This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can r	esult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting peri-	od being deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIF SUMMARY	ICATION Provider CCN: 15-015	8 Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared:
			10 12/31/2017	5/29/2018 11:46 am
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed cost report		Date: 5/29/20	18 Time: 11:46 an
use only	2. [] Manually submitted cost report			
	3. [0] If this is an amended report enter the 4. [F] Medicare Utilization. Enter "F" for fu	number of times the provide II or "L" for low.	r resubmitted this c	cost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report (4) Reopened 7. [N] Final Report (5) Amended	1	O.NPR Date: 1.Contractor's Vendo 2.[O]Ifline 5, co number of tim	or Code: 4 olumn 1 is 4: Enter nes reopened = 0-9.

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 WEST HOSPITAL (15-0158) 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)
Title	
Title	
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	163, 014	207, 967	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	163, 014	207, 967	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.

							To 12/3		ate/Ti me /29/2018		
	1.00	2.	. 00	:	3. 00			4. 00	7 2 77 20 10	11.5	+2 aiii
	Hospital and Hospital Health Care Co										
1. 00 2. 00	Street: 1111 N. RONALD REAGAN PARKWAY City: AVON	PO Box: State: I	IN 3	7in Codo	. 16122	7095 Cour	ity: HENDRIC	·vc		-	1. 00 2. 00
2.00	orty. Avon	Component Na		CCN	CBSA	Provi de	-1'		t System	(P,	2.00
				Number	Number	Туре	Certi fi e	d <u>T,</u>	0, or N)		
										(IX	
	Heenital and Heenital Based Company	1.00		2. 00	3. 00	4.00	5. 00	6.00	7. 00 8	. 00	
3. 00	Hospital and Hospital-Based Componen Hospital	IU HEALTH WEST H		150158	26900	1	12/01/200	04 N	Р	P	3. 00
4. 00	Subprovi der – IPF	TO TIETLETTI MEST TI	100111712	100100	20700	'	127017200	" "	.	.	4. 00
5.00	Subprovi der – I RF			İ						İ	5.00
6. 00	Subprovider - (Other)									1	6. 00
7. 00	Swing Beds - SNF								ļ.		7.00
8. 00 9. 00	Swing Beds - NF			-					ŀ	ł	8.00
10.00	Hospi tal -Based SNF Hospi tal -Based NF									-	9. 00 10. 00
	Hospi tal -Based OLTC										11. 00
	Hospi tal -Based HHA										12.00
13.00	Separately Certified ASC										13.00
	Hospi tal -Based Hospi ce										14.00
	Hospital - Based Health Clinic - RHC										15.00
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16. 00 17. 00
	Renal Dialysis										18.00
	Other										19. 00
							Fro	n:	To:		
							1.0		2.00	4-	
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/	-	12/31/20	17	20.00
21.00	Inpatient PPS Information						4				21. 00
22. 00	-	currently recei	ving payme	ents for	di spro	porti onat	e Y		N		22. 00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil				2. 106(c) (2) (Pi ck	:I e				
22 01	amendment hospital?) In column 2, en								V	-	22 01
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y						ı Y		Υ		22. 01
	reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)										
22. 02	Is this a newly merged hospital that								N		22. 02
	determined at cost report settlement or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for										
	or after October 1.	.,				5 1					
22. 03	Did this hospital receive a geograph						I		N		22. 03
	of the OMB standards for delineating						er				
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column						he				
	cost reporting period occurring on o										
	hospital contain at least 100 but no	t more than 499	beds (as o	counted			th				
	42 CFR 412.105)? Enter in column 3,										
23. 00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i						in	3	N		23. 00
	method of identifying the days in th						od				
	used in the prior cost reporting per										
			In-State			Out-of	Out-of	Medi cai d			
			Medicaid paid days			State	State	HMO days			
			paru uays	s eligi unpa		edicaid id days	Medicaid eligible		day	>	
				day		ru days	unpai d				
			1.00	2.0		3. 00	4. 00	5. 00	6.0	0	
24. 00	If this provider is an IPPS hospital		48		208	9	32	4, 3		-	24. 00
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai	·									
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	column 6.									
25. 00	If this provider is an IRF, enter th	e in-state		0	0	0	0		0		25. 00
	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col										

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0158 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 11:42 am Urban/Rural S Date of Geogr 2.00 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. 37.00 | If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν N hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Υ 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) V XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances N N N 46 00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν 48.00 Ν Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes Ν 56.00 or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 P† 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1. 00 2. 00 3. 00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 Ν (see instructions) any programs that meet the criteria under §413.85? Direct GME IMF Direct GME Y/N 2. 00 1.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see

instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	T HOSPITAL Provi der Co		Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre	
	Y/N	I ME	Direct GME		5/29/2018 11:	
	Y/N	INE	DITECT GME	INE	Direct GME	
4.04 5.1	1.00	2. 00	3. 00	4. 00	5. 00	(1.0)
Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 04
on the second of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61. 06
care or general surgery. (see instructions)	Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Se 22.00 Enter the number of FTE residents that your hospital				eriod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruction). 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC projections.	ctions) a Teachi	ing Health Cer	iter (THC) in			62.01
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se			ost reporting	n period? Enter	N	63.00
"Y" for yes or "N" for no in column 1. If yes, comple			67. (see ins	tructions)		
			Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
la 11 - 550			1.00	2.00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befo			inis base ye	ar is your cost	reporting	
64.00 Enter in column 1, if line 63 is yes, or your facili- in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	ty train n-priman all non d non-po	ned residents ry care nprovider rimary care	0. (0.00	0. 000000	64.00
of (column 1 divided by (column 1 + column 2)). (see	instru	ctions)			D. I	
Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0158 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/29/2018 11:42 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3

	1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider	N			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most			0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period				
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75.00
subprovider? Enter "Y" for yes and "N" for no.				

divided by (column 3 + column 4)). (see instructions)

ealth Financial Systems IU HEALTH WEST HOSPITAL OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0158	Peri od:	u of Form CMS Worksheet S	
	From 01/01/2017 To 12/31/2017	Part I Date/Time P 5/29/2018 1	repared
	1.00	2.00 3.0	
If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions	the most or "N" for e with 42 Y,	0	76. (
		1. 00	
Long Term Care Hospi tal PPS		N1	
 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers 	g period? Enter	N N	80. (
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes 5.00 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. (86. (
7.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.
1000(d)(1)(b)(v1): Litter 1 101 yes 01 N 101 110.	V	XIX	
Title V and XIX Services	1.00	2. 00	
Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.
.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.
2.00 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.
B.OO 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.
H.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.
5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95. 96.
The fine 96 is "Y", enter the reduction percentage in the applicable column. 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.	0. 00 N	0. 00 Y	97. 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	Υ	98.
B.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.
3.03 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 for title V, and in column 2 for title XIX.	N 1	N	98.
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 in column 2 for title XIX.	N	N	98.
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 i		Υ	98.
column 2 for title XIX. .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	Y	98
Rural Providers 5.00 Does this hospital qualify as a CAH?	N		105.
6.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of paymen	1		106.
for outpatient services? (see instructions) 7.00 f 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 cos	N		107.
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42	N		108.

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0158 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 11:42 am Physi cal Occupati onal Speech Respi ratory 1. 00 2. 00 3. 00 4. 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν 109.00 therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 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 110 00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1.00 2.00 111.00|f this facility qualifies as a CAH, did it participate in the Frontier Community Ν 111.00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 Miscellaneous Cost Reporting Information 115.00|Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 Ν 0 115.00 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. Ν 116.00 117.00|s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Υ 117.00 no. 118.00 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. Premi ums Losses Insurance 1. 00 2.00 3.00 0118.01 118.01 List amounts of mal practice premiums and paid losses: 287, 658 1. 00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Ν Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00|s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν Ν 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or 'N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00|Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the 5.04 122. 00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If Ν 125.00 yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare certified kidney transplant center, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. 127.00|If this is a Medicare certified heart transplant center, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 of this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|If this is a Medicare certified lung transplant center, enter the certification date in 129, 00 column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 of this is an organ procurement organization (OPO), enter the OPO number in column 1 134 00 and termination date, if applicable, in column 2.

All Providers

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	N: 15-0158		: 1/01/2017 2/31/2017	Worksheet S- Part I Date/Time Pr 5/29/2018 11	epared:
					1. 00	2. 00	_
140.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	'N" for no in column 1. I	f yes, and home	office co	ı	Υ Υ	15H059	140.00
1. 00		00	LI OHS)		3. 00		
If this facility is part of a chai			ugh 143 th	e name ar		of the home	
office and enter the home office of			lo .				
141.00 Name: INDIANA UNIVERSITY HEALTH, 142.00 Street:340 WEST 10TH ST	PO Box:	VPS	Contra	ctor s Nu	ımber: 0810) [141. 00 142. 00
143. 00 Ci ty: INDIANAPOLIS		N	Zip Co	de:	4620	12	143.00
144 00	the first test to Market street	1.40				1.00	111 00
144.00 Are provider based physicians' cos	sts included in Worksheet	t A?				Y	144.00
					1. 00	2.00	
<pre>inpatient services are cl inpatient services only? Enter "Y' no, does the dialysis facility inc period? Enter "Y" for yes or "N" l46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o</pre>	for yes or "N" for no iclude Medicare utilization for no in column 2. The graph of the previous column 1. (See CMS Pub.	n column 1. If on for this cost ously filed cost	column 1 i reporting t report?		N		145. 00 146. 00
							_
147.00Was there a change in the statisti	cal basis? Entar "V" for	s voc or "N" for	no			1. 00 N	147. 00
48.00Was there a change in the statisti						N N	148. 00
49.00 Was there a change to the simplifi				for no.		N	149.00
· · · · · · · · · · · · · · · · · · ·	-	Part A	Part E	B T	itle V	Title XIX	
Does this facility contain a provi	don that qualified for	1.00	2.00	i oo ti oo la	3. 00	4.00	
or charges? Enter "Y" for yes or '							
155. 00 Hospi tal		N	N		N	N	155. 00
56.00 Subprovi der - IPF		N	N		N	N	156. 0
57. 00 Subprovi der - I RF 58. 00 SUBPROVI DER		N	N		N	N	157. 00 158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161. 00
						1. 00	_
Multicampus						1.00	
165.00 Is this hospital part of a Multica	ampus hospital that has o	one or more campu	uses in di	fferent C	BSAs?	N	165.00
Enter "Y" for yes or "N" for no.				71 0 1	0004	FTF (0	
	Name O	County 1.00	State 2.00	Zi p Code 3.00	4. 00	FTE/Campus 5.00	-
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)			2.00	0.00	1. 60	0. (00 166. 0
						4 00	
Health Information Technology (HI	[) incentive in the Ameri	ican Recovery and	d Reinvest	ment Act		1. 00	
67.00 s this provider a meaningful user 68.00 of this provider is a CAH (line 10	under §1886(n)? Enter O5 is "Y") and is a meani	"Y" for yes or 'ngful user (line	'N" for no		r the	Y	167. 00 0168. 00
reasonable cost incurred for the H 68.01 If this provider is a CAH and is r			gualify	for a har	dshi p		168. 0
exception under §413.70(a)(6)(ii)	PEnter "Y" for yes or "N	√" for no. (see i	nstructio	ns)	·	9. 9	99169.00
169.00 If this provider is a meaningful ι							1
69.00 If this provider is a meaningful utransition factor. (see instruction				Be	gi nni ng	Endi ng	
69.00 If this provider is a meaningful ι	ons)		_		gi nni ng 1. 00 /01/2017	Endi ng 2. 00 06/30/2017	170. 0

Health Financial Systems	In Lieu of Form CMS-2552-10					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFIC					Worksheet S-2	
				om 01/01/2017	Part Date/Time Pre	parod:
			10	12/31/2017	5/29/2018 11:	
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have a	any days for indiv	viduals enrolled in		Υ	1, 959	171.00
section 1876 Medicare cost plans reported on						
"Y" for yes and "N" for no in column 1. If co	on					
1876 Medicare days in column 2. (see instruct						

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0158 Peri od: Worksheet S-2 From 01/01/2017 Part II Date/Time Prepared: 12/31/2017 5/29/2018 11:42 am Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1 00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Y/N Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1. 00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing school and/or allied health programs approved and/or renewed during the 8.00 N 8 00 cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education Ν 9.00 program in the current cost report? If yes, see instructions. . Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions γ 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Ν 15.00 Part A Part B Y/N Y/N Date Date 1.00 3.00 2.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? Ν Ν 16.00 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) 04/04/2018 17 00 Was the cost report prepared using the PS&R Report for 04/04/2018 17.00 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) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.
19.00 If line 16 or 17 is yes, were adjustments made to PS&R N N 19.00 Report data for corrections of other PS&R Report

information? If yes, see instructions.

