISTS		& LI BRARY	0, 390	0	0	3		1
INVADIT   INT ROUTINE SERVICE COST CENTERS   37,263   35,163   38,423   2,610   30,00   310		a 2. 5.0 a.c.	Ö	Ö	Ö	Ö		
30.00			4, 160	0	0	4, 068	19	19. 00
31.00   03100   INTENSIVE CARE UNIT   0   0   0   0   0   31.00   0300   NRSERY   25.00   05000   NRSERY   25.00   05000   OSE000   OSE0000   OSE000   OSE000   OSE000   OSE000   OSE000   OSE000   OSE0000   OSE000   OSE0000   OSE00000   OSE00000   OSE0000   OSE0000   OSE0000   OSE0000   OSE0000			27.2/2	25 1/2	25 1/2	20, 422	2 (10	20.00
A3. 00   04300 NURSERY   1.501   1,501   1,501   15,841   252   43. 00			37, 263 0	35, 163 0				1
MACILLARY SERVICE COST CENTERS			1, 501	1, 501				
52.00   05.200   DELIVERY ROOM & LABOR ROOM   2,816   2,816   2,816   3,856   20,714   54.00   65.00   06.000   06.000   ABORATORY   26,850   0   0   0   1,155   6.1   60.00   66.00   06.000   NEROMEROUS THERAPY   1,776   1,776   1,766   1,776   7,208   781   64.00   66.00   06.000   NEROMEROUS THERAPY   10,498   0   0   0   7,200   1010   66.00   06.000   PHSYICAL THERAPY   16,471   0   0   0   7,200   1011   66.00   07.000   PHSYICAL THERAPY   16,471   0   0   0   78,726   0   71.00   71.00   07.000   72.000   07.200   UMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   11,745   0   72.00   72.000   07.200   UMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   11,745   0   72.00   73.00   07.300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   1,347,407   73.00   73.00   07.300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   74.00   75.01   75.00   75.00   75.00   07.00   05.00   05.00   05.00   0   0   0   0   0   0   0   0   0		Γ CENTERS			,			
54.00   05400   RADIOLOGY-DI AGNOSTIC   24, 142   124   124   124   28, 556   20, 714   54, 00		LAROD DOOM					•	1
60.00   0.0000   LABORATORY   26,850   0   0   1,155   61,60.00						1	-	1
65.00   OSDO   RESPIRATORY THERAPY   10,498   0   0   31,804   42   65.00		,5110		0				1
66.00   06600   PHYSICAL THERAPY   16, 471   0 0 7, 220   101   66.00   17.00   71.0	64.00 06400 I NTRAVENOUS THEF	RAPY	1, 776	1, 776	1, 776	7, 208	781	64. 00
17.00				0				1
172.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   11,745   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   1,347,407,73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.01				0	1			1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0			0	0	0			
74. 00	73. 00 07300 DRUGS CHARGED TO	) PATIENTS	0	0	Ö	0	1, 347, 407	•
75.00   075.00   075.00   075.00   0   0   0   0   0   0   0   0   0		) PATIENTS	0	0	0	0		1
17.5		CT DADT)	0	0	0	0	-	
76. 97   07697  CARDI AC. REHABILITATION   1,636   900   900   1,135   8,114   76. 97		/ PARI)	0	0	0		0	•
88. 00 08800 RIRAL HEALTH CLINIC 0 0 0 0 0 0 0 89.00 99.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		TATI ON	1, 636	900	900	1, 135	8, 114	1
89.00   08900   EDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   99.00   99.00   09900   CLINIC   0   0   0   0   0   0   0   0   0   99.00   09100   EMERGENCY   42,176   30,412   30,412   119,013   0   91.00   99.00   09200   OBSERVATION BEDS (NON-DISTINCT PART   92.00   97.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   97.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   98.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   101.00   98.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   101.00   98.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   101.00   99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   101.00   99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   101.00   99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   101.00   99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   101.00   99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   101.00   99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   101.00   99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   101.00   99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   0   101.00   99.00   09500   OBSERVATION   0   0   0   0   0   0   0   0   0			_		_			
90. 00   09000   CLINIC   0   0   0   0   0   0   0   0   0			_	_				
99. 00   09200   095000   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   095000   095		TED HEALIN CENTER	0	0	0		0	
OTHER REIMBURSABLE COST CENTERS   0			42, 176	30, 412	30, 412	119, 013	0	
95.00   09500   AMBULANCE SERVI CES   0   0   0   0   0   0   0   0   0								92.00
101.00   10100   HOME   HEALTH AGENCY   0   0   0   0   0   101.00			0	0			0	05.00
113.00   11300   INTEREST EXPENSE				0				
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   216,675   81,945   81,945   427,017   1,383,791   118.00	SPECIAL PURPOSE COST (	CENTERS						1
NONREIMBURSABLE COST CENTERS   190.00   190.00   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190.00   190.00   190.01   190.01   190.01   190.01   190.01   190.01   190.02   190.02   190.02   190.02   190.02   190.02   190.03   190.03   190.03   190.03   190.03   190.04   190.04   190.04   190.04   190.04   190.05   19			21/ /75	01 045	01 045	407.017	1 202 701	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00 190. 00 190. 01 19001 VISITING SPECIALTY CLINIC 0 0 0 0 0 0 0 190. 01 190. 01 190. 01 19002 0UTREACH 3, 701 0 0 0 89 0 190. 02 190. 03 19003 FOUNDATION 0 0 0 0 0 0 0 190. 03 190. 04 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0 0 0 190. 04 190. 05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 0 0 0 190. 05 190. 05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 0 0 0 190. 05 190. 06 1900 0 0 191. 00 191. 00 191. 00 191. 00 191. 00 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 1. 288180 11. 654793 8. 124144 1. 431116 0. 618401 203. 00 204. 00 Part II) Unit cost multiplier (Wkst. B, Part II) 1. 288180 11. 654793 8. 124144 1. 431116 0. 618401 203. 00 204. 00 Part II] Unit cost multiplier (Wkst. B, Part II) 0. 132805 0. 326341 0. 056953 0. 136815 0. 028225 205. 00			216,675	81, 945	81, 945	427,017	1, 383, 791	]118.00
190. 01 19001 VISITING SPECIALTY CLINIC 0 0 0 0 0 190. 01 190. 02 19002 0UTREACH 3,701 0 0 0 89 0 190. 02 190. 02 19003 FOUNDATION 0 0 0 0 0 0 190. 03 190. 03 19003 FOUNDATION 0 0 0 0 0 0 0 190. 03 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0 0 0 190. 04 190. 05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 0 0 0 190. 05 190. 06 190.			0	0	0	О	0	190. 00
190. 03 19003 FOUNDATION 0 0 0 0 0 0 190. 03 19004 19004 19004 19004 19005 19005 PAOLI FAMILY PRACTICE 0 0 0 0 0 0 190. 05 190. 06 19006 OTHER PROPERTY 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 192. 00 19300 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 193. 00 19300 Physi Ci ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 193. 00 19300 Physi Ci ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 193. 00 19300 Physi Ci ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 193. 00 19300 Physi Ci ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 193. 00 193. 00 19300 Physi Ci ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 193. 00 193. 00 19300 Physi Ci ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 0 193. 00 193. 00 19300 Physi Ci ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 0 193. 00 193. 00 193. 00 19300 Physi Ci ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 0 193. 00 193		TY CLINIC	0	0				
190. 04 19004   SPRING VALLEY FAMILY PRACTICE			3, 701	0	0	89		
190. 05 19005		MILY PRACTICE	0	)   0	0	0		
191.00   19100   RESEARCH   0 0 0 0 0 0 0 0 191.00   192.00   192.00   192.00   192.00   193.			0	0	Ö	o		
192.00 19200			0	0	0	11		
193.00 19300   NONPAID WORKERS   0 0 0 0 0 0 0 193.00   200.00   201.00   Negative Cost Centers   283,884   955,052   665,733   611,254   855,738   202.00   203.00   Unit cost multiplier (Wkst. B, Part I)   1.288180   11.654793   8.124144   1.431116   0.618401   203.00   204.00   Cost to be allocated (per Wkst. B, Part II)   205.00   Unit cost multiplier (Wkst. B, Part II)   0.132805   0.326341   0.056953   0.136815   0.028225   205.00		WIE OFFICES	0	0	0	0		
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 Cross Foot Adjustments 200.00 201.00 201.00 201.00 202.00 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 205.00 Cross Foot Adjustments 200.00 201.0		ATE OFFICES	0	0	0	0		
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 207.00 Unit cost multiplier (Wkst. B, Part II) 208.00 Unit cost multiplier (Wkst. B, Part II) 208.00 Unit cost multiplier (Wkst. B, Part II) 209.00 Unit cost multiplier (Wkst. B, Part III) 209.00 Unit cost multiplier (Wkst. B, Part III) 209.00 Unit cost multiplier (Wkst. B, Part III) 209.00 Unit cost multiplier (Wkst. B, Part IIII) 209.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	1	stments					3	
Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 Cost to be allocated (per Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	201.00 Negative Cost Ce	enters						
203.00     Unit cost multiplier (Wkst. B, Part I)     1. 288180     11. 654793     8. 124144     1. 431116     0. 618401     203. 00       204.00     Cost to be allocated (per Wkst. B, Part II)     29, 267     26, 742     4, 667     58, 436     39, 057     204. 00       205.00     Unit cost multiplier (Wkst. B, Part     0. 132805     0. 326341     0. 056953     0. 136815     0. 028225     205. 00		cated (per Wkst. B,	283, 884	955, 052	665, 733	611, 254	855, 738	202. 00
204.00   Cost to be allocated (per Wkst. B, Part   29,267   26,742   4,667   58,436   39,057   204.00   205.00   Unit cost multiplier (Wkst. B, Part   0.132805   0.326341   0.056953   0.136815   0.028225   205.00		olier (Wkst. B, Part I)	1. 288180	11. 654793	8. 124144	1. 431116	0. 618401	203. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.132805 0.326341 0.056953 0.136815 0.028225 205.00	204.00 Cost to be alloc					1		
		Nior (Wks+ D D+	0 122005	0.22/244	0.054050	0 10/045	0 000005	205 00
	·	orrer (wkst. B, Part	0. 132805	0. 326341	0.056953	0. 136815	0. 028225	205.00
	1 /	!	•	•		. '		•

Health Fina	ncial Systems	IU HEALTH PAC	OLI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2017	D 1 /T' D	
					Го 12/31/2017 	Date/Time Pre 5/25/2018 10:	
	Cost Center Description	CAFETERI A	NURSI NG	HOUSE	CENTRAL	PHARMACY	
		(MAN HOURS)	ADMI NI STRATI ON	SUPERVI SORS	SERVICES &	(COSTED	
				(DIRECT NRSIN	G SUPPLY	REQUIS.)	
			(DIRECT NRSING	HRS)	(COSTED		
			HRS)		REQUIS.)		
		11. 00	13.00	13. 01	14. 00	15. 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)						

Provider CCN: 15-1306

Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

					5/25/2018 10	
	Cost Center Description		SOCIAL SERVICE	NONPHYSI CI AN		
		RECORDS &	(TIME CDENT)	ANESTHETI STS		
		LI BRARY (GROSS	(TIME SPENT)	(ASSIGNED TIME)		
		CHARGES)		IIWL)		
		16.00	17. 00	19. 00		
	GENERAL SERVICE COST CENTERS	•	'	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7.00	OO7OO   OPERATION OF PLANT   OO7O1   UTILITIES					7.00
7. 01 8. 00	00800 LAUNDRY & LINEN SERVICE					7. 01 8. 00
9. 00	00900 HOUSEKEEPING					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
13. 01	01301 HOUSE SUPERVI SORS					13. 01
	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	56, 241, 746				16. 00
	01700 SOCIAL SERVICE	0	0			17. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	100		19. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 201 154	ما			20.00
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	4, 391, 154	0	0		30.00
	04300 NURSERY	270, 160		0		43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	270, 100	<u> </u>	<u> </u>		45.00
50. 00	05000 OPERATING ROOM	6, 608, 387	o	100		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 086, 904	o	0		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 178, 544	О	0		54.00
60.00	06000 LABORATORY	6, 698, 107	o	0		60.00
64.00	06400 I NTRAVENOUS THERAPY	1, 191, 132	0	0		64. 00
65.00	06500 RESPI RATORY THERAPY	759, 295	0	0		65. 00
	06600 PHYSI CAL THERAPY	1, 798, 232	0	0		66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	359, 580	0	0		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	111, 010	0	0		72. 00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS	6, 172, 246	0	0		73. 00
74. 00	O7301   DRUGS CHARGED TO PATIENTS   O7400   RENAL DI ALYSI S	0	0	0		73. 01
75. 00	07500 ASC (NON-DISTINCT PART)	0		0		75. 00
75. 00	07501 CARDI AC REHAB	0		0		75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	211, 558	o	Ö		76. 97
	OUTPATIENT SERVICE COST CENTERS		-1	-1		
88. 00	08800 RURAL HEALTH CLINIC	0	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89. 00
90.00	09000 CLI NI C	38, 329	0	0		90. 00
91.00	09100 EMERGENCY	17, 367, 108	0	0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
	OTHER REIMBURSABLE COST CENTERS	_		al		4
	09500 AMBULANCE SERVICES	0		0		95. 00
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	0	0		101.00
113 00	11300 INTEREST EXPENSE					113. 00
118. 00	1 1	56, 241, 746	o	100		118. 00
110.00	NONREI MBURSABLE COST CENTERS	30, 241, 740	<u>ا</u>	100		110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
	19001 VISITING SPECIALTY CLINIC	0	o	0		190. 01
190. 02	19002 OUTREACH	0	o	0		190. 02
190. 03	19003 FOUNDATI ON	0	0	0		190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0		190. 04
	19005 PAOLI FAMILY PRACTICE	0	0	0		190. 05
	19006 OTHER PROPERTY	0	0	0		190. 06
	19100 RESEARCH	0	0	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		192.00
200.00	19300 NONPALD WORKERS   Cross Foot Adjustments		ا	O		193. 00 200. 00
200.00	1 1					200.00
202.00		127, 506	o	465, 370		202. 00
202.00	Part I)	127, 300		403, 370		202.00
203.00		0. 002267	0. 000000	4, 653. 700000		203. 00
204.00		35, 254	0	3, 481		204. 00
	Part II)					
205.00		0. 000627	0. 000000	34. 810000		205. 00
	11)					