HOSPI T	Financial Systems IU HEALTH WES AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	N: 15-0158	Period: From 01/01/2017	u of Form CMS Worksheet S Part II	
				To 12/31/2017	Date/Time P 5/29/2018 1	
		Descri	pti on	Y/N	Y/N	
		0		1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	report data for other. Besorred the other day astineres.	Y/N	Date	Y/N	Date	
		1. 00	2. 00	3.00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	als made dur	ing the cost	N	23.00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entere	ed into during	this cost re	eporting period?	N	24.00
25. 00	If yes, see instructions	the cost repor	ting ported	2 If you soo	N	25. 00
20.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period:	: 11 yes, see	IV	25.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	he cost reporti	ng period? I	f yes, see	N	26.00
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reportin	a period? It	f ves. submit	N	27. 00
	сору.			, , , , , ,		
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cost	t reporting	N	28.00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29.00			
29.00	treated as a funded depreciation account? If yes, see instr	IV	29.00			
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	urity with new	debt? If yes	s, see	N	30.00
31. 00	Has debt been recalled before scheduled maturity without is instructions.	N	31.00			
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser		d through co	ontractual	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		ıg to competi	tive bidding? If	N	33.00
	no, see instructions.			-		
24 00	Provi der Based Physicians	ssangamant with	n n n n l d n n h	and physicians?	V	34.00
34.00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	provi der-ba	ased physicians?	Υ	34.00
35. 00	If line 34 is yes, were there new agreements or amended exi		its with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?			Y		36.00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	? Y		37.00
38. 00				f N		38.00
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other			s, Y		39.00
	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes. see	N		40.00
40. 00	instructions.					13.30
40. 00						
40. 00		1. 0)()	2.	00	
40. 00	Cost Report Preparer Contact Information	1.0	00		00	
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	1. C	00	UTTER UTTER	00	41.00
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.				00	41.00
42. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	RHONDA				

Health Financial Systems IU HEALTH WE			ST HOSPITAL	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der CCN: 15-0158		m 01/01/2017			
				То	12/31/2017	Date/Time Pre 5/29/2018 11:	pared: 42 am	
		L						
			3. 00					
Cost Report Preparer Contact Information								
41.00 Enter the first name, last name and the t	itle/position		DIRECTOR - GOVERNMENT				41.00	
held by the cost report preparer in colum	ins 1, 2, and 3,	, F	PROGRAMS					
respecti vel y.								
42.00 Enter the employer/company name of the co	st report						42.00	
preparer.								
43.00 Enter the telephone number and email addr	ess of the cos	t					43.00	
report preparer in columns 1 and 2, respe	cti vel y.							

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-0158

				רן	o 12/31/2017	Date/Time Pre	
						I/P Days /	12 Gill
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number	0.00	Available	4.00	5.00	
1 00	Illandi tal. Adulta o Dada (aslumna 5. (7 and	1.00	2.00	3.00	4.00	5. 00	1. 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	10	36, 500	0.00	ا	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)						2.00
3. 00	HMO IPF Subprovider						3.00
4. 00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		10	36, 500	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	1	6 5, 840	0.00	0	8.00
9.00	NEONATAL INTENSIVE CARE UNIT	32.00	1	1 4, 015	0.00	0	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	l .			0	13.00
14.00	Total (see instructions)		12	46, 355	0. 00		14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVIDER - IRF						17. 00 18. 00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						20.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25. 00	CMHC - CMHC	00.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		12	27			27. 00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)			0 ()		32.00
32. 01	Total ancillary labor & delivery room			1			32. 01
00 -	outpatient days (see instructions)						
33.00	1						33.00
33. 01	LTCH site neutral days and discharges	l	l	I		1	33. 01

Provider CCN: 15-0158

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 01/01/2017 | Part |
| To 12/31/2017 | Date/Time Prepared: | 5/29/2018 | 11: 42 am

				'		5/29/2018 11:	42 am
	·	I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
				•		·	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8.00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	9, 642	249	23, 007	•		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)	5, 542	3, 808				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C)		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C)		6.00
7.00	Total Adults and Peds. (exclude observation	9, 642	249	23, 007	,		7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	2, 151	111	4, 469			8.00
9.00	NEONATAL INTENSIVE CARE UNIT	0	40	974			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		925	2, 027	'		13.00
14.00	Total (see instructions)	11, 793	1, 325	30, 477	0.00	742.06	14.00
15.00	CAH visits	0	0	C)		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	0	0	173	3		24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	742.06	27.00
28.00	Observation Bed Days		0	3, 041			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			C)		30.00
31.00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	o	17	368	В		32.00
32. 01	Total ancillary labor & delivery room			()		32. 01
	outpatient days (see instructions)						
	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01

Provider CCN: 15-0158

					12/31/2017	5/29/2018 11:	
		Full Time		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		0	2, 542	76	7, 792	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			4 4 4 0	000		0.00
2.00	HMO and other (see instructions)			1, 148	930		2.00
3.00	HMO I PF Subprovi der				U		3.00
4.00	HMO IRF Subprovider				٥		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5. 00 6. 00
6. 00 7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	NEONATAL INTENSIVE CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	2, 542	76	7, 792	14. 00
15. 00	CAH visits			_, _, _		.,	15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance 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)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days	}		0			33. 00
	LTCH site neutral days and discharges	1		0			33. 00
55. 01	2101 Si to floati ai days and di sonai ges	T I		١	I	l	33.01

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

Provider CCN: 15-0158 Period: From 01/01/2017 Part II Date/Time Prepared: 5/29/2018 11: 42 am

Wkst. A Line Amount Reclassificat Adjusted Paid Hours Average Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
1. 00	SALARIES Total salaries (see	200. 00	45, 768, 253	-238, 847	45, 529, 406	1, 475, 278. 76	30, 86	1. 00
2. 00	instructions) Non-physician anesthetist Part		0			0. 00		
	A		0					
3. 00	Non-physician anesthetist Part B		Ü	0	0	0. 00		
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 181, 611	0	1	0. 00 2, 080. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	O	0	0. 00	0. 00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	O	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	O	0	0. 00	0. 00	8. 00
9. 00	SNF	44. 00	0	0	-	0.00		
10. 00	Excluded area salaries (see instructions)		217, 854	0	217, 854	10, 680. 65	20. 40	10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		2, 563, 761	0	2, 563, 761	35, 766. 66	71. 68	11. 00
12. 00	Care Contract Labor: Top Level		0	a	0	0. 00	0. 00	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		130, 094	0	130, 094	850. 89	152. 89	13.00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	O	0	0. 00	0. 00	14. 00
14. 01	Home office salaries		12, 837, 596	0	12, 837, 596	365, 567. 00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		11, 466, 940	0	11, 466, 940			17. 00
18. 00	Wage-related costs (other) (see instructions)		0	O	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		90, 912 0	0	90, 912 0			19. 00 20. 00
	A Non-physician anesthetist Part		0	O	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25.00
25. 50	Home office wage-related (core)		0	O	0			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	O	0			25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	O	0			25. 53
	'	. '			. '		. '	

Provider CCN: 15-0158

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Table 2016 | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II

					'	0 12/31/2017	5/29/2018 11:	42 am
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4. 00	288, 339	0	288, 339	2, 105. 50	136. 95	26. 00
27.00	Administrative & General	5. 00	2, 565, 210	-7, 104	2, 558, 106	48, 465. 70	52. 78	27. 00
28.00	Administrative & General under		271, 816	0	271, 816	3, 209. 00	84. 70	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	666, 276	0	666, 276	26, 988. 06	24. 69	29. 00
30.00	Operation of Plant	7. 00	489, 810	0	489, 810	24, 073. 53	20. 35	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	966, 011	-437	965, 574	72, 443. 46	13. 33	32.00
33.00	Housekeeping under contract		0	0	C	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 030, 096	-724, 308	305, 788	19, 450. 12	15. 72	34.00
35.00	Dietary under contract (see		0	0	C	0.00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	723, 956	723, 956	45, 995. 00	15. 74	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0. 00	37.00
38.00	Nursing Administration	13. 00	2, 587, 646	-4, 685	2, 582, 961	52, 948. 19	48. 78	38. 00
39.00	Central Services and Supply	14. 00	283, 766	0	283, 766	14, 510. 94	19. 56	39. 00
40.00	Pharmacy	15. 00	2, 151, 360	-5, 395	2, 145, 965	53, 608. 22	40. 03	40.00
41.00	Medical Records & Medical	16. 00	0	0	C	0.00	0. 00	41.00
	Records Library							
42.00	Social Service	17. 00	233, 574	-2, 239	231, 335	8, 286. 00	27. 92	42.00
43.00	Other General Service	18. 00	243, 401	0	243, 401	18, 573. 45	13. 10	43.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 01/01/2017 | Part III |
| To 12/31/2017 | Date/Time Prepared: | 5/29/2018 | 11: 42 am Provider CCN: 15-0158

							5/29/2018 11:4	42 am_
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		45, 858, 458	-238, 847	45, 619, 611	1, 476, 407. 76	30. 90	1.00
	instructions)							
2.00	Excluded area salaries (see		217, 854	0	217, 854	10, 680. 65	20. 40	2.00
	instructions)							
3.00	Subtotal salaries (line 1		45, 640, 604	-238, 847	45, 401, 757	1, 465, 727. 11	30. 98	3.00
	minus line 2)							
4.00	Subtotal other wages & related		15, 531, 451	0	15, 531, 451	402, 184. 55	38. 62	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		11, 466, 940	0	11, 466, 940	0. 00	25. 26	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		72, 638, 995	-238, 847	72, 400, 148	1, 867, 911. 66	38. 76	6.00
7.00	Total overhead cost (see		11, 777, 305	-20, 212	11, 757, 093	390, 657. 17	30. 10	7.00
	instructions)							

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0158	Peri od: Worksheet S-3
		From 01/01/2017 Part IV

	To 12/31/2017	7 Date/Time Pre 5/29/2018 11:	pared: 42 am
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 971, 334	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	5, 578, 584	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	185, 693	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24, 877	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	304, 832	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	235, 902	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		1
	TAXES		
	FICA-Employers Portion Only	3, 254, 465	17. 00
	Medicare Taxes - Employers Portion Only	0	
	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	1, 981	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (se instructions))	e 0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tui ti on Rei mbursement	0	23.00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	11, 557, 668	
24.00	Part B - Other than Core Related Cost	11, 337, 000	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
20.00	15 MED MED MED 100 500 TO (OF EATT)	1 01	0.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0158	Peri od: Worksheet S-3 From 01/01/2017 Part V To 12/31/2017 Date/Time Prepared:

		1	o 12/31/2017	Date/Time Prep 5/29/2018 11:	
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		2, 563, 761	11, 521, 703	1.00
2.00	Hospi tal		2, 563, 761	11, 521, 703	2.00
3. 00	Subprovi der - IPF				3.00
4. 00	Subprovi der - I RF				4.00
5. 00	Subprovi der - (0ther)		0	0	5.00
6. 00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7.00
8. 00	Hospi tal -Based SNF				8.00
9. 00	Hospi tal -Based NF				9.00
10. 00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA				11.00
12.00	Separately Certified ASC				12.00
13. 00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital - Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
	Renal Dialysis				17.00
18. 00	Other		0	0	18.00

IOSPI T	Financial Systems IU HEALTH WEST HOST ALL UNCOMPENSATED AND INDIGENT CARE DATA P	rovider CCN	l: 15-0158	Peri od:	u of Form CMS-: Worksheet S-1	
00111	THE GROOM ENGINES HIS THEFSELL GAILS SAIN	rovider cor	. 10 0100	From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/29/2018 11:	pared 42 am
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lir	ne 202 colum	n 8)	0. 158899	1.0
	Medicaid (see instructions for each line)					
2. 00	Net revenue from Medicaid				6, 339, 675	
. 00	Did you receive DSH or supplemental payments from Medicaid?		6 M . P .	. 1. 10	N	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr			ai d?	0	4. C
. 00	Medicaid charges	om wearcard			124, 071, 547	
. 00	Medicaid cost (line 1 times line 6)				19, 714, 845	1
3. 00	Difference between net revenue and costs for Medicaid program (line 7 minu	ıs sum of li	nes 2 and 5; if	13, 375, 170	
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions for	r each line	e)			
0.00	Net revenue from stand-alone CHIP				0	
0.00					0	1
1.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line 11 mir	nus lina O:	if / zero then	0	
2.00	enter zero)		ius Title 7,	II < Zero then	O	12.0
	Other state or local government indigent care program (see inst	ructions fo	or each line)		
3. 00	Net revenue from state or local indigent care program (Not incl				0	13.0
4. 00	Charges for patients covered under state or local indigent care	program (N	lot included	in lines 6 or	0	14.0
	10)				_	l
5.00	State or local indigent care program cost (line 1 times line 14	,	(1:	15 1:	0	
6. 00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	igent care	program (11	ne is minus iine	0	16. 0
	Grants, donations and total unreimbursed cost for Medicaid, CHII	P and state	e/Local indi	gent care progra	ms (see	
	instructions for each line)					
	Private grants, donations, or endowment income restricted to fu				0	
8.00	Government grants, appropriations or transfers for support of h				0	
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	inai gent d	are program	is (sum or rines	13, 375, 170	19.0
	107 12 and 107		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
0 00	Uncompensated Care (see instructions for each line)	111+1	10 400 1	1 72/ 002	21 224 100	20.6
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	iiity	19, 490, 17	1, 736, 003	21, 226, 180	20.0
1. 00	Cost of patients approved for charity care and uninsured discou	nts (see	3, 096, 97	70 1, 736, 003	4, 832, 973	21.0
	instructions)	(222	2, 2.2,	1,133,333	.,,	
2.00	Payments received from patients for amounts previously written	off as	243, 32	23 0	243, 323	22.0
	charity care					
3. 00	Cost of charity care (line 21 minus line 22)		2, 853, 64	1, 736, 003	4, 589, 650	23.0
					1. 00	
4. 00	Does the amount on line 20 column 2, include charges for patien	t days beyo	ond a Length	of stay limit	1.00	24.0
	imposed on patients covered by Medicaid or other indigent care		ma a rongen	or oray rriii c		•
5. 00	If line 24 is yes, enter the charges for patient days beyond th		care progra	m's length of	0	25.0
6. 00	stay limit Total bad debt expense for the entire hospital complex (see ins	tructions)			15, 974, 340	26.0
7. 00	Medicare reimbursable bad debts for the entire hospital complex	,	ructions)		650, 029	
7. 01	Medicare allowable bad debts for the entire hospital complex (s	•	,		1, 000, 044	
8. 00	Non-Medicare bad debt expense (see instructions)		· ···=/		14, 974, 296	
9.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructi ons	5)	2, 729, 416	
	The contract of the contract o				7, 319, 066	
0.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus li				20, 694, 236	

Heal th	Financial Systems	IU HEALTH WEST	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre	nared.
				'	0 12/31/2017	5/29/2018 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
		1.00		0.00		col . 4)	
	CENEDAL CEDVICE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS				4 004 EEE	4 00/ FEE	1 00
1. 00 1. 01	OO100 NEW CAP REL COSTS-BLDG & FLXT OO101 MOB		339, 846	339, 846	.,	4, 086, 555 823, 311	1. 00 1. 01
1. 01	00101 MOB 00102 I NTEREST		337, 040 N	337, 640		5, 728, 464	1
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		3, 555, 939		1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	288, 339	293, 602	581, 941		8, 376, 702	1
5. 01	00540 NONPATI ENT TELEPHONES	0	106, 245			65, 458	1
5. 02	00550 DATA PROCESSING	O	25, 577			20, 076	1
5. 03	00560 PURCHASING RECEIVING AND STORES	0	76, 991			76, 840	
5.04	00590 ADMINISTRATIVE AND GENERAL	2, 565, 210	49, 677, 649	52, 242, 859	-7, 556, 218	44, 686, 641	5.04
6.00	00600 MAINTENANCE & REPAIRS	666, 276	5, 784, 226	6, 450, 502	-4, 276, 068	2, 174, 434	6.00
7.00	00700 OPERATION OF PLANT	489, 810	1, 336, 843	1, 826, 653	550, 322	2, 376, 975	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	154, 596			149, 460	
9. 00	00900 HOUSEKEEPI NG	966, 011	3, 324, 946			3, 898, 326	
10.00	01000 DI ETARY	1, 030, 096	1, 534, 182			672, 521	
11.00	01100 CAFETERI A	0	0		., ,		
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 587, 646	1, 213, 682			3, 460, 443	
14.00	01400 CENTRAL SERVICES & SUPPLY	283, 766	182, 441				
15.00	01500 PHARMACY	2, 151, 360	4, 092, 763			2, 645, 451	1
17.00	01700 SOCIAL SERVICE	233, 574	74, 331			252, 984	
16.00	01080 TRANSPORTATION NPATIENT ROUTINE SERVICE COST CENTERS	243, 401	147, 748	391, 149	-68, 321	322, 828	18. 00
30. 00	03000 ADULTS & PEDIATRICS	11, 731, 706	7, 529, 042	19, 260, 748	-7, 485, 690	11, 775, 058	30.00
31. 00	03100 NTENSI VE CARE UNI T	2, 488, 967	2, 474, 996			4, 261, 299	
32. 00	02060 NEONATAL INTENSIVE CARE UNIT	927, 738	231, 040				
43. 00	04300 NURSERY	0	0	.,,		449, 592	
	ANCILLARY SERVICE COST CENTERS	<u> </u>		•			1
50.00	05000 OPERATING ROOM	2, 599, 528	12, 949, 261	15, 548, 789	-11, 999, 675	3, 549, 114	50.00
51. 00	05100 RECOVERY ROOM	2, 265, 534	667, 019	2, 932, 553	-484, 821	2, 447, 732	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	2, 915, 060		
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 796, 959	2, 842, 225			4, 374, 942	
55. 00	05500 RADI OLOGY-THERAPEUTI C	734, 384	662, 825			1, 216, 287	1
59.00	05900 CARDI AC CATHETERI ZATI ON	654, 471	3, 461, 206			970, 008	
60.00	06000 LABORATORY	0	5, 442, 187			5, 442, 187	
63. 00 65. 00	06300 BLOOD STORING, PROCESSING, & TRANS. 06500 RESPIRATORY THERAPY	0 1, 387, 138	390, 167 510, 439			391, 299 1, 491, 839	
66.00	06600 PHYSI CAL THERAPY	1, 357, 138	510, 439				1
67.00	06700 OCCUPATI ONAL THERAPY	480, 495	103, 048				1
68. 00	06800 SPEECH PATHOLOGY	150, 360	49, 748				
69. 00	06900 ELECTROCARDI OLOGY	735, 746	872, 119			1, 398, 558	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0,2,				1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C			
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	4, 005, 916		
	03950 OTHER ANCI LLARY SERVI CES	0	0	C	0		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	225, 927	118, 322	344, 249	-93, 133	251, 116	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90.00
90. 02	09002 SLEEP LAB	0	676, 314			656, 818	•
91. 00	09100 EMERGENCY	4, 508, 142	4, 814, 730	9, 322, 872	-1, 568, 738	7, 754, 134	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
440.00	SPECIAL PURPOSE COST CENTERS					0	110 00
	11300 INTEREST EXPENSE	45 550 000	110 (70 071	150 000 770	0 240 700		113.00
118.00		45, 550, 399	112, 673, 374	158, 223, 773	340, 720	158, 564, 493]118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	86, 154	232, 126	318, 280	-38, 399	279, 881	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	86, 154	∠3∠, 1∠0 ∩	310, 280	-30, 399		190.00
	19201 RETAIL PHARMACY	0	0				192.00
	19202 MARKETI NG	o	535, 777	535, 777	7, 311	543, 088	
	19203 BACK AND NECK	131, 700	431, 617			253, 685	
200.00		45, 768, 253	113, 872, 894				
	· · · ·						