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 10:	
Cost Center Description		SOCIAL SERVICE				
	RECORDS &		ANESTHETI STS			
	LI BRARY	(TIME SPENT)	(ASSI GNED			
	(GROSS	,	TIME)			
	CHARGES)					
	16.00	17. 00	19. 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)						

Health Financial Systems	IU HEALTH PAOLI HOSPITAL		In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der	CCN: 15-1306	Peri od:	Worksheet C

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/25/2018 10:47 am	
		Ti +l o	XVIII	Hospi tal	072572018 10: Cost	47 alli
		Title	XVIII	Costs	COST	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	Total Costs	
	Part I, col.	Auj .		DI Sai i Owance		
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00	1.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	3, 558, 780		3, 558, 78	0 0	0	30.00
31. 00   03100   NTENSI VE CARE UNI T	0		0,000,70	0 0	Ö	31.00
43. 00   04300   NURSERY	260, 542		260, 54	-1	0	43. 00
ANCILLARY SERVICE COST CENTERS				=1		
50. 00 05000 OPERATING ROOM	2, 196, 599		2, 196, 59	9 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	180, 940		180, 94		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 399, 051		2, 399, 05		0	54.00
60. 00   06000   LABORATORY	1, 658, 280		1, 658, 28		0	60.00
64.00 06400 I NTRAVENOUS THERAPY	227, 575		227, 57		0	64.00
65. 00 06500 RESPIRATORY THERAPY	620, 838	0			0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 314, 577	0	1, 314, 57		0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	220, 904		220, 90		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	33, 086		33, 08		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 686, 889		2, 686, 88		0	73. 00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0		, ,	o o	0	73. 01
74.00 07400 RENAL DIALYSIS	0			o o	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0			o o	0	75. 00
75. 01   07501   CARDI AC   REHAB	0			0	0	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	220, 180		220, 18	o o	0	76. 97
OUTPATIENT SERVICE COST CENTERS	.,			-		
88. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			o o	0	
90. 00 09000 CLI NI C	97, 686		97, 68	6 0	0	90.00
91. 00 09100 EMERGENCY	4, 698, 219		4, 698, 21	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 898, 184		1, 898, 18	4	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES	0			0 0	0	95. 00
101.00 10100 HOME HEALTH AGENCY	0			0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	22, 272, 330	0	22, 272, 33	0 0		200. 00
201.00 Less Observation Beds	1, 898, 184		1, 898, 18	4	0	201. 00
202.00 Total (see instructions)	20, 374, 146	0	20, 374, 14	6 0	0	202. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL		In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CC	N: 15-1306 Peri od:	Worksheet C

Part I Date/Time Prepared: From 01/01/2017 To 12/31/2017 5/25/2018 10:47 am Title XVIII Hospi tal Cost Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 074, 499 1, 074, 499 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 04300 NURSERY 270, 160 270, 160 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 772, 768 5, 835, 619 0.332396 50.00 05000 OPERATING ROOM 6, 608, 387 52.00 05200 DELIVERY ROOM & LABOR ROOM 730, 858 356, 046 1, 086, 904 0.166473 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 79, 433 9, 099, 111 9, 178, 544 0. 261376 0.000000 54.00 06000 LABORATORY 251, 553 0. 247574 60.00 6, 446, 554 6, 698, 107 0.000000 60.00 06400 I NTRAVENOUS THERAPY 1, 191, 132 0. 191058 0.000000 64.00 4, 302 1, 186, 830 64 00 65.00 06500 RESPIRATORY THERAPY 97, 551 661, 744 759, 295 0.817651 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 73, 950 1, 724, 282 1, 798, 232 0.731039 0.000000 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 323, 104 359, 580 36, 476 0.614339 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 111,010 111,010 0. 298045 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 602, 485 5, 569, 761 6, 172, 246 0. 435318 0.000000 73.00 07301 DRUGS CHARGED TO PATIENTS 73. 01 0.000000 0.000000 73.01 07400 RENAL DIALYSIS 0.000000 0.000000 74 00 0 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.000000 75.00 07501 CARDI AC REHAB 0.000000 0.000000 75. 01 0 C 75.01 07697 CARDIAC REHABILITATION 211, 558 155, 417 1.040755 0.000000 76. 97 76.97 56, 141 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 38, 329 90.00 09000 CLI NI C 38. 329 2 548619 0.000000 90.00 0 199, 121 91.00 09100 EMERGENCY 17, 167, 987 17, 367, 108 0.270524 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 59, 330 3, 257, 325 3, 316, 655 0.572319 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.000000 95.00 0 0.000000 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00 200.00 Subtotal (see instructions) 4, 308, 627 51, 933, 119 56, 241, 746 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 4, 308, 627 51, 933, 119 56, 241, 746 202.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1306	Peri od: From 01/01/2017	Worksheet C Part I
			To 12/31/2017	Date/Time Prepared:

				10 12/31/2017	5/25/2018 10:47 am
			Title XVIII	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	NPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.00
	03100 INTENSIVE CARE UNIT				31.00
	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
	O5000 OPERATING ROOM	0. 000000			50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
	06000 LABORATORY	0. 000000			60. 00
	06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
	06500 RESPI RATORY THERAPY	0. 000000			65. 00
	06600 PHYSI CAL THERAPY	0. 000000			66. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00	D7300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73. 01	07301 DRUGS CHARGED TO PATIENTS	0. 000000			73. 01
74.00	07400 RENAL DIALYSIS	0. 000000			74. 00
75. 00	D7500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
75. 01	07501 CARDI AC REHAB	0. 000000			75. 01
76. 97	07697 CARDIAC REHABILITATION	0. 000000			76. 97
	OUTPATIENT SERVICE COST CENTERS				
	D8800 RURAL HEALTH CLINIC				88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
	09000 CLI NI C	0. 000000			90.00
	09100 EMERGENCY	0. 000000			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES	0. 000000			95. 00
	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE				113. 00
200.00	Subtotal (see instructions)				200. 00
201. 00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1306	Peri od: From 01/01/2017	Worksheet C Part I

12/31/2017 Date/Time Prepared: To 5/25/2018 10:47 am Title XIX 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) 2.00 4. 00 5. 00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 3, 558, 780 3, 558, 780 0 3, 558, 780 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04300 NURSERY o 43.00 260, 542 260, 542 260, 542 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 196, 599 2, 196, 599 2, 196, 599 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 180, 940 180, 940 0 180, 940 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 399, 051 2, 399, 051 2, 399, 051 54.00 1, 658, 280 60.00 06000 LABORATORY 1, 658, 280 1, 658, 280 60 00 0 64.00 06400 I NTRAVENOUS THERAPY 227, 575 227, 575 227, 575 64.00 65.00 06500 RESPIRATORY THERAPY 620, 838 620, 838 0 0 0 0 0 0 620, 838 65.00 06600 PHYSI CAL THERAPY 1, 314, 577 1, 314, 577 1, 314, 577 66.00 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 220, 904 220, 904 71.00 220, 904 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 33,086 33,086 33, 086 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 686, 889 73.00 2, 686, 889 2, 686, 889 73.00 07301 DRUGS CHARGED TO PATIENTS 73 01 0 0 73 01 0 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 07501 CARDI AC REHAB 0 75. 01 0 75.01 0 07697 CARDIAC REHABILITATION 220, 180 220, 180 220, 180 76 97 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 0 89.00 0 97,686 97, 686 0 90.00 09000 CLI NI C 97,686 90.00 91.00 09100 EMERGENCY 4, 698, 219 4, 698, 219 0 4, 698, 219 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 1, 898, 184 1, 898, 184 1, 898, 184 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 200.00 Subtotal (see instructions) 22, 272, 330 0 22, 272, 330 0 22, 272, 330 200. 00 201.00 1, 898, 184 1, 898, 184 1, 898, 184 201. 00 Less Observation Beds 20, 374, 146 202.00 Total (see instructions) 20, 374, 146 0 20, 374, 146 202. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1306	Peri od:	Worksheet C

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1306	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre	
	Title XIX Hospital				5/25/2018 10:47 am PPS	
	_	Charges	e viv	nospi tai	I FF3	
Cost Center Description	I npati ent	Outpati ent	Total (col. + 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	2.20			1.00		
30. 00 03000 ADULTS & PEDI ATRI CS	1, 074, 499		1, 074, 49	9		30. 00
31.00 03100 INTENSIVE CARE UNIT	0			0		31. 00
43. 00 04300 NURSERY	270, 160		270, 16	0		43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	772, 768	5, 835, 619	6, 608, 38	0. 332396	0.000000	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	730, 858	356, 046	1, 086, 90	0. 166473	0.000000	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	79, 433	9, 099, 111	9, 178, 54	0. 261376	0.000000	54.00
60. 00   06000   LABORATORY	251, 553	6, 446, 554	6, 698, 10	0. 247574	0.000000	60.00
64. 00   06400   I NTRAVENOUS THERAPY	4, 302	1, 186, 830			0.000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	97, 551	661, 744			0.000000	65. 00
66. 00  06600 PHYSI CAL THERAPY	73, 950	1, 724, 282			0.000000	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	36, 476	323, 104			0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	111, 010			0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	602, 485	5, 569, 761	6, 172, 24		0.000000	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0. 000000	0.000000	73. 01
74.00   07400   RENAL DIALYSIS	0	0		0. 000000	0.000000	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0. 000000	0.000000	75. 00
75. 01   07501   CARDI AC   REHAB	0	0		0. 000000	0.000000	75. 01
76. 97 07697 CARDI AC REHABILI TATI ON	56, 141	155, 417	211, 55	1. 040755	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0. 000000	0. 000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 000000	0. 000000	89. 00
90. 00 09000 CLI NI C	0	38, 329			0. 000000	90. 00
91. 00   09100   EMERGENCY	199, 121	17, 167, 987			0. 000000	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	59, 330	3, 257, 325	3, 316, 65	0. 572319	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS	_		1			
95. 00 09500 AMBULANCE SERVICES	0	0	•	0. 000000	0. 000000	95. 00
101. 00 10100 HOME HEALTH AGENCY	0	0		0		101. 00
SPECIAL PURPOSE COST CENTERS						112 00
113.00 11300 INTEREST EXPENSE	4 200 (27	E1 022 110	E4 241 74			113.00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	4, 308, 627	51, 933, 119	56, 241, 74	·O		200. 00 201. 00
202.00   Total (see instructions)	4, 308, 627	51, 933, 119	56, 241, 74	6		201.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1306	Peri od: From 01/01/2017	Worksheet C
				Date/Time Prepared:

			10 12/31/2017	Date/II me Prepared:   5/25/2018 10:47 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u> </u>	
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30. 00
31.00 03100 INTENSIVE CARE UNIT				31. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 332396			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 166473			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 261376			54. 00
60. 00   06000   LABORATORY	0. 247574			60.00
64.00   06400   I NTRAVENOUS THERAPY	0. 191058			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 817651			65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 731039			66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 614339			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 298045			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 435318			73. 00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0. 000000			73. 01
74.00 07400 RENAL DIALYSIS	0. 000000			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
75. 01   07501   CARDI AC   REHAB	0. 000000			75. 01
76. 97 07697 CARDIAC REHABILITATION	1. 040755			76. 97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00  09000  CLI NI C	2. 548619			90.00
91. 00  09100 EMERGENCY	0. 270524			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 572319			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems IU HEALTH PAOLI HOSPITAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-1306

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2017	Part II
To 12/31/2017	Date/Time Prepared:
5/25/2018	10: 47 am