Provi der CCN: 15-0158

Peri od: Worksheet A From 01/01/2017 Date/Time Prepared: 5/29/2018 11:42 am

Cost Center Description					5/29/2018 11:	
All location CENERAL SERVICE COST CRITERS C. 0.0 7.00		Cost Center Description	Adjustments	Net Expenses		
		·	(See A-8)	For		
ENRINAL SERVICE COST CRITERS				Allocation		
1.00			6. 00	7. 00		
1.01 0.0101 MOB						
1.02 00102 INTEREST			·			
2.00 0.0200 NEW CAP REL COSTS-MABLE EQUIP 0 3 , 555, 939 2 , 0 4.00 0.0400 pull-profer Binner First Department -955, 467 4, 241, 235 5.01 0.0550 0.0560 0.0680 1.0681 1.0681 1.0681 5.02 0.0550 0.0680 0.0680 1.0681 1.0681 5.03 0.0550 0.0680 0.0680 0.0680 0.0680 5.04 0.0560 0.0680 0.0680 0.0680 0.0680 5.05 0.0560 0.0680 0.0680 0.0680 0.0680 5.06 0.0680 0.06		1	_		·	1
4.00 0.0400 EMPLOYEE BENEFITS DEPARTIENT -955, 467		1	0		l e e e e e e e e e e e e e e e e e e e	1
5.01 00-540 MOMPATIENT TELEPHONES 0 6.5, 458 5.02 5.02 00-550 DATA PROCESSID NO AND STORES 5.5, 1214 6.28, 054 6.50-50 5.03 00-560 PURCHASING RECELY IN OR AND STORES 5.5, 1214 6.28, 054 6.50-50 6.00 00-600 DURNEHAN ING RECELY IN OR AND STORES 5.5, 1214 6.28, 054 6.50-50 6.00 00-600 PURCHASING RECELY IN OR AND STORES 7.00 6.00 00-600 PURCHASING RECELY IN OR AND STORES 7.00 6.00 00-600 PURCHASING RECELY IN OR AND STORES 7.00 6.00 00-600 PURCHASING IN LINEN SERVICE 0 3.998, 226 9.90 6.00 00-600 PURCHASING IN LINEN SERVICE 0 3.998, 226 9.90 6.00 00-600 PURCHASING IN LINEN SERVICE 0 3.998, 226 9.90 6.00 00-600 PURCHASING IN LINEN SERVICE 0 3.998, 226 9.90 6.00 00-600 PURCHASING IN LINEN SERVICE 0 6.288, 647 7.472 11.00 6.11 0.00 01-600 PURCHASING IN LINEN SERVICE 0 6.288, 647 4.14 6.00 01-600 PURCHASING IN LINEN SERVICE 0 6.288, 647 4.14 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00 01-600 PURCHASING IN LINEN SERVICE 0 252, 984 17.00 6.00		1	0	1		
5.02 00550 (DATA PROCESSING			-955, 467			
5.03 00560 PURCHASING RECELY IN KAND STORES 551, 214 6.28, 054 5.00 00590 JAMIN ISTRATIVE AND GENERAL 2-24, 969, 412 19, 717, 229 5.00 6.00 00500 JAMIN ISTRATIVE AND GENERAL 2-24, 969, 412 19, 717, 229 5.00 6.00 7.00 00700 JOPPOLIVAT 0.00 00700 JOPPOLIVAT 0.00 14, 460 8.00 9.00 00900 JOPPOLIVAT 2 LI NEN SERVI CE 0.0 149, 460 8.00 9.00 00900 JOSEQUE PLANTRY 8 LI NEN SERVI CE 0.0 149, 460 8.00 9.00 00900 JOSEQUE PLANTRY 8 LI NEN SERVI CE 0.0 149, 460 9.00 10.00 01 DETARY 0.0 10000 JUSE PLANTRY 8 LI NEN SERVI CE 0.0 12, 376, 975 472 11.00 11.00 011.00			4 (44 052			1
5.0 d 00590 JAMIM INSTRATIVE ANID GENERAL -24, 969, 412 11, 717, 229 5.0 d 6.0 0 00600 LAM INTENANCE & REPAIR IS -343, 932 1, 830, 502 6.00 7.0 0 00700 (PERATI ON OF PLANT) 0 2, 376, 975 7.00 8.0 0 00800 (LAMINORY & LINEW SERVICE) 0 1, 460 8.00 9.0 0 009000 (HOUSEKEEPING) 0 672, 521 10.00 11.0 00 01000 (LETARY) -832, 896 757, 472 11.00 11.0 00 01000 (LINES) KA SANIM INSTRATION -29, 63 3.490, 106 13.00 15.0 00 01000 (MISSIN KA SANIM INSTRATION) 29, 63 3.490, 106 13.00 15.0 00 01500 (MISSIN KA SERVI CES & SUPLY) -24, 703 2.20, 048 15.00 16.0 00 01500 (MISSIN KA SANIM INSTRATION) 0 322, 200, 48 15.00 18.0 00 01500 (MISSIN KA SANIM INSTRATION) 0 322, 200, 48 15.00 18.0 00 01500 (MISSIN KA SANIM INSTRATION) 0 322, 200, 48 15.00 18.0 00 01500 (MISSIN KA						1
0.00 00000 MAINTENANCE & REPAIR IS 7.40, 39.22					•	1
0.00 0.0700 DERARTI						
8. 00			-343, 732 N			1
9.00 00900 HOUSEKEEPING		1	0			1
10. 00 10000 DIETRAY 0 6.72, 521 10. 00 13.		1	0			
11. 00 01100 CAFETERIA -832,896 757,472 11. 00 14. 00 01400 CENTRAL SERVICES & SUPPLY 0 6, 288,647 14. 00 14. 00 CENTRAL SERVICES & SUPPLY 0 6, 288,647 15. 00 15. 00 15. 00 01500 PARRIMACY -24,703 2, 620,748 15. 00 10. 00 01700 SOCIAL SERVICE 0 252,984 18. 00 1080 TRANSPORTATIO 0 0 322,828 18. 00 01800 TRANSPORTATIO 0 0 322,828 18. 00 01800 TRANSPORTATIO 0 0 322,828 18. 00 01800 TRANSPORTATIO 0 0 30. 00 31. 00 001176 SERVICE COST CENTERS 0 449,592 32. 00 02600 MOUNTS & PEDIATRICS 0 52. 00 52. 00 05500 MOUNTS & PEDIATRICS 0 0 0 0 0 0 0 0 0			0	l		1
13.00 01300 NURSIN O ADMINISTRATION 29, 663 3, 490, 100 13.00 15.00 01500 PARMACY 0 6, 288, 647 14.00 10.00 10.00 CENTRAL SERVICES & SUPPLY 0 6, 288, 647 17.00 17.00 01700 05001 SCRIVICES & SUPPLY 0 0.252, 984 17.00 17.00 01700 SOCIAL SERVICE 0 252, 984 17.00 17.00 01700 SOCIAL SERVICE 0 0.252, 984 17.00 17.00 01700 SOCIAL SERVICE 0 0.2000 18.00 18			-832 896	1		
14 00 01400 CENTRAL SERVICES & SUPPLY 0 6 , 288, 647 15.00 1050 PHARMACY -24, 703 2 , 260, 748 15.00 1050 PHARMACY -24, 703 2 , 260, 748 17.00 17.00 17.00 SOCIAL SERVICE 0 252, 984 18.00 1080 TRANSPORTATION 0 0 322, 828 18.00 1080 TRANSPORTATION 0 0 322, 828 18.00 1080 TRANSPORTATION 0 0 30.00 17.00		1	·			1
15.00 O1500 PHARMACY						
17. 00 01700 001710 00		1	-24, 703	1		
18. 00	17. 00		0			
30.00 03000 ADULTS & PEDIATRICS -953,885 10,921,173 30.00 31.00	18.00	01080 TRANSPORTATI ON	0			18.00
31 00 03100 INTENSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS				
32 00 02060 NEONATAL INTENSIVE CARE UNIT 0 998, 340 449, 592 43.00	30.00		-853, 885	10, 921, 173		30.00
A3. 00 04300 NURSERY	31.00	03100 INTENSIVE CARE UNIT	-841, 845	3, 419, 454		31.00
ANCILLARY SERVICE COST CENTERS Str.	32.00		0	998, 340		32.00
50.00	43. 00		0	449, 592		43.00
51.00 05100 RECOVERY ROOM 0 2, 447,732 51.00 52.00 05200 DELIVERY ROOM 0 2, 915, 060 52.00 52.00 05200 DELIVERY ROOM 0 2, 915, 060 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 58,551 4, 433, 493 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 39, 322 1, 255, 609 55.00 05000 CARDI AC CATHETERI ZATI ON 0 970,008 59.00 060,00						
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 2,915,060 54.00 05400 RADI OLOGY-DI AGNOSTIC 58,551 4,433,493 55.00 55.00 05500 RADI OLOGY-THERAPEUTI 39,322 1,255,609 55.00 55.00 05500 RADI OLOGY-THERAPEUTI 39,322 1,255,609 55.00 65.00				l '	·	1
54.00 05400 RADI OLOGY-DI AGNOSTI C 58,551 4,433,493 55.00 05500 RADI OLOGY-THERAPEUTI C 39,322 1,255,609 55.00 05900 CARDI AC CATHETERI ZATI ON 0 0 970,008 59.00 06000 06000 CARDIAC CATHETERI ZATI ON 0 5,442,187 66.00 06000 06000 05000 05001 NGP ING, PROCESSI NG, & TRANS. 0 391,299 63.00 06000 06000 06000 07001 NGP ING, PROCESSI NG, & TRANS. 0 391,299 65.00 06000 06000 07001 NGP ING, PROCESSI NG, & TRANS. 0 391,299 065.00 06000 07001 NGP ING, PROCESSI NG, & TRANS. 0 391,299 065.00 06000 07001 NGP ING, PROCESSI NG, & TRANS. 0 1,491,839 065.00 06000 07000		1	0		l e e e e e e e e e e e e e e e e e e e	1
55. 00 05500 CARDI AC CATHERAPEUTI C 39, 322 1, 255, 609 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 970, 008 59. 00 06000 CABDRATORY 0 0 5, 442, 187 60. 00 06000 CABDRATORY 0 0 5, 442, 187 60. 00 06000 CABDRATORY 0 0 391, 299 63. 00 06500 RESPI RATORY THERAPY 0 1, 491, 839 65. 00 06600 PHYSI CAL THERAPY 2, 083 1, 501, 602 66. 00 06600 PHYSI CAL THERAPY 0 516, 370 67. 00 06700 OCCUPATI ONAL THERAPY 0 516, 370 67. 00 06800 SPECE PATHOLOGY 0 161, 355 68. 00 06900 ELECTROCARDI OLOGY 0 161, 355 68. 00 06900 ELECTROCARDI OLOGY 0 161, 355 69. 00 07.		1	TO FF1	1		
59.00 05900 05900 CARDI AC CATHETERI ZATI ON 0 970, 008 060.00 06000 LABORATORY 0 5,442, 187 60.00 063000 063000 063000 063000 063000 063000 063000 063000 063000 063000 063000				l		
60. 00 06000 LABORATORY 0 5,442,187 60. 00 63. 00 63.00 BLODD STORI NG, PROCESSI NG, & TRANS. 0 3.97,299 63. 00 66			_	1		
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 0 391, 299 63. 00 650. 00 06500 RESPI RATORY THERAPY 0 0 1, 491, 839 65. 00 660. 00 06600 PHYSI CAL THERAPY 2, 083 1, 501, 602 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 516, 370 67. 00 680. 00 06800 SPEECH PATHOLOGY 0 161, 355 68. 00 680. 00 06900 ELECTROCARDI OLOGY 0 161, 355 68. 00 06900 ELECTROCARDI OLOGY 0 0100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 3, 013, 313 71. 00 77. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 7, 772, 214 72. 00 73. 00 73.00 DRUSC CHARGED TO PATI ENTS 0 4, 005, 916 73. 00 73. 00 73.00 DRUSC CHARGED TO PATI ENTS 0 4, 005, 916 73. 00 76. 90			0	1		
65. 00 06500 RESPI RATORY THERAPY 0 1, 491, 839 66. 00 66. 00 06600 PHYSI CAL THERAPY 2, 083 1, 501, 602 66. 00 67. 00 06700 06CUPATI ONAL THERAPY 0 516, 370 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 161, 355 68. 00 69. 00 06900 ELECTROCARDI OLOGY -410, 588 987, 970 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 3, 013, 313 71. 00 73. 00 73.00 DRUGS CHARGED TO PATI ENTS 0 4, 005, 916 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 4, 005, 916 73. 00 76. 00 03950 OTHER ANCI LLARY SERVI CES 0 0 0 76. 90 76.			0			
66. 00			0			
67. 00 06700 OCCUPATI ONAL THERAPY 0 516, 370 68. 00 680. 00 SPEECH PATHOLOGY 0 161, 355 68. 00 690. 00 SPEECH PATHOLOGY 0 161, 355 68. 00 690. 00 690. 00 ELECTROCARDI OLOGY -410, 588 987, 970 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3, 013, 313 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 4, 005, 916 73. 00 03950 OTHER ANCI LLARY SERVI CES 0 0 0 0 76. 00 76. 97 OUTPATI ENT SERVI CE COST CENTERS 0 4, 005, 916 76. 97 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0			2 083			1
68. 00 06800 SPEECH PATHOLOGY 0 161, 355 68. 00 69. 00 06900 ELECTROCARDI OLOGY -410, 588 987, 970 69. 00 71. 00 07100 MPIL CAL SUPPLIES CHARGED TO PATIENTS 0 3, 013, 313 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 7, 772, 214 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 4, 005, 916 73. 00 76. 00 03950 OTHER ANCILLARY SERVICES 0 0 0 76. 97 O7697 CARDI AC REHABI LITATION 0 251, 116 76. 97 00179ATIENT SERVICE COST CENTERS 90. 00 90. 00 90. 02 09002 SLEEP LAB 0 656, 818 99. 02 91. 00 09100 EMERGENCY -2, 085, 075 5, 669, 059 91. 00 92. 00 09200 DSERVATION BEDS (NON-DISTINCT PART) 92. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -26, 506, 800 132, 057, 693 118. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 192. 01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 01 19201 RETAIL PHARMACY 0 0 0 192. 01 19202 MARKETI NG 0 543, 088 192. 03 192. 03 19203 BACK AND NECK 0 253, 685 192. 03		1	2,000			1
69. 00		1	0			
71. 00		1	-410, 588			1
72. 00			0	1		
73. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0			72.00
76. 97 07697 CARDI AC REHABILITATION 0 251, 116 76. 97 00000 0000 0000 0000 00000 0000 0000 00000 00000 00000 00000	73.00	07300 DRUGS CHARGED TO PATIENTS	0			73.00
OUTPATI ENT SERVI CE COST CENTERS O O O O O O O O O	76.00	03950 OTHER ANCILLARY SERVICES	0	0		76.00
90. 00	76. 97	07697 CARDIAC REHABILITATION	0	251, 116		76. 97
90. 02						
91. 00			0			•
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS 0 0 113. 00 11300 INTEREST EXPENSE 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -26, 506, 800 132, 057, 693 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 279, 881 190. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 192. 01 19201 RETAI L PHARMACY 0 0 0 192. 01 192. 01 19202 MARKETI NG 0 543, 088 192. 02 192. 03 19203 BACK AND NECK 0 253, 685 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 04 192. 05 192. 05 192. 03 192. 05			-			
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -26,506,800 132,057,693 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 279,881 190.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 192.00 19201 RETAI L PHARMACY 0 0 0 192.01 192.01 19201 RETAI L PHARMACY 0 543,088 192.02 192.03 19203 BACK AND NECK 0 253,685 192.03			-2, 085, 075	5, 669, 059		
113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 19200 HYSI, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 19200 RETAIL PHARMACY 192. 01 19201 19201 RETAIL PHARMACY 192. 02 19202 MARKETI NG 192. 03 19203 19203 BACK AND NECK 0 113. 00 0 132, 057, 693 118. 00 1279, 881 0 0 0 0 0 192. 00 192. 01 192. 02 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03	92. 00					92.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -26, 506, 800 132, 057, 693 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 279, 881 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 00 19201 RETAIL PHARMACY 0 0 0 192. 00 192. 01 19202 MARKETI NG 0 543, 088 192. 02 192. 03 19203 BACK AND NECK 0 253, 685 118. 00	112 0		^	_		112 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 279, 881 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 01 19201 RETAIL PHARMACY 0 0 0 192. 01 192. 01 19202 MARKETI NG 0 543, 088 192. 02 192. 03 19203 BACK AND NECK 0 253, 685 192. 03					i e	
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 279, 881 190. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 00 192. 01 19201 RETAI L PHARMACY 0 0 192. 01 192. 02 19202 MARKETI NG 0 543, 088 192. 02 192. 03 19203 BACK AND NECK 0 253, 685 192. 03	118.00		-20, 506, 800	132,057,693	<u> </u>	1118.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	100 00		^	270 001		100 00
192. 01 19201 RETAI L PHARMACY 0 0 192. 01 192. 02 19202 MARKETI NG 0 543, 088 192. 02 192. 03 19203 BACK AND NECK 0 253, 685 192. 03			0	1		
192. 02 19202 MARKETI NG 0 543, 088 192. 02 192. 03 19203 BACK AND NECK 0 253, 685 192. 03			0	l e	l e e e e e e e e e e e e e e e e e e e	
192. 03 19203 BACK AND NECK 0 253, 685 192. 03			0		l .	
200.00 TOTAL (SUM OF LINES 118 through 199) -26,506,800 133,134,347 200.00			0			
5 2 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			-26, 506, 800			
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	C+ C+	1 ! //	C-1	0+1				
		Increases						
						From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 11:	
(ECLASS	IFICATIONS			Provider	CCN. 13-0136	Perrou.	WOLKSHEEL A-C)

		Increases			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00	
	A - DEPRECIATION	3.00	4.00	5.00	 _
	NEW CAP REL COSTS-BLDG &	1.00	0	3, 676, 516	1.00
	FIXT NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	3, 483, 374	2. 00
3.00		0. 00	О	0	3. 00
4. 00		0.00	0	0	4.00
5. 00 6. 00		0. 00 0. 00	0	0	5. 00 6. 00
7. 00		0.00	o	0	7. 00
8.00		0.00	o	0	8. 00
9. 00		0.00	0	0	9. 00
10. 00 11. 00		0. 00 0. 00	0	0	10. 00 11. 00
12.00		0.00	0	0	12.00
13. 00		0.00	Ö	Ö	13.00
14.00		0.00	o	0	14.00
15. 00		0.00	0	0	15.00
16. 00 17. 00		0. 00 0. 00	0	0	16. 00 17. 00
18. 00		0.00	o	Ö	18. 00
19. 00		0.00	o	0	19.00
20.00		0.00	0	0	20.00
21. 00 22. 00		0. 00 0. 00	0	0	21. 00 22. 00
23. 00		0. 00	О	Ö	23. 00
	0			7, 159, 890	
	B - LEASE NEW CAP REL COSTS-BLDG &	1 00	0	410, 020	1 00
	FIXT	1. 00	ď	410, 039	1.00
2.00	MOB	1. 01	О	483, 465	2.00
	NEW CAP REL COSTS-MVBLE	2. 00	0	72, 565	3. 00
	EQUI P PHARMACY	15. 00	0	2, 400	4.00
5. 00	117 (13,00)	0.00	Ö	2, 100	5. 00
6. 00		0.00	o	0	6. 00
7. 00		0.00	0	0	7.00
8. 00 9. 00		0. 00 0. 00	0	0	8. 00 9. 00
7. 00	0 — — — — —		o	968, 469	7.00
	C - INTEREST				
1. 00	INTEREST	102	0	5, 72 <u>8, 464</u> 5, 728, 464	1.00
	D - BENEFITS			5, 720, 404	i
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 794, 761	1.00
2.00		0.00	0	0	2.00
3. 00 4. 00		0. 00 0. 00	0	0	3. 00 4. 00
5. 00		0.00	o	Ö	5. 00
6. 00		0.00	o	0	6.00
7. 00 8. 00		0. 00 0. 00	0 0	0	7.00
9. 00		0.00	0	0	8. 00 9. 00
10. 00		0.00	Ö	Ö	10.00
11. 00		0.00	0	0	11.00
12.00		0. 00 0. 00	0	0	12.00
13. 00 14. 00		0.00	0	0	13. 00 14. 00
15. 00		0.00	Ö	Ö	15. 00
16.00		0.00	o	0	16.00
17. 00		0.00	0	0	17. 00 18. 00
18. 00 19. 00		0. 00 0. 00	0	0	19.00
20. 00		0. 00	o	0	20.00
21.00		0. 00	0	0	21.00
22. 00		0.00	0	0	22.00
23. 00 24. 00		0. 00 0. 00	0	0	23. 00 24. 00
25. 00		0. 00	o	0	25. 00
26.00		0. 00	0	0	26.00
27. 00		0.00	0	0	27.00
28. 00		0.00		<u>0</u> 7, 794, 761	28. 00
	·				

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/29/2018 11: 42 am Provider CCN: 15-0158

						5/29/2018 11: 42 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00	-	
1. 00	F - LABOR & DELIVERY DELIVERY ROOM & LABOR ROOM	E2 00	2 045 112	849, 948		1.00
1.00	DELIVERY ROOM & LABOR ROOM	5200	2, 065, 112 2, 065, 112	<u>849, 948</u>		1.00
	H - NURSERY		2,003,112	047, 740		
1. 00	NURSERY	43. 00	390, 789	58, 803		1.00
	0		390, 789	58, 803		
	I - DIETARY					
1.00	CAFETERI A	1100	72 <u>3, 9</u> 56	<u>866, 4</u> 12		1.00
	0		723, 956	866, 412		
4 00	J - IP CARE SERVICES	40.00	2 720	0.4.7		1.00
1.00	NURSI NG ADMI NI STRATI ON	13. 00	2, 789	217		1.00
2. 00	INTENSIVE CARE UNIT	3100	5 <u>6, 5</u> 44 59, 333	<u>4, 398</u> 4, 615		2. 00
	K - STD		39, 333	4,013		
1. 00	ADMINISTRATIVE AND GENERAL	5. 04	0	7, 104		1.00
2. 00	HOUSEKEEPI NG	9. 00	o	437		2.00
3.00	DI ETARY	10.00	О	352		3.00
4.00	NURSING ADMINISTRATION	13. 00	0	7, 474		4.00
5.00	PHARMACY	15. 00	0	5, 395		5. 00
6.00	SOCIAL SERVICE	17. 00	0	2, 239		6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	0	102, 374		7.00
8.00	I NTENSI VE CARE UNI T	31. 00	0	5, 142		8.00
9. 00	NEONATAL INTENSIVE CARE UNIT	32. 00	0	15, 946		9.00
10. 00 11. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	7, 340 32, 040		10. 00 11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	13, 310		12.00
13. 00	CARDI AC CATHETERI ZATI ON	59. 00	o	4, 186		13.00
14. 00	RESPIRATORY THERAPY	65. 00	Ö	6, 689		14. 00
15. 00	PHYSI CAL THERAPY	66. 00	o	2, 320		15. 00
16.00	ELECTROCARDI OLOGY	69. 00	О	2, 064		16. 00
17.00	CARDIAC REHABILITATION	76. 97	O	4, 140		17. 00
18.00	EMERGENCY	<u>91.</u> 00	0	<u>20, 2</u> 95		18. 00
	0		0	238, 847		
4 00	L - UTILITIES	7 00	ما	4 404 000		1.00
1.00	OPERATION OF PLANT	7. 00	0	1, 431, 209		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2.00
3.00		<u> </u>		1, 431, 209		3.00
	M - MARKETI NG		<u> </u>	1, 431, 207		
1.00	MARKETI NG	192. 02	0	7, 311		1.00
2.00		0.00	О	0		2.00
3.00		0. 00	0	0		3.00
4.00		0.00		0		4.00
	0		0	7, 311		
1 00	N - BILLABLE DRUGS	72.00		4 005 017		1.00
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	4, 005, 916		1.00
3. 00	1	0.00	0	0		3.00
4. 00		0.00	o	0		4.00
5. 00		0.00	Ö	Ö		5. 00
6.00		0.00	0	0		6. 00
	0			4, 005, 916		
	O - NON-BILLABLE DRUGS					
1.00	PHARMACY	15. 00	0	342, 862		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6.00
7. 00		0.00	0	Ö		7.00
8. 00		0.00	o	Ö		8.00
9. 00		0. 00	ō	Ö		9. 00
10.00		0.00	o	O		10.00
11.00		0. 00	О	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 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
10.00				342, 862		10.00
	P - BILLABLE IMPLANTS		J J	J4Z, 00Z		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	21, 505		1.00
	PATI ENTS		1	.,		
	·	•	'	,		•

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0158

					To 12/31/2017 Date/Time Pro 5/29/2018 11:	
		Increases		0.11	, , , , , , , , , , , , , , , , , , , ,	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
2. 00	I MPL. DEV. CHARGED TO	72. 00	4.00	7, 772, 214		2.00
	PATI ENT			, ,		
3.00		0.00	0	0		3. 00
4. 00		0.00	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	o	0		7. 00
	0		ō	7, 793, 719		
	Q - BILLABLE SUPPLIES					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 991, 808		1. 00
2. 00	PATIENTS RECOVERY ROOM	51.00	o	546		2. 00
3. 00	REGOVERT ROOM	0.00	o	0		3.00
4.00		0. 00	O	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6.00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	Ö	0		9. 00
10.00		0.00	o	0		10.00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00			— — — o	0 2, 992, 354		13. 00
	R - NON-BILLABLE SUPPLIES		<u> </u>	2, 772, 334		
1.00	PURCHASI NG RECEIVI NG AND	5. 03	0	589		1.00
	STORES					
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	6, 255, 896		2.00
3. 00 4. 00	BACK AND NECK	192. 03 0. 00	0	52 0		3. 00 4. 00
5. 00		0.00	o	0		5. 00
6. 00		0.00	Ö	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 11. 00		0. 00 0. 00	0	0		10.00 11.00
12. 00		0.00	o	0		12.00
13.00		0. 00	О	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	o	0		18. 00
19. 00		0.00	o	0		19.00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	0		21.00
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
24. 00		0.00	Ö	0		24.00
			o	6, 256, 537		
4 0-	S - DRUG REBATES RECLASS		.1			
1. 00 2. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	4, 443 1, 217		1. 00 2. 00
3. 00	OPERATING ROOM	50.00	ol Ol	40, 532		3.00
4. 00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	1, 577		4. 00
5.00	CARDI AC CATHETERI ZATI ON	59. 00	O	9, 242		5. 00
6.00	EMERGENCY	91.00	0	<u>2, 8</u> 30		6. 00
	TOTALS		0	59, 841		
1. 00	T - SUPPLY REBATES RECLASS ADMINISTRATIVE AND GENERAL	5. 04	ol	1		1. 00
2. 00	MAINTENANCE & REPAIRS	6. 00	o	1		2.00
3.00	HOUSEKEEPI NG	9. 00	ō	7		3. 00
4. 00	DIETARY	10. 00	O	76		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	9, 692		5.00
6. 00 7. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 32. 00	0	2, 432 5		6. 00 7. 00
8. 00	OPERATING ROOM	50. 00	0	139, 932		8.00
9. 00	RECOVERY ROOM	51.00	o	56		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54. 00	o	2, 298		10.00
11.00	CARDI AC CATHETERI ZATI ON	59.00	0	111, 305		11.00
12. 00	BLOOD STORING, PROCESSING, & TRANS.	63. 00	0	1, 132		12. 00
13. 00	PHYSI CAL THERAPY	66. 00	o	24		13. 00
	1	30. 00	<u> </u>	27		