						5/25/2018 10:	47 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 196, 599	193, 310			0	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	180, 940	12, 825			0	52.00
	D5400 RADI OLOGY-DI AGNOSTI C	2, 399, 051	187, 647			0	54.00
	06000 LABORATORY	1, 658, 280	66, 317	1, 591, 96	3 0	0	60.00
	06400 INTRAVENOUS THERAPY	227, 575	16, 013			0	64.00
65.00	06500 RESPI RATORY THERAPY	620, 838	16, 899	603, 93	9 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 314, 577	150, 709	1, 163, 86	8 0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	220, 904	11, 475	209, 42	.9 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	33, 086	1, 748	31, 33	8 0	0	72.00
73.00	D7300 DRUGS CHARGED TO PATIENTS	2, 686, 889	50, 102	2, 636, 78	17 0	0	73.00
73. 01	D7301 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0	73. 01
74.00	07400 RENAL DIALYSIS	o	0	)	0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	)	0 0	0	75. 00
75. 01	07501 CARDI AC REHAB	o	0	1	0 0	0	75. 01
76. 97	07697 CARDIAC REHABILITATION	220, 180	21, 733	198, 44	.7	0	76. 97
C	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	C	)	0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	1	0 0	0	89. 00
90.00	09000 CLI NI C	97, 686	3, 119	94, 56	7 0	0	90. 00
91.00	09100 EMERGENCY	4, 698, 219	178, 149	4, 520, 07	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 898, 184	159, 286	1, 738, 89	8 0	0	92.00
C	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	·				
95. 00	09500 AMBULANCE SERVICES	0	C		0 0	0	95. 00
101.00 1	10100 HOME HEALTH AGENCY	o	0	1	0 0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>					
113.001	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	18, 453, 008	1, 069, 332	17, 383, 67	6 0		200.00
201.00	Less Observation Beds	1, 898, 184					201. 00
202.00	Total (line 200 minus line 201)	16, 554, 824					202. 00
- 1					•		1

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Provider CCN: 15-1306
From 01/01/2017
To 12/31/2017
Part II
Date/Time Prepared:

Cost Center Description				'	0 12/31/201/	5/25/2018 10	
Capital and Reduction   Col. 6   Reduction   Ratio (col. 6   Col. 7   Reduction   Ratio (col. 6   Col. 7   Col					Hospi tal		
ANCILLARY SERVICE COST CENTERS   A. O.	Cost Center Description	Cost Net of T	Total Charges	Outpati ent			
Reduction   8)							
ANCILLARY SERVICE COST CENTERS		Operating Cost P	art I, column	Ratio (col. 6			
ANCILLARY SERVICE COST CENTERS   50.00				/ col . 7)			
50. 00   05000   OPERATI NG ROOM   2, 196, 599   6, 608, 387   0.332396   50. 00   52. 00   05200   DELIVERY ROOM & LABOR ROOM   180, 940   1, 086, 904   0.166473   52. 00   52. 00   05400   RADIOLOGY-DIAGNOSTIC   2, 399, 051   9, 178, 544   0.261376   54. 00   60. 00		6.00	7. 00	8. 00			
52. 00   05200   DELI VERY ROOM & LABOR ROOM   180, 940   1, 086, 904   0. 166473   52. 00							
54. 00   05400   RADI OLOGY - DI AGNOSTI C   2, 399, 051   9, 178, 544   0. 261376   0. 400   06000   LABORATORY   1, 658, 280   6, 698, 107   0. 247574   0. 60. 00   06000   LABORATORY   227, 575   1, 191, 132   0. 191058   05. 00   06500   RESPI RATORY THERAPY   620, 838   759, 295   0. 817651   05. 00   06500   RESPI RATORY THERAPY   1, 314, 577   1, 798, 232   0. 731039   066. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   220, 904   359, 580   0. 614339   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   2, 686, 889   07300   DRUGS CHARGED TO PATIENTS   2, 686, 889   07300   DRUGS CHARGED TO PATIENTS   2, 686, 889   0. 111, 010   0. 298045   72. 00   07400   RENAL DI ALYSIS   0 0 0. 000000   73. 01   07400   RENAL DI ALYSIS   0 0 0. 000000   75. 00   07500   ASC (NON-DI STI NCT PART)   0 0 0. 000000   75. 01   07500   ASC (NON-DI STI NCT PART)   0 0 0. 000000   75. 01   07500   ASC (NON-DI STI NCT PART)   0 0 0. 000000   75. 01   07500   07500   ASC (NON-DI STI NCT PART)   0 0 0. 000000   75. 01   07500   0750							
60. 00   06000   LABORATORY   1, 658, 280   6, 698, 107   0. 247574   60. 00   064. 00   06400   INTRAVENOUS THERAPY   227, 575   1, 191, 132   0. 191058   64. 00   06500   RSPI RATORY THERAPY   620, 838   759, 295   0. 817651   65. 00   06600   PHYSI CAL THERAPY   1, 314, 577   1, 798, 232   0. 731039   66. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   220, 904   359, 580   0. 614339   71. 00   07200   IMPL DEV. CHARGED TO PATIENTS   33, 086   111, 010   0. 298045   72. 00   07300   DRUGS CHARGED TO PATIENTS   2, 686, 889   6, 172, 246   0. 435318   73. 00   73. 01   07301   DRUGS CHARGED TO PATIENTS   0   0   0. 000000   74. 00   74. 00   7400   RENAL DI ALYSIS   0   0   0. 000000   74. 00   75. 01   07500   ASC (NON-DISTINCT PART)   0   0   0. 000000   75. 01   07501   CARDI AC REHAB   0   0   0. 000000   0. 000000   75. 01   07501   CARDI AC REHAB   0   0   0. 000000   0. 000000   75. 01   07501   CARDI AC REHAB   1. TATION   220, 180   211, 558   1. 040755   0. 000000   89. 00   99. 00   09000   CUINI C   97, 686   38, 329   2. 548619   90. 00   99. 00   09000   CUINI C   97, 686   38, 329   2. 548619   90. 00   99. 00   09000   EMERGENCY   4, 698, 219   17, 367, 108   0. 270524   991. 00   000000   000000   000000   000000   000000				•			
64. 00   06400   INTRAVENDUS THERAPY   227, 575   1, 191, 132   0. 191058   64. 00   65. 00   06500   RESPIRATORY THERAPY   620, 838   759, 295   0. 817651   65. 00   66. 00   06600   PHYSI CAL THERAPY   1, 314, 577   1, 798, 232   0. 731039   66. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   220, 904   359, 580   0. 614339   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   33, 086   111, 010   0. 298045   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   2, 686, 889   6, 172, 246   0. 435318   73. 00   73. 01   07301   DRUGS CHARGED TO PATI ENTS   0   0   0. 000000   74. 00   74. 00   07400   RENAL DI LAVIS   0   0   0. 000000   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0. 000000   75. 00   76. 01   07501   CARDI AC REHAB   0   0   0. 000000   75. 01   76. 97   07697   CARDI AC REHAB   1   1   1   1   1   76. 97   07697   CARDI AC REHAB   1   1   1   1   88. 00   08900   RURAL HEALTH CLINI C   0   0   0. 000000   0. 000000   89. 00   09000   CLINI C   0   0   0. 000000   0. 000000   89. 00   09000   CLINI C   0   0   0. 000000   0. 000000   91. 00   09000   CLINI C   97, 686   38, 329   2. 548619   90. 00   90. 00   09000   DEMERGENCY   4, 698, 219   17, 367, 108   0. 270524   91. 00   91. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   91. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   91. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   91. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   92. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   95. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   97. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   98. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   99. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   99. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   99. 00   09500   AMBULANCE SERVI CES   0   0   0. 000000   99. 00   0500   AMBULANCE SERVI CES   0   0. 000000   99. 00   0500   AMBULANCE SERVI CES   0   0. 000000   99. 00   0500   AMBULANCE SERV				•			
65. 00							
66. 00 06600 PHYSI CAL THERAPY 1, 314, 577 1, 798, 232 0. 731039 66. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 220, 904 359, 580 0. 614339 71. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 33, 086 111, 010 0. 298045 72. 00 7300 DRUGS CHARGED TO PATIENTS 2, 686, 889 6, 172, 246 0. 435318 73. 00 7330 DRUGS CHARGED TO PATIENTS 2, 686, 889 6, 172, 246 0. 435318 73. 00 73. 01 DRUGS CHARGED TO PATIENTS 0 0 0. 0. 000000 73. 01 0740 RENAL DIALYSIS 0 0 0. 0. 000000 74. 00 0. 000000 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0. 000000 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0. 000000 75. 00 07501 CARDIAC REHAB 0 0 0 0. 000000 75. 01 07697 CARDIAC REHAB 1 LITATION 220, 180 211, 558 1. 040755 76. 97 0000000 100000 100000 100000 100000 100000 100000 100000 1000000							
71. 00		1	· ·	•			
72. 00							
73. 00							
73. 01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 73. 01 74. 00 07400 RENAL DI ALYSI S 0 0 0.000000 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 75. 01 76. 07 07697 CARDI AC REHABI LI TATI ON 220, 180 211, 558 1.040755 76. 97  001760 08900 RURAL HEALTH CLINI C 0 0.000000 89. 00 90. 00 09000 CLINI C 97, 686 38, 329 2.548619 90. 00 91. 00 09100 EMERGENCY 4, 698, 219 17, 367, 108 0.270524 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 1, 898, 184 3, 316, 655 0.572319 92. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0.000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0.000000 95. 00 101. 00 SUBSTINCT PART 1, 898, 184 0.0000000 95. 00 101. 00 Less Observati on Beds 1, 898, 184 0 113. 00 201. 00 Subtotal (sum of lines 50 thru 199) 18, 453, 008 54, 897, 087 200. 00 201. 00 Less Observati on Beds 1, 898, 184 0 00000000 90.000000 90.00000000000000			· ·	•			
74. 00		2, 686, 889	6, 172, 246				
75. 00		0	0				
75. 01		0	0				
76. 97   O7697   CARDI AC REHABILITATION   220, 180   211, 558   1. 040755   76. 97   OUTPATI ENT   SERVI CE   COST   CENTERS		0	0				
SECOND   SUBSTRICT   SERVICE COST CENTERS   SECOND   SUBSTRICT   SERVICE COST CENTERS   SECOND   SEC		0	0				
88. 00  89. 00  89. 00  89. 00  90. 00		220, 180	211, 558	1. 040755			76. 97
89. 00							
90. 00   9900   CLINIC   97, 686   38, 329   2.548619   90. 00   91. 00   9100   EMERGENCY   4, 698, 219   17, 367, 108   0.270524   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   1, 898, 184   3, 316, 655   0.572319   92. 00   07   07   07   07   07   07   07		0	0				
91. 00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000			89. 00
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   1,898,184   3,316,655   0.572319   92. 00   OTHER REIMBURSABLE COST CENTERS   95. 00   0.000000   95. 00   O.000000   O.0000000   O.000000   O.000000   O.000000   O.000000   O.000000   O.000000   O.000000   O.000000   O.0000000   O.0000000   O.0000000   O.0000000   O.0000000   O.0000000   O.0000000   O.000000   O.000	90. 00   09000   CLI NI C	97, 686	38, 329	2. 548619			90. 00
OTHER REI MBURSABLE COST CENTERS  95. 00	91. 00   09100   EMERGENCY	4, 698, 219	17, 367, 108	0. 270524			91. 00
95. 00   09500   AMBULANCE SERVI CES   0   0.000000   101. 00   10100   HOME   HEALTH   AGENCY   0   0.000000   101. 00   SPECIAL   PURPOSE   COST   CENTERS   113. 00   11300   INTEREST   EXPENSE   200. 00   Subtotal   (sum of lines 50 thru 199)   18, 453, 008   54, 897, 087   200. 00   201. 00   Less   Observation   Beds   1, 898, 184   0   201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 898, 184	3, 316, 655	0. 572319			92. 00
101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   0   0   0   0   0   0	OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (sum of lines 50 thru 199)   18,453,008   54,897,087   200.00   201.00   Less Observation Beds   1,898,184   0   201.00	95. 00 09500 AMBULANCE SERVICES	0	0	0.000000			95. 00
113. 00	101.00 10100 HOME HEALTH AGENCY	0	0	0.000000			101. 00
200.00   Subtotal (sum of lines 50 thru 199)   18,453,008   54,897,087   200.00   201.00   Less Observation Beds   1,898,184   0   201.00	SPECIAL PURPOSE COST CENTERS						
201. 00 Less Observation Beds 1, 898, 184 0 201. 00	113. 00 11300 I NTEREST EXPENSE						113. 00
	200.00 Subtotal (sum of lines 50 thru 199)	18, 453, 008	54, 897, 087				
202.00   Total (line 200 minus line 201)   16,554,824   54,897,087   202.00	201.00 Less Observation Beds		0				201.00
	202.00   Total (line 200 minus line 201)	16, 554, 824	54, 897, 087				202. 00

Health Financial Systems	IU HEALTH PAOL	LI HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	_ COSTS	Pi	rovi der C	CN: 15-1306	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/25/2018 10:	pared: 47 am
			Titl∈	: XVIII	Hospi tal	Cost	
	Capital Related Cost (from Wkst. B, Part II, col.	(from Part	Wkst. C,		Program	Capital Costs (column 3 x column 4)	

					5/25/2018 10:	47 am_
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		(from Wkst. C,		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   OPERATI NG ROOM	193, 310			0	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	12, 825			0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	187, 647			28, 246	577	54.00
60. 00   06000   LABORATORY	66, 317			60, 357	598	60.00
64.00   06400   I NTRAVENOUS THERAPY	16, 013			0	0	64. 00
65. 00  06500 RESPIRATORY THERAPY	16, 899	759, 295	0. 022256	56, 260	1, 252	65. 00
66. 00  06600 PHYSI CAL THERAPY	150, 709	1, 798, 232	0. 083810	13, 241	1, 110	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 475		0. 031912	960	31	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 748	111, 010	0. 015746	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	50, 102	6, 172, 246	0. 008117	159, 238	1, 293	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73. 01
74. 00   07400   RENAL DI ALYSI S	0	0	0.000000	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75. 00
75. 01   07501   CARDI AC   REHAB	0	0	0.000000	0	0	75. 01
76. 97 07697 CARDIAC REHABILITATION	21, 733	211, 558	0. 102728	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89. 00
90. 00   09000   CLI NI C	3, 119	38, 329	0. 081374	0	0	90.00
91. 00 09100 EMERGENCY	178, 149	17, 367, 108	0. 010258	87, 257	895	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	159, 286	3, 316, 655	0. 048026	29, 536	1, 418	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	1, 069, 332	54, 897, 087		435, 095	7, 174	200. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1306	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

12/31/2017 Date/Time Prepared: To 5/25/2018 10:47 am Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Anesthetist Post-Stepdown Post-Stepdown Cost Adjustments Adjustments 2.00 3.00 1.00 2A 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 465, 370 50.00 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 54.00 0 0 0 0 0 0 0 0 0 0 60.00 06000 LABORATORY 60.00 06400 INTRAVENOUS THERAPY 0 0 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 Ω 73. 01 07301 DRUGS CHARGED TO PATIENTS 0 0 73.01 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 0 07501 CARDI AC REHAB 75.01 75. 01 C 0 76.97 07697 CARDIAC REHABILITATION 0 76.97 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 0 92.00 0 92.00 09500 AMBULANCE SERVICES 95.00 0 200.00 0 200.00 Total (lines 50 through 199) 465, 370 0 0

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS   Provi der CCN: 15-1306	From 01/01/2017 F To 12/31/2017 E	Worksheet D Part IV Date/Time Prepared: 5/25/2018 10:47 am

THROUGH COSTS				To 12/31/2017	Date/Time Pre 5/25/2018 10:	
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost	9	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
	4.00	5. 00	4) 6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATING ROOM		465, 370		6, 608, 387	0. 070421	50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM		403, 370		1, 086, 904		
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0		9, 178, 544		
60. 00   06000   LABORATORY		0		6, 698, 107		
64. 00   06400   NTRAVENOUS THERAPY		0		1, 191, 132		
65. 00   06500   RESPI RATORY   THERAPY		0		759, 295		
66. 00   06600 PHYSI CAL THERAPY		0		1, 798, 232		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		359, 580		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		111, 010		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		6, 172, 246		
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0		0, 172, 240	0.000000	
74. 00   07400   RENAL DI ALYSI S	0	0			0.000000	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0			0.000000	
75. 01 07501 CARDI AC REHAB	0	0			0. 000000	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		211, 558		
OUTPATIENT SERVICE COST CENTERS				211, 330	0.000000	70. 77
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0.000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	
90. 00  09000   CLI NI C	0	0		38, 329	0.000000	90.00
91. 00 09100 EMERGENCY	0	0		17, 367, 108		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		3, 316, 655		
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	0	465, 370	(	54, 897, 087		200. 00

Hool +h	Financial Customs	IU HEALTH PAOLI	HOCDI TAI		المانا	eu of Form CMS-2	DEE2 10
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provider C	CN: 15-1306	Period:	Worksheet D	2552-10
	H COSTS				From 01/01/2017	Part IV	
					To 12/31/2017	Date/Time Prep 5/25/2018 10:	pared:
			Title	: XVIII	Hospi tal	Cost	47 alli
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	F	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	Ü	Costs (col. 8	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	0		0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	28, 246		0	0	54.00
60.00	06000 LABORATORY	0. 000000	60, 357		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	56, 260		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	13, 241		0 0	0	66. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	960		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	159, 238		0 0	0	73. 00
73. 01	07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
75. 01	07501 CARDI AC REHAB	0. 000000	0		0 0	0	75. 01
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89. 00
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90. 00
91.00	09100 EMERGENCY	0. 000000	87, 257		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	29, 536		0 0	0	92. 00
	OTHED DELMDIDGADLE COST CENTEDS						I

0

435, 095

0

95. 00 0 200. 00

99. 00 | 08900 | EDERALLY QUALIFIED HEALTH CENTER
90. 00 | 099000 | CLINIC |
91. 00 | 09100 | EMERGENCY
92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART
OTHER REIMBURSABLE COST CENTERS
95. 00 | 09500 | AMBULANCE SERVICES
200. 00 | Total (lines 50 through 199)

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017		paradi
				10 12/31/201/	5/25/2018 10:	
		Title	: XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		_	1			
50. 00 05000 OPERATING ROOM	0. 332396		1, 761, 00		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 166473	l .	0 ((0 0	0 0	0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 261376	0	2, 663, 99		0	
60. 00 06000 LABORATORY	0. 247574	0	1, 989, 67		0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 191058	0	378, 13		0	
65. 00 06500 RESPI RATORY THERAPY	0. 817651	0	198, 79		0	
66. 00   06600   PHYSI CAL THERAPY	0. 731039	l .	587, 51		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 614339	l e	67, 53		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 298045		28, 37		0	1 /2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 435318		2, 419, 56	2, 680	0	
73. 01 07301 DRUGS CHARGED TO PATIENTS	0. 000000			0	0	
74. 00   07400   RENAL DI ALYSI S	0. 000000	l e		0	0	1
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			0	0	, , , , , ,
75. 01   07501   CARDI AC   REHAB	0. 000000			0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	1. 040755	0	73, 66	0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	0.00000	Γ	1			00.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	l e			0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000		40.75		0	
90. 00   09000   CLI NI C	2. 548619	l e	,		0	
91. 00 09100 EMERGENCY	0. 270524		.,,		0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 572319	0	1, 435, 45	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	0.000000	Γ	I			05 00
95. 00 09500 AMBULANCE SERVICES	0. 000000	ŀ	4/ 450 44	0		95.00
200.00 Subtotal (see instructions)		0	16, 153, 41	2, 680	U	200.00
201.00 Less PBP Clinic Lab. Services-Program						201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)		0	14 150 41	2 490	_	202. 00
202.00   Net Charges (Title 200 - Title 201)		ı	16, 153, 41	2, 680	U	1202.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1306	Peri od:	Worksheet D

From 01/01/2017 Part V
To 12/31/2017 Date/Time Prepared: 5/25/2018 10:47 am Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 585, 350 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 696, 305 0 54.00 0 60.00 06000 LABORATORY 492, 592 60.00 64.00 06400 I NTRAVENOUS THERAPY 72, 246 64.00 65.00 06500 RESPIRATORY THERAPY 162, 542 0 65.00 06600 PHYSI CAL THERAPY 429, 494 0 66.00 66.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 41, 492 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 457 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 1, 053, 282 73 00 1.167 73.01 07301 DRUGS CHARGED TO PATIENTS 0 73.01 74.00 07400 RENAL DIALYSIS 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 07501 CARDI AC REHAB 75.01 0 0 75.01 76.97 07697 CARDIAC REHABILITATION 76, 662 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88. 00 0 |08900| FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 0 90.00 09000 CLI NI C 35, 044 0 90.00 91.00 09100 EMERGENCY 1, 227, 084 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 821, 540 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 5, 702, 090 200. 00 Subtotal (see instructions) 1, 167 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 5, 702, 090 1, 167 202. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1306	Peri od:	Worksheet D

near th Frhancial Systems	TO HEALTH FAU			III LIE	u or rorm cws	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
				From 01/01/2017		
		Component	CCN: 15-Z306	To 12/31/2017		
		Ti +Lo	e XVIII S	Swing Beds - SNF	5/25/2018 10: Cost	47 am
		11116	Charges	owing beus - Sivi	Costs	
Cost Center Description	Cost to Charge	DDS Doimburged		Cost	PPS Services	
cost center bescription		Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(See Thst.)	
	Part I, col. 9	11131.)	Subject To	Subject To		
	rait i, coi. 7		Ded. & Coi ns.			
			(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. 332396	0	1		0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 166473				0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 160473				0	1
60. 00   06000   LABORATORY	0. 247574				0	1
64. 00   06400   NTRAVENOUS THERAPY	0. 247374			0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 171038			0	0	
66. 00   06600   PHYSI CAL THERAPY	0. 731039			0	0	
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 731039			0	0	1
				0	ŭ	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 298045		(	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 435318		(	0	0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	U	<u>'</u>	0	0	
74. 00   07400   RENAL DI ALYSI S	0. 000000			0	0	
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000		)	0	0	
75. 01   07501   CARDI AC REHAB	0. 000000		)	0	0	1
76. 97 O7697 CARDI AC REHABI LI TATI ON	1. 040755	0	)	0  0	0	76. 97
OUTPATIENT SERVICE COST CENTERS				1		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			_	0	
90. 00   09000   CLI NI C	2. 548619	0	)	0	0	
91. 00   09100   EMERGENCY	0. 270524	0	)	0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 572319	0	)	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	T			1		
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95. 00
200.00 Subtotal (see instructions)		0	)	이	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				이		201. 00
Only Charges				_		
202.00   Net Charges (line 200 - line 201)	1	0	P	U  0	0	202. 00

Health Financial Systems		IU HEALTH PAOL	I HOSPITAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HE	EALTH SERVICES AND V	VACCINE COST	Provider CO	CN: 15-1306 CCN: 15-Z306	Period: From 01/0° To 12/3°		Worksheet D Part V Date/Time Pre 5/25/2018 10:4	
			Title	XVIII	Swing Beds	- SNF	Cost	
		Cost	S					
Cost Center Descripti	on	Cost Reimbursed Services	Cost Reimbursed Services Not					

			Title	XVIII	Swing Beds -	SNF Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0	0				50. 00
	O DELIVERY ROOM & LABOR ROOM	0	0				52. 00
	O RADI OLOGY-DI AGNOSTI C	0	0				54. 00
	0 LABORATORY	0	0				60. 00
	O I NTRAVENOUS THERAPY	0	0				64. 00
	O RESPI RATORY THERAPY	0	0				65. 00
	O PHYSI CAL THERAPY	0	0				66. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	ODRUGS CHARGED TO PATIENTS	0	0				73. 00
	1 DRUGS CHARGED TO PATIENTS	0	0				73. 01
74.00 0740	O RENAL DIALYSIS	0	0				74.00
	O ASC (NON-DISTINCT PART)	0	0				75. 00
	1 CARDI AC REHAB	0	0				75. 01
76. 97 0769	7 CARDIAC REHABILITATION	0	0				76. 97
	ATIENT SERVICE COST CENTERS	1					
	ORURAL HEALTH CLINIC	0	0				88. 00
	OFEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
	O CLI NI C	0	0				90. 00
	O EMERGENCY	0	0				91. 00
	O OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
	R REIMBURSABLE COST CENTERS						
	O AMBULANCE SERVICES	0					95. 00
200. 00	Subtotal (see instructions)	0	0				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	0	] 0				202. 00

Health Financial Systems	IU HEALTH PAC	DLI HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2017		
				Γο 12/31/2017	Date/Time Pre 5/25/2018 10:	
		Ti tl	e XIX	Hospi tal	PPS	17 dili
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	-	Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	298, 636	23, 481	275, 15!	5 1, 033	266. 36	30. 00
31.00 INTENSIVE CARE UNIT	C	)		0	0.00	31.00
43. 00 NURSERY	11, 073	3	11, 07;	3 179	61. 86	43. 00
200.00 Total (lines 30 through 199)	309, 709		286, 228	1, 212		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	5	1, 332	2			30. 00
31.00   INTENSIVE CARE UNIT	C	) C	)			31. 00
43. 00 NURSERY	6	371	1			43. 00
200.00 Total (lines 30 through 199)	11	1, 703	<b>3</b>			200. 00

Health Financial Systems	IU HEALTH PAO	LI H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	1	Provi der C	CN: 15-1306	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/25/2018 10:	
			Ti tl	e XIX	Hospi tal	PPS	T/ alli
Cost Center Description	Capi tal	Tota	al Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(fro	m Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		t I, col.		I. Charges	column 4)	