Heal th Financial SystemsIU HEALTH WEST HOSPITALIn Lieu of Form CMS-2552-10RECLASSIFICATIONSProvider CCN: 15-0158Period: From 01/01/2017Worksheet A-6

KECEASS	TITIONS			rrovider	50N. 13-0130	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 11:	pared:
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				

		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
14.00	ELECTROCARDI OLOGY	69. 00	0	15		14.00
15.00	CARDIAC REHABILITATION	76. 97	0	4		15.00
16.00	SLEEP LAB	90. 02	0	3		16.00
17.00	EMERGENCY	91. 00	0	8, 738		17.00
	TOTALS		0	275, 721		
500.00	Grand Total: Increases		3, 239, 190	46, 835, 679	5	500.00

Provider CCN: 15-0158

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/29/2018 11: 42 am

		D				5/29/2018 11: 42	
	Coat Contar	Decreases	Coloru	O+hon	Wka+ 4 7 Daf		
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref. 10.00		
	6. 00 A - DEPRECIATION	7. 00	8. 00	9. 00	10.00		
1 00		F 01	ما	40.707			1 00
1.00	NONPATIENT TELEPHONES DATA PROCESSING	5. 01	0	40, 787	9	•	1.00
2.00	ADMINISTRATIVE AND GENERAL	5. 02	0	5, 501	9	4	2.00
3.00		5. 04	0	869, 726		4	3.00
4.00	MAINTENANCE & REPAIRS	6. 00	0	2, 747, 249	0	4	4.00
5.00	OPERATION OF PLANT	7. 00	0	758, 153	0	1	5.00
6. 00	LAUNDRY & LINEN SERVICE	8. 00	0	584	0	4	6.00
7. 00	HOUSEKEEPI NG	9. 00	0	2, 451	0	1	7.00
8. 00	DI ETARY	10. 00	0	12, 118	0	1	8. 00
9. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	69, 223	0	•	9. 00
10. 00	PHARMACY	15. 00	0	53, 443	0	•	0. 00
11. 00	ADULTS & PEDIATRICS	30. 00	0	441, 772	0	•	1. 00
12.00	INTENSIVE CARE UNIT	31. 00	0	6, 993	0	•	2. 00
13.00	OPERATING ROOM	50. 00	0	930, 435	0	•	3.00
14.00	RECOVERY ROOM	51. 00	0	2, 251	0	•	4. 00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	654, 853	0	•	5. 00
16.00	RADI OLOGY-THERAPEUTI C	55. 00	0	34, 084	0	16	6. 00
17.00	CARDI AC CATHETERI ZATI ON	59. 00	0	300, 964	0	17	7. 00
18.00	RESPI RATORY THERAPY	65. 00	0	56, 619	0	18	8. 00
19.00	PHYSI CAL THERAPY	66. 00	O	18, 928	0	19	9.00
20.00	ELECTROCARDI OLOGY	69. 00	O	38, 641	0	20	0.00
21.00	SLEEP LAB	90. 02	0	1, 131	o	21	1.00
22. 00	EMERGENCY	91.00	o	60, 456	o	•	2.00
23.00	BACK AND NECK	192. 03	0	53, 528	o	•	3.00
20.00	0		— — o	7, 159, 890			0.00
	B - LEASE		<u> </u>	77 1077 070			
1. 00	ADMINISTRATIVE AND GENERAL	5. 04	0	607, 459	10	1	1. 00
2. 00	ADULTS & PEDIATRICS	30.00	o	42, 272	10	•	2. 00
3. 00	INTENSIVE CARE UNIT	31. 00	0	30, 355	10	4	3.00
4. 00	OPERATING ROOM	50.00	0	1, 015	0	4	4. 00
5. 00	RESPIRATORY THERAPY	65. 00	0	1, 323	0	4	5. 00
6. 00	PHYSICAL THERAPY	66. 00	0	25, 882	0	1	6. 00
7. 00	1	•	0		0	4	
	CARDI AC REHABI LI TATI ON	76. 97	0	25, 882	0	1	7.00
8. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00	٩	24, 391	U	6	8. 00
9. 00	BACK AND NECK	192. 03		209, 890	o		9. 00
9.00	DACK AND INECK	192.03		209, 690		7	9.00
				049 440			
	O LINTEDEST		0	968, 469			
1 00	C - INTEREST	5 04	0			1	1 00
1. 00	C - INTEREST ADMINISTRATIVE AND GENERAL	5.04	0	5, 728, 464	11	1	1. 00
1. 00	ADMINISTRATIVE AND GENERAL 0	5.04	0 0			1	1. 00
	ADMINISTRATIVE AND GENERAL O D - BENEFITS		ō	5, 72 <u>8, 4</u> 64 5, 72 <u>8, 4</u> 64	11		
1.00	ADMI NI STRATI VE AND GENERAL O D - BENEFITS PURCHASI NG RECEI VI NG AND	5. 04		5, 728, 464	11		1.00
1. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES	5. 03	0	5, 728, 464 5, 728, 464 740	11	1	1. 00
1. 00 2. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL	5. 03 5. 04	0 0	5, 728, 464 5, 728, 464 740 281, 021	0	1	1. 00 2. 00
1. 00 2. 00 3. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS	5. 03 5. 04 6. 00	0	5, 728, 464 5, 728, 464 740 281, 021 113, 015	0 0 0	1 2 3	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT	5. 03 5. 04 6. 00 7. 00	0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624	0 0 0 0 0	1 2 3 4	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING	5. 03 5. 04 6. 00 7. 00 9. 00	0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788	0 0 0 0 0 0	1 2 3 4 5	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00	0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445	0 0 0 0 0	1 2 3 4 4 5 6 6	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00	0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459	0 0 0 0 0 0 0	1 2 3 3 4 4 5 6 6 7	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00	0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454	0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00	0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971	0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00	0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921	0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8 9	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00	0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321	0 0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8 9	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00	0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079	0 0 0 0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8 9 10 11 12	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00	0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698	0 0 0 0 0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8 9 10 11 12 13	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00	0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087	0 0 0 0 0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8 9 10 11 12 13	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00	0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898	0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8 9 10 11 11 12 13	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00	0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164	0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 2 2 3 4 4 5 6 7 7 8 6 9 9 10 11 12 13 14 15 16 16 16 16 16 16 16 16 16 16 16 16 16	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 4. 00 5. 00 6. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00	0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898	0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9 10 11 12 13 14 15 16 17 17 17 18 18 18 18 18 18 18 18 18 18 18 18 18	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 4. 00 5. 00 6. 00 7. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00 55. 00	0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9 10 11 12 13 14 15 16 17 17 17 18 18 18 18 18 18 18 18 18 18 18 18 18	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 4. 00 5. 00 6. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00	0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164 576, 927	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8 9 9 10 11 12 13 14 15 16 17 18	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 4. 00 5. 00 6. 00 7. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00 55. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164 576, 927 131, 666	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10 10 11 12 13 14 15 16 17 18	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC CARDIAC CATHETERIZATION	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00 55. 00 59. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164 576, 927 131, 666 84, 773	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10 22 33 4 5 6 7 10 11 12 13 14 15 16 17 18	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 9.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC CARDIAC CATHETERIZATION RESPIRATORY THERAPY	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00 55. 00 65. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164 576, 927 131, 666 84, 773 241, 441	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10 10 11 12 13 14 15 16 17 18 19 20 20 21	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 6. 00 7. 00 8. 00 9. 00 1. 00 8. 00 9.
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1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC RADIOLOGY-DIAGNOSTIC CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY CARDIAC REHABILITATION	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00 55. 00 66. 00 67. 00 68. 00 69. 00 76. 97	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164 576, 927 131, 666 84, 773 241, 441 213, 372 65, 129 38, 291 143, 030 60, 029	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10 10 11 11 12 13 14 15 16 17 18 19 20 21 22 23	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 9.
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY CARDIAC REHABILITATION EMERGENCY	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00 55. 00 66. 00 67. 00 68. 00 69. 00 76. 97 91. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164 576, 927 131, 666 84, 773 241, 441 213, 372 65, 129 38, 291 143, 030 60, 029 746, 499	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10 10 11 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 9. 00 1. 00 9.
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY CARDIAC REHABILITATION EMERGENCY GIFT, FLOWER, COFFEE SHOP &	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00 55. 00 66. 00 67. 00 68. 00 69. 00 76. 97	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164 576, 927 131, 666 84, 773 241, 441 213, 372 65, 129 38, 291 143, 030 60, 029	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10 10 11 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 9.
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	ADMINISTRATIVE AND GENERAL O D - BENEFITS PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT HOUSEKEEPING DIETARY NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT OPERATING ROOM RECOVERY ROOM RADIOLOGY-DIAGNOSTIC CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY CARDIAC REHABILITATION EMERGENCY	5. 03 5. 04 6. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 32. 00 50. 00 51. 00 54. 00 55. 00 66. 00 67. 00 68. 00 69. 00 76. 97 91. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 728, 464 5, 728, 464 740 281, 021 113, 015 122, 624 367, 788 281, 445 312, 459 59, 454 290, 971 54, 921 68, 321 2, 180, 079 396, 698 116, 087 428, 898 360, 164 576, 927 131, 666 84, 773 241, 441 213, 372 65, 129 38, 291 143, 030 60, 029 746, 499	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 6 7 7 8 8 7 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 9. 00 1. 00 9.