Cost Center Description					0 12/31/2017	5/25/2018 10:	
Related Cost			Ti tl	e XIX	Hospi tal	PPS	
ANCILLARY SERVICE COST CENTERS   1,00   2,00   3,00   4,00   5,00	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
Part II, col.   260   200   3.00   4.00   5.00							
26					Charges	column 4)	
1.00   2.00   3.00   4.00   5.00			8)	2)			
ANCI LLARY SERVICE COST CENTERS							
50. 00		1.00	2.00	3.00	4. 00	5. 00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 12, 825 1, 086, 904 0.011800 19, 547 231 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 187, 647 9, 178, 544 0.020444 1, 115 23 54. 00 64. 00 06400 LABORATORY 66, 317 6, 698, 107 0.009901 11, 416 113 60. 00 64. 00 06400 INTRAVENOUS THERAPY 16, 013 1, 191, 132 0.013444 0 0.64. 00 65. 00 06500 RESPI RATORY THERAPY 16, 899 759, 295 0.022256 179 4 65. 00 66. 00 06600 PHYSI CAL THERAPY 150, 709 1, 798, 232 0.083810 0 0.66. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 11, 475 359, 580 0.031912 2, 454 78 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 475 359, 580 0.031912 2, 454 78 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 50, 102 6, 172, 246 0.008117 9, 333 76 73. 00 73. 01 07301 DRUGS CHARGED TO PATIENTS 0 0 0.000000 0 0 74. 00 07400 REMAL DI ALYSI S 0 0 0.000000 0 0 75. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 0 75. 00 75. 01 07501 CARDI AC REHABI LI TATI ON 21, 733 211, 558 0.10278 0.000000 0 0 75. 01 76. 97 07697 CARDI AC REHABI LI TATI ON 21, 733 211, 558 0.10278 0.00000 0 0 99. 00 99. 00 09000 CLINI C 3, 119 38, 329 0.081374 0 0 90. 00 90. 00 09000 DEMERGENCY 178, 149 17, 367, 108 0.010258 0 0 91. 00 91. 00 09100 EMERGENCY 178, 149 17, 367, 108 0.010258 0 0 91. 00 91. 00 09500   ABSULANCE SERVI CES		T		1	1	ı	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 187, 647 9, 178, 544 0. 0. 020444 1, 115 23 54. 00 60. 00 06000 LABORATORY 66, 317 6, 698, 107 0. 009901 11, 416 113 60. 00 60. 00 06400 INTRAVENOUS THERAPY 16, 013 1, 191, 132 0. 0. 13444 0 0 0. 64. 00 65. 00 06500 RESPI RATORY THERAPY 16, 899 759, 295 0. 022256 179 4. 65. 00 66. 00 06600 PHYSI CAL THERAPY 150, 709 1, 798, 232 0. 0. 083810 0 0. 66. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 11, 475 359, 580 0. 031912 2, 454 78 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 11, 475 359, 580 0. 031912 2, 454 78 71. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 1, 748 111, 010 0. 015746 0 0 0. 72. 00 07300 DRUGS CHARGED TO PATIENTS 50, 102 6, 172, 246 0. 008117 9, 333 76 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0. 000000 0 0 0. 000000 0 0 0. 73. 01 074. 00 07400 RENAL DI ALYSIS 0 0 0 0. 000000 0 0 0 0. 000000 0 0 0				•	· ·		
60. 00						<b>l</b>	
64. 00   06400   INTRAVENOUS THERAPY   16, 013   1, 191, 132   0. 013444   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   16, 899   759, 295   0. 022256   179   4   65. 00   66. 00   06600   PHYSI CAL THERAPY   150, 709   1, 798, 232   0. 083810   0   0   0   66. 00   071.00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   11, 475   359, 580   0. 031912   2, 454   78   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   1, 748   111, 010   0. 015746   0   0   72. 00   073.00   07300   DRUGS CHARGED TO PATIENTS   50, 102   6, 172, 246   0. 008117   9, 333   76   73. 00   07301   DRUGS CHARGED TO PATIENTS   0   0   0. 000000   0   0   73. 01   07301   DRUGS CHARGED TO PATIENTS   0   0   0. 000000   0   0   73. 01   07301   DRUGS CHARGED TO PATIENTS   0   0   0. 000000   0   0   74. 00   07400   RENAL DIALYSIS   0   0   0   0. 000000   0   0   74. 00   07500   ASC (NON-DISTINCT PART)   0   0   0. 000000   0   0   0   75. 00   07501   CARDI AC REHAB   0   0   0   0. 000000   0   0   0   75. 01   07501   CARDI AC REHAB   0   0   0. 000000   0   0   0   75. 01   07697   CARDI AC REHAB   1   TATI ON   21, 733   211, 558   0. 102728   0   0   76. 97   0000000   0   0   0   0   0   0   0					· ·	•	
65. 00 06500 RESPIRATORY THERAPY 10, 899 759, 295 0.022256 179 4 65. 00 66. 00 06600 PHYSI CAL THERAPY 150, 709 1, 798, 232 0.083810 0 0 66. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 11, 475 359, 580 0.031912 2, 454 78 71. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 11, 475 359, 580 0.031912 2, 454 78 71. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 11, 478 111, 010 0.015746 0 0 72. 00 73. 01 07300 DRUGS CHARGED TO PATIENTS 50, 102 6, 172, 246 0.008117 9, 333 76 73. 00 73. 01 07301 DRUGS CHARGED TO PATIENTS 0 0 0 0.000000 0 0 73. 01 74. 00 07400 RENAL DIALYSIS 0 0 0.000000 0 0 0 74. 00 0.000000 0 0 75. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0.000000 0 0 0 75. 00 75. 01 07501 CARDIA C REHAB 0 0 0 0.000000 0 0 0 75. 01 07501 CARDIA C REHAB 0 0 0 0.000000 0 0 75. 01 76. 97 07697 CARDIA C REHABILITATION 21, 733 211, 558 0.102728 0 0 76. 97 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 0 89.00 9000 CLINIC 3, 119 38, 329 0.081374 0 0 90.00 90.00 9000 CLINIC 3, 119 38, 329 0.081374 0 0 90.00 90.00 9000 D91.00 D9200 D8SERVATION BEDS (NON-DISTINCT PART 159, 286 3, 316, 655 0.048026 1, 448 70 92.00 OTHER REIMBURSABLE COST CENTERS					· ·	l .	
66. 00							
71. 00		· ·				1	
72. 00							
73. 00   07300   DRUGS CHARGED TO PATIENTS   50, 102   6, 172, 246   0.008117   9, 333   76   73. 00   73. 01   07301   DRUGS CHARGED TO PATIENTS   0   0   0.000000   0   0   73. 01   74. 00   07400   RENAL DIALYSIS   0   0   0.000000   0   0   0.000000   0		· ·				l	
73. 01   07301   DRUGS CHARGED TO PATIENTS   0   0   0.000000   0   0   73. 01   74. 00   07400   RENAL DIALYSIS   0   0   0.000000   0   0   74. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0.000000   0   0   75. 00   75. 01   07501   CARDIAC REHAB   0   0   0.000000   0   0   75. 01   76. 97   OARDIAC REHABILITATION   21, 733   211, 558   0.102728   0   0   75. 01   76. 97   OUTPATIENT SERVICE COST CENTERS   0   0   0.000000   0   0   88. 00   08900   RURAL HEALTH CLINIC   0   0   0.000000   0   0   89. 00   09900   CLINIC   3, 119   38, 329   0.081374   0   0   90. 00   90. 00   09100   EMERGENCY   0.000000   0   0   0.000000   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   159, 286   3, 316, 655   0.048026   1, 448   70   95. 00   09500   AMBULANCE SERVICES   95. 00							
74. 00   07400   RENAL DI ALYSIS   0   0   0.000000   0   0   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0.000000   0   0   75. 00   0.000000   0   0   0.000000   0		50, 102	6, 172, 246			76	
75. 00   07500   ASC (NON-DI STINCT PART)   0   0   0.000000   0   0   75. 00   75. 00   75. 01   07501   CARDI AC REHAB   0   0   0.000000   0   0   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   21, 733   211, 558   0.102728   0   0   76. 97   0000000   0   0   0   0   0   0   0		0	0			0	
75. 01   07501   CARDI AC REHAB   0   0   0.000000   0   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   21, 733   211, 558   0.102728   0   0   76. 97   0   0   0   0   0   0   0   0   0		0	0			0	
76. 97 O7697 CARDIAC REHABILITATION 21, 733 211, 558 0. 102728 0 0 76. 97 OUTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 0 88. 00 89. 00 9000 CLINIC 3, 119 38, 329 0. 081374 0 0 90. 00 9000 CLINIC 3, 119 17, 367, 108 0. 010258 0 0 91. 00 9200 OBSERVATION BEDS (NON-DISTINCT PART 159, 286 3, 316, 655 0. 048026 1, 448 70 92. 00 OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES	,	0	0			0	
SECTION   SURVICE COST CENTERS   SECTION		0	0			0	
88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   000000   0   88. 00   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0000000   0   0   89. 00   09. 00   09000   CLINIC   3,119   38,329   0   081374   0   0   90. 00   09100   EMERGENCY   178,149   17,367,108   0   010258   0   0   91. 00   09200   085ERVATION BEDS (NON-DISTINCT PART   159,286   3,316,655   0   048026   1,448   70   70   70   70   70   70   70   7		21, 733	211, 558	0. 102728	0	0	76. 97
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   000000   0   0   89. 00   90. 00   90. 00   90. 00   91. 00   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   159, 286   3, 316, 655   0   048026   1, 448   70   92. 00   09500   AMBULANCE SERVICES   95. 00   95. 00   95. 00   95. 00   95. 00   95. 00   96. 00   95. 00   96. 0							
90. 00   09000   CLI NI C   3, 119   38, 329   0. 081374   0   0   90. 00   91. 00   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   159, 286   3, 316, 655   0. 048026   1, 448   70   92. 00   09500   AMBULANCE SERVI CES   95. 00   09500   AMBULANCE SERVI CES   95. 00   99. 00   9		0	0			0	
91. 00   09100   EMERGENCY   178, 149   17, 367, 108   0. 010258   0   0   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   159, 286   3, 316, 655   0. 048026   1, 448   70   92. 00   OTHER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00		0	0			0	
92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   159, 286   3, 316, 655   0. 048026   1, 448   70   92. 00   OTHER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00	90. 00  09000  CLI NI C	3, 119	38, 329	0. 081374	0	0	90.00
OTHER REI MBURSABLE COST CENTERS  95. 00   09500   AMBULANCE SERVI CES   95. 00		178, 149				0	
95. 00 09500 AMBULANCE SERVICES 95. 00		159, 286	3, 316, 655	0. 048026	1, 448	70	92. 00
200. 00   Total (Lines 50 through 199)   1, 069, 332  54, 897, 087    87, 983  1, 838 200. 00	· ·						
	200.00   Total (lines 50 through 199)	1, 069, 332	54, 897, 087		87, 983	1, 838	200. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	PASS THROUGH COSTS			Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Pre 5/25/2018 10:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments 1A	ursing School	Allied Health Post-Stepdown Adjustments 2A	Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I IA	1.00	2/1	2.00	3.00	
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY 200. 00   Total (Lines 30 through 199)	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0 0	31. 00
Cost Center Description	Adjustment ( Amount (see instructions) m	Total Costs sum of cols. I through 3, inus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT 43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0	0 0 0	1, 03 17 1, 21	0. 00 9 0. 00	0	30. 00 31. 00 43. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	v	., 2.			200. 00
30. 00	0 0 0 0					30. 00 31. 00 43. 00 200. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-1306	
THROUGH COSTS		From 01/01/2017   Part IV

				j	To 12/31/2017	Date/Time Pre 5/25/2018 10:	
				e XIX	Hospi tal	PPS	
	Cost Center Description			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			1			
50. 00	05000 OPERATI NG ROOM	465, 370	0	(	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54. 00
60.00	06000 LABORATORY	0	0	(	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	(	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
73. 01	07301 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	0	(	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(	0	0	75. 00
75. 01	07501 CARDI AC REHAB	0	0	(	0	0	75. 01
76. 97	07697 CARDIAC REHABILITATION	0	0	(	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(	0	0	89. 00
90.00	09000 CLI NI C	0	0	(	0	0	90.00
91.00	09100 EMERGENCY	0	0	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	465, 370	0	(	0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-1306   Period:   Worksheet D	
THROUGH COSTS From 01/01/2017 Part IV	

	H COSTS	WICE OTHER PAS.	3 Frovider C	F	From 01/01/2017 o 12/31/2017		
			Ti tl	e XIX	Hospi tal	PPS	17 (3111
	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	T	T .	T			
	05000 OPERATI NG ROOM	0	465, 370		6, 608, 387	0. 070421	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		1, 086, 904		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		9, 178, 544		
60.00	06000 LABORATORY	0	0		6, 698, 107		
64. 00	06400 I NTRAVENOUS THERAPY	0	0		1, 191, 132		
65. 00	06500 RESPI RATORY THERAPY	0	0		759, 295		
	06600 PHYSI CAL THERAPY	0	0		1, 798, 232		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		359, 580		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		111, 010		
	07300 DRUGS CHARGED TO PATIENTS	0	0		6, 172, 246		
	07301 DRUGS CHARGED TO PATIENTS	0	0		0	0.000000	
	07400 RENAL DIALYSIS	0	0		0	0.000000	
	07500 ASC (NON-DISTINCT PART)	0	0		0	0. 000000	
	07501 CARDI AC REHAB	0	0		0	0. 000000	
76. 97	07697 CARDI AC REHABILITATION	] 0	0		211, 558	0. 000000	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS					0.00000	00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0.000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	
90.00	09000 CLI NI C	0	0		38, 329		
	09100 EMERGENCY	0	0		17, 367, 108		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1 0	0	1	3, 316, 655	0. 000000	92.00
05.00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES			ı			05 00
			445 270		E4 007 007		95.00
200.00	Total (lines 50 through 199)	0	465, 370	(	54, 897, 087		200. 00

	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S HROUGH COSTS		Provi der CC	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet D Part IV Date/Time Pre 5/25/2018 10:	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati 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. 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				_		
0.00   05000   OPERATING ROOM	0. 000000	42, 491	2, 992	. 0	0	50.00
2.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	19, 547	0	0	0	52. 00
4. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	1, 115	0	0	0	54. 00
0. 00  06000 LABORATORY	0. 000000	11, 416	0	0	0	60.00
4. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64. 00
5. 00 06500 RESPIRATORY THERAPY	0. 000000	179	0	0	0	65. 00
6. 00 06600 PHYSI CAL THERAPY	0. 000000	0	0	0	0	66. 00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 454	0	0	0	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72. 00
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	9, 333	0	0	0	73. 00
3.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0	0	0	0	73. 01
4. 00 07400 RENAL DIALYSIS	0. 000000	0	0	0	0	74.00
5.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	0	75. 00
5. 01 07501 CARDI AC REHAB	0. 000000	0	0	0	0	75. 01
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
8. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
0. 00   09000   CLI NI C	0. 000000	0	0	0	0	90.00
1. 00   09100   EMERGENCY	0. 000000	0	0	0	0	91.00
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1. 448	Ö	Ö	ő	92.00
OTHER REIMBURSABLE COST CENTERS		.,	-	_		1
5. 00 09500 AMBULANCE SERVICES						95. 00
00.00 Total (lines 50 through 199)		87, 983	2, 992	. 0	0	200.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2017	Part V	
				To 12/31/2017	Date/Time Pre 5/25/2018 10:	
		Ti tl	e XIX	Hospi tal	PPS	17 dili
·			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 332396	0	25, 68		0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 166473	0	28, 75		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 261376	0	152, 87	2 0	0	54. 00
60. 00   06000   LABORATORY	0. 247574	0	160, 50	8 0	0	60.00
64.00   06400   I NTRAVENOUS THERAPY	0. 191058	0	6, 67	9 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 817651	0	11, 93	4 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 731039	0	25, 89	2 0	0	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 614339	0	6, 22	8 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 298045	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 435318	0	73, 18	4 0	0	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73. 01
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
75. 01 07501 CARDI AC REHAB	0. 000000	0		0 0	0	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	1. 040755	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						1
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00  09000   CLI NI C	2. 548619	0	9	9 0	0	90.00
91. 00 09100 EMERGENCY	0. 270524	0	472, 87	3 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 572319	0	84, 70	8 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		
95. 00 09500 AMBULANCE SERVICES	0. 000000	0		0		95. 00
200.00 Subtotal (see instructions)		0	1, 049, 41	1 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)		0	1, 049, 41	1 0	0	202. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part V | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/2

Cost					10 12/31/2017	5/25/2018 10:	
Cost Center Description			Ti tl	e XIX	Hospi tal	PPS	
Relimbursed   Services   Sevices							
Services   Subject To   Ded. & Coin s.   See inst.	Cost Center Description	1 1 1 1					
Subject To Ded. & Coin Score in St. )							
Ded. & Coi ns.   See inst.							
See inst.   See							
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS   So. 00   Cost							
50. 00   05000   0PERATI NG ROOM	ANCLLIADY SEDVICE COST CENTERS	6.00	7.00				
52.00   05200   DELI VERY ROOM & LABOR ROOM		0 527	<u> </u>				50 00
54. 00							
60. 00   06000   LABORATORY   39, 738   0   60. 00   64. 00   06400   INTRAVENOUS THERAPY   1, 276   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   9, 758   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   18, 928   0   66. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   3, 826   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   31, 858   0   73. 00   73. 01   07301   DRUGS CHARGED TO PATIENTS   31, 858   0   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   75. 01   07501   CARDI AC REHAB   1   TATION   0   0   76. 97   07697   CARDI AC REHAB   LITATI ON   0   0   77. 00   078900   CARDI AC REHAB   CONTEST   88. 00   08800   RURAL HEALTH CLINIC   0   0   0   90. 00   09000   CLINIC COST CENTERS   88. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   90. 00   09000   DIBLERGENCY   127, 923   0   91. 00   09100   DEMERGENCY   127, 923   0   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   48, 480   0   95. 00   09500   ABBULANCE SERVICES   0   90. 00   09500   ABBULANCE SERVICES   0			0				
64. 00   06400   INTRAVENOUS THERAPY   1, 276   0   65. 00   65. 00   665. 00   666. 00   06600   RESPIRATORY THERAPY   9, 758   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   18, 928   0   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   3, 826   0   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   3, 826   0   71. 00   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   31, 858   0   73. 01   73. 01   73.01			0				1
65. 00   06500   RESPIRATORY THERAPY   9, 758   0   66. 00   06600   PHYSI CAL THERAPY   18, 928   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   3, 826   0   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0			0				1
66.00   06600   PHYSICAL THERAPY   18, 928   0     07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   3,826   0     07200   1MPL. DEV. CHARGED TO PATIENTS   0   0   0     0     0     0     0   0     0			0				1
71.00			0				
72. 00			0				
73. 00		0,020	0				
73. 01 07301 DRUGS CHARGED TO PATIENTS 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75. 01 07501 CARDIA CREHAB 0 0 0 0 75. 01 07697 CARDIA CREHABILITATION 0 0 0 75. 01 07697 CARDIA CREHABILITATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		31, 858	0				
75. 00		0	0				73. 01
75. 01	74. 00 07400 RENAL DIALYSIS	0	0				74. 00
76. 97   O7697   CARDI AC REHABILITATION   O   O   O	75.00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
SECTION   SUBSTITUTE   SUBSTI	75. 01   07501   CARDI AC   REHAB	0	0				75. 01
88. 00	76. 97 07697 CARDIAC REHABILITATION	0	0				76. 97
89. 00							
90. 00		0	0				
91. 00		0	0				
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   48, 480   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   95. 00   200. 00   Subtotal (see instructions)   335, 319   0   200. 00   201. 00   0nly Charges   0   0nly Charges		1	0				
OTHER REIMBURSABLE COST CENTERS   95.00							
95. 00		48, 480	0				92.00
200.00   Subtotal (see instructions)   335,319   0   200.00   201.00   Less PBP Clinic Lab. Services-Program   0   0   0   0   0   0   0   0   0							05.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges		0					
Only Charges		335, 319	0				
		0					201.00
202. 00		225 210	Ō				202 00
	202.00	330,319	0	I			1202.00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1306	From 01/01/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 10:47 am
	Ti +1 \( \Delta  Y\/	Hospi tal	Cost

		Title XVIII	Hospi tal	5/25/2018 10: Cost	47 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed room days (excluding swing-bed and observation bed day do not complete this line.	vate room days,	1, 202 1, 033 0	1. 00 2. 00 3. 00	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roof reporting period	~ 31 of the cost	435 84	4. 00 5. 00	
6. 00	Total swing-bed SNF type inpatient days (including private roof 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 reporting period	n days) through December	31 of the cost	85	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	0 1		149	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)	,	84	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en	nter O on this line)	,	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3	,	0	12.00
13. 00 14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	13. 00 14. 00
15. 00	Total nursery days (title V or XIX only)	ill (excluding swing-bed to	lays)	0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	155. 02	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ng period (line	3, 558, 780 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 $ ine 19)	31 of the cost reporti	ng period (line	13, 177	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 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)		279, 811 3, 278, 969	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation hed ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed che	11 903)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	· line 28)		0.000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		1 0113)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	.5 6.7		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	3, 278, 969	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUENTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			2 474 00	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see	•		3, 174. 22	38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		472, 959 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)	,		472, 959	

	Financial Systems	IU HEALTH PAO	_	ON. 15 1007		u of Form CMS-	
COMPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1306	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/25/2018 10:	epared:
			Title	e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	r Program Days ÷	Program Cost (col. 3 x col. 4)	
40.00	ANDREEDY (1) II WA WAY II Y	1.00	2. 00	3.00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(	<u>)                                    </u>	00 0		42.00
43. 00	INTENSIVE CARE UNIT	0	(	0.	00 0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description				<u>'</u>		
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 188, 425	48.00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		661, 384	1
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, su	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fi	om Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-phy	ysician anest	hetist, and	0	
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0. 00	55. 00
56.00	Target amount (line 54 x line 55)	ing coot and to	ract omount (	ino E/ minuo	lino E2)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	ine 56 minus	Tine 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996, เ	updated and c	compounded by the		59.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line					0. 00 0	60.00
	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
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	1
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doso	mbor 21 of the	cost roport	ing pariod (Saa	266, 634	64.00
	instructions)(title XVIII only)	· ·		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)			•		0	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)		•		•	266, 634	
67. 00	(line 12 x line 19)					0	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil	ty/ICF/IID rou	tine service (	cost (line 37	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•			Part II, column		75. 00
76. 00	Per diem capital related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der record	ds)			79.00
80.00	Total Program routine service costs for comp	arison to the c			nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		-,				84. 00
85. 00	Utilization review - physician compensation	(see instructio					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions					598	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			3, 174. 22	88. 00
	Observation bed cost (line 87 x line 88) (se					1, 898, 184	

Health Financial Systems	IU HEALTH PAO	LI 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 Pre 5/25/2018 10:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	298, 636	3, 558, 780	0. 08391	5 1, 898, 184	159, 286	90.00
91.00 Nursing School cost	0	3, 558, 780	0.00000	0 1, 898, 184	0	91.00
92.00 Allied health cost	0	3, 558, 780	0.00000	0 1, 898, 184	0	92.00
93.00 All other Medical Education	0	3, 558, 780	0. 00000	1, 898, 184	0	93. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-130	From 01/01/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 10:47 am
	Ti +l o VI V	Hospi tal	DDS

		Title XIX	Hospi tal	5/25/2018 10: PPS	47 am_
	Cost Center Description	TI LIE XIX	nospi tai	113	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		1, 202	1. 00
2. 00	Inpatient days (including private room days, excluding swing-k			1, 033	2.00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.		_		
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	435	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	31 of the cost	84	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	85	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 2	Lof the cost	0	8. 00
6.00	reporting period (if calendar year, enter 0 on this line)	i days) arter beceiliber 3	i oi the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	5	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		Join days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)	, 3	,	179	15. 00
16. 00	Nursery days (title V or XIX only)			6	16. 00
47.00	SWING BED ADJUSTMENT		^ ·		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of i	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	155. 02	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
20.00	reporting period	arter becomber or or tr	10 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			3, 558, 780	21. 00
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)	of the cost reporting	g perrou (rine o	O	25.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	13, 177	24. 00
05.00	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December $(x, y)$	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			279. 811	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		3, 278, 969	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 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 mir		tions)	0.00	34. 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)	ne 31)		0.00	35. 00 36. 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	ferential (line	3, 278, 969	36.00
500	27 minus line 36)		. 17 0	5, 2, 5, 707	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			3, 174. 22	38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			15, 871 0	39. 00 40. 00
41. 00		•		15, 871	
	, , , , , , , , , , , , , , , , , , , ,	,	'	.,	

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH PAOL		CN: 1F 120/	In Lie	u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1306	From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/25/2018 10:	pared:
			Ti tl	e XIX	Hospi tal	PPS	-7 aiii
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	260, 542	179	1, 455.	54 6	8, 733	42.00
43. 00	INTENSIVE CARE UNIT	O	C	0.	00 0	0	43.00
44. 00	CORONARY CARE UNIT	1					44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
40.00	Drogram i posti ent ancil l'any comi ce acet (Wk	a+ D 2 aal 2	Line 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		27, 041 51, 645	
50. 00	Pass through costs applicable to Program inp.	atient routine :	services (from	n Wkst. D, su	m of Parts I and	1, 703	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	4, 830	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				6, 533	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital re	ated, non-phy	ysician anest	hetist, and	45, 112	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	]   54. 00
55. 00	Target amount per discharge						55. 00
56. 00	Target amount (line 54 x line 55)					0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period (	endi ng 1996, ເ	updated and c	ompounded by the		59. 0
60. 00	Lesser of lines 53/54 or 55 from prior year					0.00	60.0
61. 00	If line 53/54 is less than the lower of line					0	61.0
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (IInes 54 X	60), or 1% o	r the target		
62. 00	Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.0
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost report	ing period (See	0	64. 0
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65. 0
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line o	64 plus line 6	55)(title XVI	II only). For	0	66. 0
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost r	eporting period	0	67. 0
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Do	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					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 c	,		•	,		71.00
72. 00	Program routine service cost (line 9 x line						72. 0
73. 00 74. 00	Medically necessary private room cost applications are program general inpatient routine serv						73.00
75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	,			Part II, column		75. 0
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 0
77. 00	Program capital-related costs (line 9 x line						77. 0
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider record	15)			78. 00 79. 00
30.00	Total Program routine service costs for comp				nus line 79)		80. 0
31. 00	Inpatient routine service cost per diem limi	tati on			,		81. 0
32.00	Inpatient routine service cost limitation (I						82.0
33. 00 34. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		>)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 0
	Total Program inpatient operating costs (sum	of lines 83 th					86. 0
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					EOO	87. O
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			3, 174. 22	1
88. 00	, -					i i	