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/29/2018 11:42 am Provider CCN: 15-0158

					'	/29/2018 11:42 am
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10.00	
	F - LABOR & DELIVERY					
1. 00	ADULTS & PEDI ATRI CS	3000	<u>2, 065, 1</u> 12	84 <u>9, 9</u> 48		1.00
	0		2, 065, 112	849, 948		
	H - NURSERY					
1. 00	ADULTS & PEDIATRICS	3000	39 <u>0, 7</u> 89	5 <u>8, 8</u> 03		1.00
	0		390, 789	58, 803		
1 00	I - DIETARY	10.00	722 05/	0// 412		1 00
1. 00	DI ETARY	1000	723, 956	866, 412		1.00
	J - IP CARE SERVICES		723, 956	866, 412		
1. 00	ADULTS & PEDIATRICS	30.00	59, 333	4, 615	O	1.00
2. 00	ADOLIS & FLDIAIRICS	0.00	37, 333	4,013		2.00
2.00			59, 333	<u>4, 615</u>		2.00
	K - STD		37, 333	4,013		
1.00	ADMINISTRATIVE AND GENERAL	5. 04	7, 104	0	0	1.00
2. 00	HOUSEKEEPI NG	9. 00	437	0		2.00
3. 00	DI ETARY	10. 00	352	0	-	3.00
4. 00	NURSING ADMINISTRATION	13. 00	7, 474	0		4.00
5. 00	PHARMACY	15. 00	5, 395	0	0	5. 00
6. 00	SOCI AL SERVI CE	17. 00	2, 239	0	0	6. 00
7. 00	ADULTS & PEDIATRICS	30.00	102, 374	0	o	7.00
8.00	INTENSIVE CARE UNIT	31.00	5, 142	0	o	8.00
9. 00	NEONATAL INTENSIVE CARE UNIT	32. 00	15, 946	0	0	9.00
10.00	OPERATING ROOM	50. 00	7, 340	0	0	10.00
11.00	RECOVERY ROOM	51.00	32, 040	0	0	11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	13, 310	0	0	12.00
13.00	CARDI AC CATHETERI ZATI ON	59. 00	4, 186	0	0	13.00
14.00	RESPI RATORY THERAPY	65. 00	6, 689	0	0	14.00
15.00	PHYSI CAL THERAPY	66. 00	2, 320	0	0	15.00
16. 00	ELECTROCARDI OLOGY	69. 00	2, 064	0	0	16. 00
17. 00	CARDIAC REHABILITATION	76. 97	4, 140	0	0	17.00
18. 00	EMERGENCY	<u>91.</u> 00	2 <u>0, 2</u> 95	0	0	18. 00
	0		238, 847	0		
	L - UTILITIES		اه	4 445 500		1.00
1.00	MAINTENANCE & REPAIRS	6.00	0	1, 415, 589		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	14, 459	0	2.00
3. 00	BACK AND NECK	1 <u>92.</u> 03	0	<u>1, 1</u> 6 <u>1</u> 1, 431, 209	<u> </u>	3.00
	M - MARKETING		U _I	1, 431, 209		
1. 00	ADMINISTRATIVE AND GENERAL	5. 04	0	6, 648	O	1.00
2. 00	NURSI NG ADMI NI STRATI ON	13. 00	Ö	262		2.00
3. 00	CARDI AC REHABI LI TATI ON	76. 97	o	207		3.00
4. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	o	194		4.00
	CANTEEN					
						İ
	N - BILLABLE DRUGS					
1.00	ADMINISTRATIVE AND GENERAL	5. 04	0	19, 334		1.00
2.00	PHARMACY	15. 00	0	3, 505, 860		2.00
3. 00	ADULTS & PEDIATRICS	30. 00	0	109		3.00
4.00	OPERATING ROOM	50. 00	0	40, 117	0	4.00
5. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	405, 821		5. 00
6. 00	CARDI AC CATHETERI ZATI ON	<u> </u>	•	3 <u>4, 6</u> 75		6. 00
	0		0	4, 005, 916		
4 00	O - NON-BILLABLE DRUGS	5.04	ما	0.7		4.00
1.00	ADMINISTRATIVE AND GENERAL	5. 04	0	27	1	1.00
2.00	HOUSEKEEPI NG	9.00	0	20. 770		2.00
3.00	NURSI NG ADMI NI STRATI ON	13. 00	0	30, 770		3.00
4. 00 5. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00	0	62, 365		4.00
6. 00	NEONATAL INTENSIVE CARE UNIT	31. 00 32. 00	0	20, 587 1, 690	1	5. 00 6. 00
7. 00	OPERATING ROOM	50. 00	0	41, 712		7.00
8. 00	RECOVERY ROOM	51. 00	0	1, 401	0	8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	20, 889		9. 00
10. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	363	1	10.00
11. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	7, 003	1	11. 00
12. 00	RESPIRATORY THERAPY	65. 00	0	7,003		12.00
13. 00	PHYSI CAL THERAPY	66. 00	ol Ol	544		13.00
14. 00	ELECTROCARDI OLOGY	69. 00	0	797		14. 00
15. 00	CARDI AC REHABI LI TATI ON	76. 97	o	26		15.00
16. 00	EMERGENCY	91. 00	Ö	154, 642		16.00
	0	— — — †	— — <u> </u>	342, 862		
		'	- 1	•	, '	•

RECLASSI FI CATI ONS

Provider CCN: 15-0158

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

15.00

5/29/2018 11:42 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - BILLABLE IMPLANTS 1.00 CENTRAL SERVICES & SUPPLY 14.00 14, 092 1.00 0 0 2.00 ADULTS & PEDIATRICS 30.00 254 2.00 3.00 NEONATAL INTENSIVE CARE UNIT 32.00 0 0 3.00 23 4.00 OPERATING ROOM 50.00 0 6, 449, 144 0 4.00 RECOVERY ROOM 51.00 0 287 0 5.00 5.00 o 6.00 CARDIAC CATHETERIZATION 59.00 1, 329, 845 0 6.00 EMERGENCY 0 7.00 91.00 0 74 7.00 7, 793, 719 Q - BILLABLE SUPPLIES 1.00 ADMINISTRATIVE AND GENERAL 5. 04 0 191 0 1 00 0 0 2.00 NURSING ADMINISTRATION 13.00 2.00 3.00 CENTRAL SERVICES & SUPPLY 14.00 o 507 0 3.00 4.00 ADULTS & PEDIATRICS 30.00 0 102, 961 0 4.00 0 INTENSIVE CARE UNIT 0 31.00 5 00 10, 435 5 00 6.00 NEONATAL INTENSIVE CARE UNIT 32.00 0 1, 190 6.00 7.00 OPERATING ROOM 50.00 o 1, 522, 799 0 7.00 RADI OLOGY-DI AGNOSTI C 0 8.00 54.00 0 128, 273 8.00 0 0 9 00 CARDIAC CATHETERIZATION 59.00 9 00 1, 188, 556 10.00 RESPIRATORY THERAPY 65.00 0 1, 342 0 10.00 PHYSICAL THERAPY o 11.00 66.00 9,852 11.00 0 0 ELECTROCARDI OLOGY 69.00 12 00 129 12.00 13.00 EMERGENCY 91.00 26, 117 0 13.00 2, 992, 354 R - NON-BILLABLE SUPPLIES ADMINISTRATIVE AND GENERAL 1 00 5.04 0 43.349 0 1.00 2.00 MAINTENANCE & REPAIRS 6. 00 0 216 0 2.00 3.00 OPERATION OF PLANT 7. 00 o 0 3.00 110 0 0 LAUNDRY & LINEN SERVICE 4, 552 4.00 8.00 4.00 5 00 HOUSEKEEPI NG 9 00 22, 397 5 00 0 6.00 DI ETARY 10.00 0 7, 902 6.00 7.00 NURSING ADMINISTRATION 13.00 o 398 0 7.00 0 PHARMACY 0 8.00 15.00 33, 819 8.00 ADULTS & PEDIATRICS 0 9.00 30.00 1, 241, 413 9.00 0 INTENSIVE CARE UNIT 31.00 0 302, 187 10.00 10.00 NEONATAL INTENSIVE CARE UNIT 0 11.00 32.00 41, 453 11.00 0 OPERATING ROOM 0 12.00 50.00 2, 766, 019 12.00 o 13.00 RECOVERY ROOM 51.00 121, 320 13.00 RADI OLOGY-DI AGNOSTI C 14.00 14.00 54.00 0 481, 354 0 0 15.00 RADI OLOGY-THERAPEUTI C 55.00 14, 809 15.00 0 CARDIAC CATHETERIZATION 59.00 320, 400 16.00 16.00 0 17.00 RESPIRATORY THERAPY 65.00 0 104, 969 17.00 0 PHYSI CAL THERAPY 0 102, 760 18.00 66.00 18.00 OCCUPATIONAL THERAPY 67.00 0 2.044 19.00 19.00 0 SPEECH PATHOLOGY 0 20.00 68.00 462 20.00 21.00 ELECTROCARDI OLOGY 69.00 0 26, 725 0 21.00 22.00 CARDIAC REHABILITATION 76.97 0 6, 993 0 22.00 SIFFP LAR 90.02 0 0 23.00 18, 368 23.00 24.00 EMERGENCY 91.00 592, 518 0 24.00 ō 6, 256, 537 S - DRUG REBATES RECLASS 1.00 PHARMACY 15.00 0 59,841 0 1.00 2.00 0.00 0 0 0 2.00 0 3.00 0.00 0 0 3.00 0 0 4 00 0 00 0 4 00 5.00 0.00 0 0 0 5.00 6.00 0 6.00 0.00 ō TOTALS 59, 841 T - SUPPLY REBATES RECLASS 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 275, 721 0 1.00 0.00 2.00 0 0 0 2.00 0 0 3.00 0.00 0 3.00 4.00 0.00 0 4 00 0 5.00 0.00 0 0 5.00 o 0 6.00 0.00 0 6.00 0 0 7.00 0.00 0 7.00 0 0 8.00 0.00 8.00 9.00 0.00 0 0 0 9.00 0 0 10.00 0.00 0 10.00 O 0 0.00 0 11.00 11.00 0 12.00 0.00 0 12.00 0 0 13.00 0.00 0 13.00 0.00 0 0 14.00 14.00 0

0.00

15.00

Heal th Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-0158
From 01/01/2017
To 12/31/2017
Date/Time Prepared:

							5/29/2018 11:	42 am
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10.00			
16.00		0. 00	0	0	0			16.00
17.00		0. 00	0	0	0)		17.00
	TOTALS		0	275, 721				
500.00	Grand Total: Decreases		3, 478, 037	46, 596, 832				500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS IU HEALTH WEST HOSPITAL

Provider CCN: 15-0158

					o 12/31/2017	Date/Time Pre 5/29/2018 11:	
				Acqui si ti ons		3/2//2010 11.	72 diii
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0	(0	0	1.00
2.00	Land Improvements	6, 800, 703	0	(0	0	2.00
3.00	Buildings and Fixtures	74, 901, 135	0	(0	0	3.00
4.00	Building Improvements	27, 446, 148	0	(0	0	4. 00
5.00	Fixed Equipment	0	0	(0	0	5. 00
6.00	Movable Equipment	68, 047, 676	4, 120, 869	(4, 120, 869	1, 291, 896	6.00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	177, 195, 662	4, 120, 869	(4, 120, 869	1, 291, 896	8. 00
9. 00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	177, 195, 662	4, 120, 869	(4, 120, 869	1, 291, 896	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
		/ 00	Assets				
	DART I ANALYCIC OF CHANCEC IN CARLTAL ACCE	6.00	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	I BALANCES					1 00
	Land	/ 000 700	U				1.00
2. 00 3. 00	Land Improvements	6, 800, 703 74, 901, 135	0				2. 00 3. 00
4. 00	Buildings and Fixtures		0				4.00
4. 00 5. 00	Building Improvements	27, 446, 148	0				5.00
6. 00	Fixed Equipment Movable Equipment	70, 876, 649	0				6.00
7. 00	HIT designated Assets	70, 676, 649	0				7.00
8. 00	Subtotal (sum of lines 1-7)	180, 024, 635	0				8.00
9. 00	Reconciling Items	100, 024, 033	0				9.00
10.00	Total (line 8 minus line 9)	180, 024, 635	0				10.00
10.00	Total (Tine o milius Tine 7)	100,024,033	υĮ			ļ	10.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-0158	Period: Worksheet A-7

			1	rom 01/01/2017 o 12/31/2017		pared: 42 am
		SU	JMMARY OF CAPI	ΓAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9. 00	10. 00	11. 00	12. 00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	C	0	0	1.00
1. 01 MOB	0	276, 912		0	0	1.01
1. 02 INTEREST	0	0			0	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	276, 912			0	2.00 3.00
5.00 Total (Suill Of Titles 1-2)	SUMMARY 0			,	0	3.00
	30WWWART 0	I ONITINE				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at					
	ed Costs (see	9 through 14)				
	instructions)					
DART II DECONCLITATION OF AMOUNTS FROM WOR	14.00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR 1.00 NEW CAP REL COSTS-BLDG & FIXT	KSHEET A, CULUI	MIN Z, LINES I a	and 2			1.00
1.00 New CAP REL COSTS-BLDG & FIXT	62, 934	339, 846				1.00
1. 02 I NTEREST	02, 754	337, 040				1.01
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	62, 934	339, 846				3. 00