Health Financial Systems	IU HEALTH PAO	LI 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 Pre 5/25/2018 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	298, 636	3, 558, 780	0. 08391	5 1, 898, 184	159, 286	90.00
91.00 Nursing School cost	0	3, 558, 780	0.00000	1, 898, 184	0	91.00
92.00 Allied health cost	0	3, 558, 780	0.00000	1, 898, 184	0	92.00
93.00 All other Medical Education	0	3, 558, 780	0. 00000	1, 898, 184	0	93. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-1306	Peri od: From 01/01/2017	Worksheet D-3	
				To 12/31/2017	Date/Time Pre 5/25/2018 10:	
		Titl∈	: XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						ļ
30. 00 03000 ADULTS & PEDI ATRI CS				312, 621		30.00
31.00 03100 INTENSIVE CARE UNIT				0		31.00
43. 00 04300 NURSERY						43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM			0. 33239		0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 1664		0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C			0. 2613			
60. 00   06000   LABORATORY			0. 2475		14, 943	
64. 00 06400 I NTRAVENOUS THERAPY			0. 1910		0	64. 00
65. 00 06500 RESPI RATORY THERAPY			0. 8176		46, 001	65. 00
66. 00   06600   PHYSI CAL THERAPY			0. 73103		9, 680	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 61433		590	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS			0. 29804		0	
73.00 O7300 DRUGS CHARGED TO PATIENTS			0. 4353			
73. 01 07301 DRUGS CHARGED TO PATIENTS			0.00000		0	
74. 00   07400   RENAL DIALYSIS			0.00000		0	74. 00
75. 00   07500   ASC (NON-DISTINCT PART)			0. 00000		0	75. 00
75. 01   07501   CARDI AC   REHAB			0.00000		0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON			1. 0407	55 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC			0.00000		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000		0	89. 00
90. 00   09000   CLI NI C			2. 5486		0	90.00
91. 00   09100   EMERGENCY			0. 27052			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 5723	19 29, 536	16, 904	92.00
OTHER REIMBURSABLE COST CENTERS			1			
95.00 09500 AMBULANCE SERVICES  200.00 Total (sum of Lines 50 through 94 and	0( 11 1 00)		[	135 005	199 425	95. 00
ZULL LULU - LIOTAL (SUM OT LINES SU TREGUAN U/ AND	AP TULUIUM AXI		1	435 1105	1 188 /175	

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)

201. 00

202. 00

188, 425 200. 00

435, 095

435, 095

200.00

201.00

202.00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	IU HEALTH PAOLI HOSPITAL	CCN: 15-1306	Peri od:	worksheet D-3	
THE ATTENT AND LEART SERVICE COST ALTORITONIMENT			From 01/01/2017		
	Component	CCN: 15-Z306	To 12/31/2017	Date/Time Pre 5/25/2018 10:	epared: 47 am
	Ti tl	e XVIII S	Swing Beds - SNF		
Cost Center Description		Ratio of Cost	Inpati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LNDATI ENT. DOUTLING CEDIU OF COCT CENTEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS  30.00 O3000 ADULTS & PEDIATRICS		1	0	I	30. 0
31.00  03000 ADULTS & PEDIATRICS 31.00  03100 INTENSIVE CARE UNIT				ł	31. 0
43. 00   04300   NURSERY					43. 0
ANCI LLARY SERVI CE COST CENTERS					43.0
50. 00 05000 OPERATING ROOM		0. 332390	6 0	0	50.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 166473			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 261376		147	
60. 00 06000 LABORATORY		0. 247574			
64.00 06400 INTRAVENOUS THERAPY		0. 191058	8 0	0	64.0
65. 00 06500 RESPIRATORY THERAPY		0. 81765	1 3, 278	2, 680	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 731039	9 36, 048	26, 352	66.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S	0. 614339		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 29804!		0	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 435318	·	13, 548	
73. 01 07301 DRUGS CHARGED TO PATIENTS		0. 000000		0	
74. 00   07400   RENAL DI ALYSI S		0. 000000		0	1
75. 00 07500 ASC (NON-DISTINCT PART)		0.000000		0	1
75. 01   07501   CARDI AC   REHAB		0.000000		0	1 , 0, 0
76. 97 O7697 CARDI AC REHABI LI TATI ON		1. 04075!	5  0	0	76. 9
OUTPATIENT SERVICE COST CENTERS  88.00 O8800 RURAL HEALTH CLINIC		0.00000		1	88. 0
38.00   08800   RURAL HEALTH CLINIC 39.00   08900   FEDERALLY QUALIFIED HEALTH CENTER		0. 000000 0. 000000		0	
20. 00 009000 CLINIC		2. 548619			
91. 00   09100   EMERGENCY		0. 270524			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-	0. 572319			
OTHER REIMBURSABLE COST CENTERS		0. 37231	, <sub>1</sub>		7 /2.
95. 00 09500 AMBULANCE SERVI CES					95. 0
200.00 Total (sum of lines 50 through 94 a	and 96 through 98)		76, 806	44, 161	
201.00 Less PBP Clinic Laboratory Services			0		201.0

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)

95. 00 200. 00 201. 00 202. 00

76, 806

201. 00 202. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/25/2018 10:	pared:
		Ti +I	e XIX	Hospi tal	PPS	47 alli
Cost Center Description		11 (1	Ratio of Cos		Inpati ent	
5550 5511tol 555511 pt 1511			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				5, 389		30. 00
31.00  03100   INTENSIVE CARE UNIT				0		31. 00
43. 00 04300 NURSERY				9, 759		43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM			0. 33239		14, 124	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM			0. 16647			
54. 00   05400   RADI OLOGY-DI AGNOSTI C			0. 26137		l e	54.00
60. 00   06000   LABORATORY			0. 24757		l	1
64.00   06400   I NTRAVENOUS THERAPY			0. 19105			64. 00
65. 00 06500 RESPI RATORY THERAPY			0. 81765		146	65. 00
66. 00   06600 PHYSI CAL THERAPY			0. 73103		0	66. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 61433		1, 508	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 29804		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 43531			1
73. 01 07301 DRUGS CHARGED TO PATIENTS			0.00000		0	73. 01
74. 00   07400   RENAL DI ALYSI S			0.00000		0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)			0.00000		0	75. 00
75. 01   07501   CARDI AC REHAB			0.00000		· -	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON			1. 04075	55 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00   08800   RURAL HEALTH CLINIC			0.00000		1	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000		0	89. 00
90. 00   09000   CLI NI C			2. 54861		0	90.00
91. 00 09100 EMERGENCY			0. 27052		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 57231	9 1, 448	829	92. 00

87, 983

87, 983

27, 041 200. 00 201. 00 202. 00

95.00

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

200.00

201.00 202.00

		T1.11 \0.0011		5/25/2018 10:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			5 700 057	
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	tions)		5, 703, 257 0	1. 00 2. 00
3.00	OPPS payments	ti ons)		0	
4. 00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)			Ō	4. 01
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	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)	17 1 12 1: 200		0	8. 00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, COI. 13, TINE 200		0	9.00
11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			5, 703, 257	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 703, 237	11.00
	Reasonable charges				
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
45.00	Customary charges			1	45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for particular that would have been realized from patients liable for			0 0	15. 00 16. 00
10.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(		i a ciiai gebasi s	0	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	1
19.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			5, 760, 290	21. 00
22. 00	Interns and residents (see instructions)			0, 700, 270	1
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		l o	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			39, 869	1
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for		1 007 (	2, 930, 845	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plantsustions)	olus the sum of lines 22	and 23] (see	2, 789, 576	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)			Ö	29. 00
30.00	Subtotal (sum of lines 27 through 29)			2, 789, 576	1
31.00	Primary payer payments			874	31. 00
32.00	Subtotal (line 30 minus line 31)			2, 788, 702	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		1 -	
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 1, 113, 489	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			723, 768	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		1, 070, 606	
37. 00	Subtotal (see instructions)			3, 512, 470	
38.00	MSP-LCC reconciliation amount from PS&R			0	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 instruc	tions)	0 0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			3, 512, 470	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)			70, 249	
40. 02	Demonstration payment adjustment amount after sequestration			0	1
41.00	Interim payments			3, 304, 909	41. 00
42.00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			137, 312	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, (	chapter 1,	135, 686	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				-
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	1
92. 00	1			0.00	
93. 00	Time Value of Money (see instructions)			0	
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:
5/25/2018	10: 47 am Health Financial Systems IU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1306

1.						5/25/2018 10: 4	47 am
1.00			Title	XVIII	Hospi tal	Cost	
1.00   2.00   3.00   4.00   3.04   00   3.04   00   3.04   00   2.00   1nterim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero   2.00   2.0			Inpatien	t Part A	Par	t B	
1.00   Total Interim payments paid to provider   1.00   2.00   3.00   4.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Total interim payments paid to provider   A46,400   3,304,909				2.00		4.00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero   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	1.00	Total interim payments paid to provider		446, 40	0	3, 304, 909	1. 00
write "NONE" or enter a zero	2. 00	submitted or to be submitted to the contractor for			O	0	2. 00
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   ADJUSTMENTS TO PROVIDER   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00	write "NONE" or enter a zero					0.00
payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	3.00	amount based on subsequent revision of the interim rate					3. 00
ADJUSTMENTS TO PROVIDER							
3.02   0							
3.03   0   0   0   0   0   0   0   0   0	3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.04   0	3.02				0	0	3. 02
3.05   Provider to Program	3.03				0	0	3. 03
Provider to Program	3.04						3. 04
3.50   ADJUSTMENTS TO PROGRAM   0   0   0   0   0   0   0   0   0	3.05				0	0	3. 05
3.51							
3.52   3.53   3.54   3.54   3.55   3.54   3.55   3.54   3.54   3.55		ADJUSTMENTS TO PROGRAM			-	1 - 1	3. 50
3.53   3.54   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)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   446, 400   3, 304, 909   446, 400							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)   446, 400   3, 304, 909   470   4					-	1 - 1	3. 53 3. 54
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 PROVIDER  5.02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Subtatal (sum of lines 2.01.2.40 minus sum of lines					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  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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 99				U .	ا	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	4 00			446.40	0	3 304 909	4. 00
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00			170, 70		3, 304, 707	4.00
TO BE COMPLETED BY CONTRACTOR							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Write "NONE" or enter a zero. (1)   Program to Provider	5.00	List separately each tentative settlement payment after					5.00
Program to Provider							
TENTATI VE TO PROVIDER		write "NONE" or enter a zero. (1)					
5. 02		Program to Provider					
5. 03  Provider to Program  5. 50  TENTATI VE TO PROGRAM  0 0 0 0 5 5 5 1		TENTATI VE TO PROVI DER					5. 01
Provider to Program						1 - 1	5. 02
5.50 TENTATI VE TO PROGRAM  0 0 0 5.51 5.52 0 0 0 0 9 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 0 159,012 137,312 0	5. 03				0	0	5. 03
5.51	F F0						F F0
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 0 0 9		IENIATI VE TU PKUGKAM					5. 50 5. 51
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 159, 012 137, 312 00 00 00 00 00 00 00 00 00 00 00 00 00					-		5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 0 0 0		Subtotal (sum of lines 5 01-5 40 minus sum of lines			-	- 1	5. 92 5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 0 0 0		5. 50-5. 98)				l	
6.02 SETTLEMENT TO PROGRAM 0 0		the cost report. (1)					6. 00
				159, 01			6. 01
	6.02				-	1 - 1	6. 02
	7. 00	Total Medicare program liability (see instructions)		605, 41		3, 442, 221	7. 00
Contractor NPR Date Number (Mo/Day/Yr)					Number	(Mo/Day/Yr)	
0 1.00 2.00			(	)	1. 00	2. 00	
8.00  Name of Contractor     8	8. 00	Name of Contractor					8. 00

Health Financial Systems IU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 IU HEALTH PAOLI HOSPITAL Peri od: Worksheet E-1
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/25/2018 10: 47 am Provider CCN: 15-1306 Component CCN: 15-Z306 Title XVIII Swing Beds - SNF Cost

			t Part A	Par	rt B	
		•				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	T=	1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		263, 779		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3.04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		263, 779		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		203, 777			4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	'		l.		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Drawi dan ta Drawan		0		0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM	I	0		1 0	5. 50
5. 50 5. 51	TENTATIVE TO PROGRAM	•	0			5. 50
5. 52			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
J. 77	5. 50-5. 98)					5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		43, 201		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		306, 980		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.05		(	)	1. 00	2. 00	- 0.05
8. 00	Name of Contractor					8. 00

	Financial Systems	IU HEALTH PAOLI			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1306	Peri od:	Worksheet E-1	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/25/2018 10:	
			Title XVIII	Hospi tal	Cost	47 alli
			II the XVIII	поѕрітаі	COST	
					1.00	
	TO BE COURTETED BY CONTRACTOR FOR MONOTANIBARD				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD					-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
1. 00	Total hospital discharges as defined in AARA	§4102 from Wkst.	S-3, Pt. I col. 15 line	14		1. 00
2.00	.00   Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					2. 00
3.00	3.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					4.00
5.00	Total hospital charges from Wkst C, Pt. I, co	ol. 8 line 200				5. 00
6.00						6.00
7. 00	CAH only - The reasonable cost incurred for t			Wkst S-2 Pt I		7. 00
7.00	line 168	ino par onaco or o	5. t ou tooo. ogy			1.00
8. 00	Calculation of the HIT incentive payment (see	e instructions)				8. 00
9. 00	Seguestration adjustment amount (see instruct					9.00
10. 00						10.00
10.00			(see Tristructions)			10.00
00.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &					00.00
30.00	Initial/interim HIT payment adjustment (see i	nstructions)				30.00
	Other Adjustment (specify)					31. 00
32 00	00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)   32.00					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

		Component CCN: 15-Z306	To 12/31/2017	Date/Time Pre 5/25/2018 10:	
		Title XVIII	Swing Beds - SNF		17 (111
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		269, 300	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		44, 603	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4. 00
г оо	instructions)		0.4		F 00
5.00	Program days	natruati ana)	84	0	1
6. 00 7. 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional met			U	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	inod only	313, 903	0	8.00
9. 00	Primary payer payments (see instructions)		313, 703	0	
10. 00	Subtotal (line 8 minus line 9)		313, 903	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	010, 700	0	
	professional services)	azi e te priyereran		Ŭ	
12.00	Subtotal (line 10 minus line 11)		313, 903	0	12. 00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	658	0	13. 00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	(4)	313, 245	0	1
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
1/ 00	adjustment (see instructions)			0	14 00
16. 99 17. 00	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	16. 99 17. 00
17. 00	Adjusted reimbursable bad debts (see instructions)		0	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	
19. 00	Total (see instructions)	uctions)	313, 245	0	
19. 01	Sequestration adjustment (see instructions)		6, 265	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0, 200	Ö	
20. 00	Interim payments		263, 779	0	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	43, 201	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	7, 416	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement  Medicare swing-bed SNF inpatient routine service costs (from V	West D 1 Dt II lino			201. 00
201.00	66 (title XVIII hospital))	NSt. D-1, Ft. 11, Tille			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst D-3 col 3 line	2		202. 00
	200 (title XVIII swing-bed SNF))				
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curren	nt 5-year demonst	ration	
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs Program reimbursement under the §410A Demonstration (see instr				207 00
	,	•			207. 00
208.00  Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)					208. 00
209 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	rtions)			209. 00
	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				1
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-13	From 01/01/2017	Worksheet E-3 Part V Date/Time Prepared: 5/25/2018 10:47 am

			10 12/31/2017	5/25/2018 10:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE P	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			661, 384	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ns)		0	2.00
3.00	Organ acquisition			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			661, 384	4.00
5. 00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			667, 998	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
10.00	Customary charges		l	0	10.00
11. 00	Aggregate amount actually collected from patients liable for pa	nument for services on a	charge hasis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for	3	9	0	12. 00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services or	i a charge basis	U	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0.000000	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds lin	no 6) (coo	0	15. 00
13.00	instructions)	7 II IIIIe 14 exceeds III	(366	O	13.00
16. 00	Excess of reasonable cost over customary charges (complete only	/if line 6 exceeds line	14) (500	0	16. 00
10.00	instructions)	, IT TITLE O EXCECUS TITLE	(300	O	10.00
17. 00	Cost of physicians' services in a teaching hospital (see instru	ictions)		0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	3011 0113)		Ü	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	11116 17)		667, 998	
20. 00	Deductibles (exclude professional component)			55, 272	20.00
21. 00	Excess reasonable cost (from line 16)			00, 272	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			612, 726	
23. 00	Coi nsurance			012, 720	23. 00
24. 00	Subtotal (line 22 minus line 23)			612, 726	
25. 00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		7, 755	
26. 00	Adjusted reimbursable bad debts (see instructions)	(300 111311 4011 6113)		5, 041	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		7, 755	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	2011 0113)		617, 767	28. 00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			017, 707	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30. 00	Subtotal (see instructions)			617, 767	30.00
30. 00	Sequestration adjustment (see instructions)			12, 355	
30. 01	Demonstration payment adjustment amount after sequestration			12, 355	30. 01
30. 02	Interim payments			446, 400	
31.00	1 3			446, 400	31.00
32.00	Tentative settlement (for contractor use only)	21 and 22)		159, 012	32.00
34. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02, Protested amounts (nonallowable cost report items) in accordance		hontor 1	159, 012	34.00
34.00	§115. 2	CE WILLII CWO PUD. 15-2, C	партег г,	10, 709	34.00
	[3110.2		ı		I

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

Provi der CCN: 15-1306

| Peri od: | Worksheet G | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/25/2018 10: 47 am

oni y)					5/25/2018 10:	47 am
		General Fund	Specific	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		1	-		
1. 00 2. 00	Cash on hand in banks	24, 533, 770		0	0 0	
3.00	Temporary investments Notes receivable				0	
4. 00	Accounts receivable	2, 374, 801		,	Ö	
5. 00	Other recei vable	-3, 185, 384		o o	Ō	
6.00	Allowances for uncollectible notes and accounts receivable	0		0	0	
7.00	Inventory	464, 321	(	0	0	
8.00	Prepai d expenses	121, 285		0	0	
9. 00 10. 00	Other current assets Due from other funds	0		0	0	
11. 00	Total current assets (sum of lines 1-10)	24, 308, 793	1			1
11.00	FIXED ASSETS	24, 300, 773		,		11.00
12. 00	Land	148, 000	(	0	0	12. 00
13.00	Land improvements	438, 464		0	0	13. 00
14. 00	Accumulated depreciation	-329, 979	1	0		1
15. 00	Bui I di ngs	6, 077, 459	1	-	0	
16.00	Accumulated depreciation	-3, 152, 066	1	-	0	1
17. 00 18. 00	Leasehold improvements	791, 602	1	,	0   0	
19. 00	Accumulated depreciation Fixed equipment	-218, 723		, 	0	
20. 00	Accumulated depreciation				0	
21. 00	Automobiles and trucks	16, 632		o o	Ö	
22.00	Accumul ated depreciation	0		0	0	22. 00
23.00	Major movable equipment	10, 597, 849	(	0	0	23. 00
24.00	Accumulated depreciation	-6, 480, 691	(	0	0	
25. 00	Mi nor equi pment depreci abl e	0	(	0	0	
26. 00	Accumulated depreciation	0		0	0	
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0			0	
29. 00	Mi nor equi pment-nondepreci abl e			-	0	
30.00	Total fixed assets (sum of lines 12-29)	7, 888, 547	1	-		
	OTHER ASSETS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
31.00	Investments	1, 059, 882	(	0	-	
32.00	Deposits on leases	0	(	-	0	
33. 00	Due from owners/officers	0	(	<u> </u>	0	1
34. 00	Other assets	7, 172, 828	1	,	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	8, 232, 710 40, 430, 050	1	,		
30.00	CURRENT LIABILITIES	1 40, 430, 030		,		30.00
37. 00	Accounts payable	1, 107, 651		0	0	37. 00
38. 00	Salaries, wages, and fees payable	814, 990		0	0	38. 00
39. 00	Payroll taxes payable	0	(	0	0	1
40.00	Notes and loans payable (short term)	0	(	0	0	
41.00	Deferred income	0		) O	0	
42. 00 43. 00	Accel erated payments Due to other funds	0	,		0	42. 00 43. 00
44. 00	Other current liabilities	2, 957, 674				
45. 00	Total current liabilities (sum of lines 37 thru 44)	4, 880, 315		o o		
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	(	0	0	
47. 00	Notes payable	0	(			1
48. 00	Unsecured Loans	0			-	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	29, 591 29, 591			0	1
50.00	Total liabilities (sum of lines 45 and 50)	4, 909, 906	1			
31.00	CAPITAL ACCOUNTS	4, 707, 700	1	,		31.00
52.00	General fund balance	35, 520, 144				52. 00
53.00	Specific purpose fund		(			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	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	35, 520, 144		o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	40, 430, 050	1	o o	Ö	
	59)					

Provider CCN: 15-1306

					То	12/31/2017	Date/Time Prep 5/25/2018 10:4	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	77 (311)
		1.00	0.00	2.00		4 00	F 00	
1 00	[F.m.] balance at basins as a second	1.00	2. 00 40, 730, 544	3. 00		4. 00	5. 00	1. 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		1, 017, 804			U		2. 00
3.00	Total (sum of line 1 and line 2)	1	41, 748, 348			0		3. 00
4. 00	DONATED PP&F	43, 202	41, 740, 340		0	U	0	4. 00
5.00	DONATED IT WE	43, 202			0		0	5. 00
6. 00		o o			0		0	6. 00
7. 00		0			0		ő	7. 00
8. 00		O			0		0	8. 00
9.00		o			0		0	9. 00
10.00	Total additions (sum of line 4-9)		43, 202			0		10.00
11.00	Subtotal (line 3 plus line 10)		41, 791, 550			0		11.00
12.00	INTERCOMPANY CAPITAL TRANSFER	6, 271, 406			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		0			0		0	16. 00
17. 00	T	0	( 074 40(		0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		6, 271, 406			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		35, 520, 144			U		19. 00
	Tariet (Title II milius IIIIe 10)	Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	DONATED PP&E		0					4. 00
5.00			0					5. 00 6. 00
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	J		0			10.00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12.00	INTERCOMPANY CAPITAL TRANSFER		0					12.00
13.00		i	0					13.00
14.00			0					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)	0			0			18. 00
19. 00	Fund balance at end of period per balance				O			19. 00
	sheet (line 11 minus line 18)			I			l	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1306

			0 12/31/201/	5/25/2018 10:	
	Cost Center Description	Inpati ent	Outpati ent	Total	17 (3111
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	1, 344, 660		1, 344, 660	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	C		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)	1, 344, 660		1, 344, 660	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	C		0	11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	C		0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 344, 660		1, 344, 660	1
18. 00	Ancillary services	2, 705, 518	31, 469, 477	34, 174, 995	
19. 00	Outpati ent servi ces	258, 451	20, 463, 641	20, 722, 092	19. 00
20.00	RURAL HEALTH CLINIC	C	0	0	20.00
21. 00		C	0	0	
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES	C	0	0	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER NRCC	C	68, 596	68, 596	1
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	4, 308, 629	52, 001, 714	56, 310, 343	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		00 004 400		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		23, 804, 428		29. 00
30.00	ADD (SPECIFY)	C			30.00
31.00		C			31.00
32.00		C			32.00
33. 00		C			33. 00
34. 00		C			34.00
35. 00	T + 1   1111	C			35. 00
36.00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)	C			37. 00
38. 00					38. 00
39. 00		C			39. 00
40.00		C			40.00
41. 00	Total deductions (our of lines 27 44)	C			41.00
42.00	Total deductions (sum of lines 37-41)	For	0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	l el	23, 804, 428		43. 00
	to Wkst. G-3, line 4)	I	1	I	I

Heal th	Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-1306	Peri od:	Worksheet G-3	
				From 01/01/2017	5	
				To 12/31/2017	Date/Time Pre 5/25/2018 10:	
	· · · · · · · · · · · · · · · · · · ·				372372016 10.	47 alli
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	I. column 3. lin	e 28)	,	56, 310, 343	1. 00
2.00	Less contractual allowances and discounts on				32, 691, 983	2. 00
3.00	Net patient revenues (line 1 minus line 2)	•			23, 618, 360	3. 00
4.00	Less total operating expenses (from Wkst. G-2	, Part II, line	43)		23, 804, 428	4. 00
5.00	Net income from service to patients (line 3 m	ninus line 4)			-186, 068	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 miscellaneo	ous communication	servi ces		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 gues	its			0	14. 00
15. 00	Revenue from rental of living quarters				0	15. 00
16. 00	Revenue from sale of medical and surgical sup		han patients		0	16. 00
17. 00	Revenue from sale of drugs to other than pati				0	17. 00
18. 00	Revenue from sale of medical records and abst				0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, e	,			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, an	id 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				1, 203, 872	24. 00
25. 00	Total other income (sum of lines 6-24)				1, 203, 872	25. 00
26. 00	, ,				1, 017, 804	
27 00	LAG REVENUE AND NONLAB SUPPLIES				0	27 00

27.00 LAG REVENUE AND NONLAB SUPPLIES
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)

0 27. 00 28.00

1, 017, 804 29. 00