Health Financial Systems		IU HEALTH WEST HOSPITAL			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der CCN: 15-0158		Peri od: From 01/01/2017 To 12/31/2017 Date/Time Pre 5/29/2018 11:			
		COMPUTATION OF RATIOS		ALLOCATION OF	OTHER CAPITAL			
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1. 00	2. 00	3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C							
1. 00 1. 01 1. 02	NEW CAP REL COSTS-BLDG & FIXT MOB INTEREST	109, 147, 986 0	0	,,	0. 606295 0. 000000 0. 000000	0 0 0	1. 00 1. 01 1. 02	
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	70, 876, 649	0	70, 876, 64		0	2.00	
3. 00	Total (sum of lines 1-2)	180, 024, 635	0	180, 024, 63		- 1	3. 00	
			ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6. 00	7. 00	8. 00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	1	4, 048, 285		1.00	
1. 01 1. 02	MOB I NTEREST	0	0		0	483, 168 0	1. 01 1. 02	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		3, 483, 374	72, 565	2. 00	
3. 00	Total (sum of lines 1-2)	0	0		7, 531, 659		3. 00	
SUMMARY OF CAPITAL							0.00	
	Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
		11. 00	12. 00	13.00	14.00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0	3, 955, 456	1.00	
1.01	MOB	0	0	•	62, 934		1.01	
1. 02	I NTEREST	5, 728, 464	0		0	5, 728, 464	1.02	
2. 00 3. 00	NEW CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	5, 728, 464	0		0 62, 934	3, 555, 939 13, 785, 961	2. 00 3. 00	
3.00	Total (Sum Of Titles 1-2)	5, 720, 404	U	1	02, 934	13, 703, 901	3.00	

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0158 Peri od: Worksheet A-8 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/29/2018 11:42 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5. 00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter lfi xt 2) 1.01 омов Investment income - MOB 1.01 1.01 (chapter 2) O I NTEREST 1.02 Investment income - INTEREST 1.02 1.02 (chapter 2) Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P Investment income - other 3.00 3.00 0.00 (chapter 2) Trade, quantity, and time 4 00 0 0.000 4 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 -502,868 NEW CAP REL COSTS-BLDG & 1.00 10 6.00 FLXT 7.00 Tel ephone services (pay 7.00 0.00 stations excluded) (chapter 8.00 Television and radio service 8.00 0.00 (chapter 21) 9.00 Parking Lot (chapter 21) 9.00 0.00 10.00 Provi der-based physici an A-8-2 -12, 165, 598 10.00 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) 5, 193, 623 12.00 Related organization A-8-1 12 00 transactions (chapter 10) Laundry and linen service 0.00 13.00 13.00 14.00 Cafeteria-employees and guests В -832, 896 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents Sale of drugs to other than 17.00 17.00 0.00 0 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20 00 Vending machines 0 00 0 20.00 Income from imposition of 21.00 21.00 0.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 22.00 0.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 23.00 A-8-3 65.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 24.00 Adjustment for physical A-8-3 66.00 24.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT FLXT омов 26.01 Depreciation - MOB 1.01 26.01 Depreciation - INTEREST Depreciation - NEW CAP REL OI NTEREST 1. 02 ol 26 02 26 02 27.00 ONEW CAP REL COSTS-MVBLE 2.00 27.00 COSTS-MVBLE EQUIP EQUI P 0 *** Cost Center Deleted *** 28.00 Non-physician Anesthetist 19.00 28.00

From 01/01/2017 | Worksheet A-8 | Worksheet A-8 | To 12/31/2017 | Date/Time Prepared:

					12/01/201/	5/29/2018 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
29. 00	1 3		0		0. 00	0	
30.00		A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)		_				
31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
00.00	limitation (chapter 14)				0.00		00.00
32.00			0		0. 00	0	32.00
33. 00	Depreciation and Interest MISCELLANEOUS INCOME	В	010 075	ADMINISTRATIVE AND GENERAL	5. 04	0	33.00
33. 00	MI SCELLANEOUS I NCOME	l B		MAINTENANCE & REPAIRS	6. 00	0	
33. 01	MISCELLANEOUS INCOME	l B		PHARMACY	15. 00	0	
33. 02		B B		ADULTS & PEDIATRICS	30.00	- 1	
33. 04	MOB RENT EXPENSE	D	-277, 209	l I	1. 01	10	1
33. 05	CONTRIBUTION EXPENSE	A	, ,	ADMINISTRATIVE AND GENERAL	5. 04	0	
33. 06	HAF FEES	A		ADMINISTRATIVE AND GENERAL	5. 04 5. 04	0	
33. 07	ACCRUED PTO TO HO	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00		
33. 07		A		ADMINISTRATIVE AND GENERAL	5. 04	0	
33. 09	BENEFITS TO HO	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.09
50.00	TOTAL (sum of lines 1 thru 49)		-26, 506, 800		4.00	U	50.00
30.00	(Transfer to Worksheet A,		-20, 300, 800				30.00
	column 6, line 200.)						
	COLUMN 0, TITLE 200.)	l					

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

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

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 15-0158

Worksheet A-8-1

From 01/01/2017 12/31/2017 Date/Time Prepared: 5/29/2018 11:42 am Li ne No. Cost Center Expense Items Amount of Amount

	21110 1101	3331 3311131	2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OF	R CLAIMED HOME	
	OFFICE COSTS:					
1. 00		NEW CAP REL COSTS-BLDG & FIX	l .		· ·	
2.00			INTERCOMPANY/HO CR ALLOCATIO			
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	l .		12, 790	3.00
4.00	5. 02	DATA PROCESSING	INTERCOMPANY/HO CR ALLOCATIO	4, 644, 853	0	4.00
4. 01	5. 03	PURCHASING RECEIVING AND STO	INTERCOMPANY/HO CR ALLOCATIO	551, 214	0	4.01
4.02	5. 04	ADMINISTRATIVE AND GENERAL	INTERCOMPANY/HO CR ALLOCATIO	22, 892, 200	30, 289, 598	4.02
4. 03	13. 00	NURSING ADMINISTRATION	INTERCOMPANY/HO CR ALLOCATIO	642, 865	613, 202	4.03
4.04	30.00	ADULTS & PEDIATRICS	I NTERCOMPANY	833, 515	833, 515	4.04
4. 05	31.00	INTENSIVE CARE UNIT	I NTERCOMPANY	975, 470	975, 470	4.05
4.06	54. 00	RADI OLOGY-DI AGNOSTI C	I NTERCOMPANY	-136, 413	-23, 425	4.06
4. 07	55.00	RADI OLOGY-THERAPEUTI C	I NTERCOMPANY	262, 792	262, 792	4.07
4.08	60.00	LABORATORY	I NTERCOMPANY	5, 442, 187	5, 442, 187	4.08
4.09	65.00	RESPI RATORY THERAPY	I NTERCOMPANY	400	400	4.09
4. 10	66.00	PHYSI CAL THERAPY	I NTERCOMPANY	12, 561	12, 561	4. 10
4. 11	69.00	ELECTROCARDI OLOGY	I NTERCOMPANY	573, 581	573, 581	4. 11
4. 12	90. 02	SLEEP LAB	INTERCOMPANY	642, 460	642, 460	4. 12
4. 13	91.00	EMERGENCY	INTERCOMPANY	2, 085, 075	2, 085, 075	4.13
4. 14	192. 02	MARKETI NG	INTERCOMPANY	156, 857	156, 857	4.14
4. 15	192. 03	BACK AND NECK	I NTERCOMPANY	49, 789	49, 789	4. 15
5.00	0		0	53, 264, 276	48, 070, 653	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

 			nour a bo riiai oatoa rii ooraiiii		
			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 RELATE	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	IU HEALTH	100.00	IU HEALTH-HO	100.00	6.00
7.00			0.00		0.00	7.00
8. 00			0.00		0.00	8.00
9. 00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	FINANCIAL				100.00
	non-financial) specify:					

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

* 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.

4.11

4 12

4.13

4.14

4.15

5.00

1105 110	t been posted to not kencet A,	cordinate 1 dray or 2, the amount arrowable should be rival cated in cordinate or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6.00
7.00		7.00
7. 00 8. 00		8.00
9.00		9.00
9. 00 10. 00		10.00
100.00		100.00

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

0

0

0

0

0

5, 193, 623

4.11

4 12

4.13

4.14

4.15

5.00

0

0

0

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

| Period: | Worksheet A-8-2 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-0158

					-	To 12/31/2017	Date/Time Pre 5/29/2018 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	IIIKSC: A EITIG #	I denti fi er	Remuneration	Component	Component	TOE AMOUNT	ider Component	
		1 40.1111101	Tromarior a cr on	oomponone	oomponone		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADMINISTRATIVE AND GENERAL	8, 082, 304	8, 082, 304	0		0	1. 00
2.00		ADULTS & PEDIATRICS	852, 355		0			2. 00
3. 00		INTENSIVE CARE UNIT	841, 845					3. 00
4. 00		OPERATING ROOM	106, 375					4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	-171, 539			271, 900		5. 00
6.00		RADI OLOGY-THERAPEUTI C	-39, 322					6. 00
7. 00		PHYSI CAL THERAPY	-2, 083			197, 500		7. 00
8. 00		ELECTROCARDI OLOGY	410, 588					8. 00
9. 00		EMERGENCY	2, 085, 075			197, 500		9. 00
10.00	0.00		0	0				10.00
200.00			12, 165, 598	12, 165, 598	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	5. 04	ADMINISTRATIVE AND GENERAL	0	0	_	_	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0			0	2. 00
3.00		INTENSIVE CARE UNIT	0	0		_	0	3. 00
4. 00		OPERATING ROOM	0	0	0	0	0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	5. 00
6.00	55.00	RADI OLOGY-THERAPEUTI C	0	0	0	0	0	6.00
7.00		PHYSI CAL THERAPY	0	0	0	0	0	7. 00
8.00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	8.00
9.00		EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	J	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADMI NI STRATI VE AND GENERAL	15.00					1. 00
2. 00		ADULTS & PEDIATRICS		0		., ,		2.00
3. 00		INTENSIVE CARE UNIT		0	_	,		3. 00
4. 00		OPERATING ROOM		0	_			4. 00
5. 00		RADI OLOGY-DI AGNOSTI C		0	_			5. 00
6. 00	•	RADI OLOGY-THERAPEUTI C	0	0	_	-39, 322		6. 00
7. 00	•	PHYSI CAL THERAPY		0	_			7. 00
8. 00		ELECTROCARDI OLOGY		0	_	2,000		8. 00
9. 00		EMERGENCY		0				9. 00
10.00	0.00			0	_	2,003,073		10.00
200.00	0.00		0	_	_	_		200.00
200.00	I	I	1	ı	1	12, 103, 370	I I	200.00

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Ti me Prepared: 5/39/2018 11:42 am

				10		5/29/2018 11:	
				CAPI TAL REL	ATED COSTS		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	MOB	INTEREST	NEW MVBLE EQUIP	
		0	1.00	1. 01	1. 02	2. 00	
1.00	GENERAL SERVICE COST CENTERS	0.055.454	0.055.454				
1. 00 1. 01	OO100 NEW CAP REL COSTS-BLDG & FIXT OO101 MOB	3, 955, 456 546, 102	3, 955, 456 229, 113	775, 215			1. 00 1. 01
1. 02	00102 NTEREST	5, 728, 464	0	0	5, 728, 464		1.02
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	3, 555, 939				3, 555, 939	2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES	7, 421, 235	7 245	69, 357 0	11 221	0 45 424	4. 00 5. 01
5. 02	00550 DATA PROCESSING	65, 458 4, 664, 929	7, 365 49, 372	0	11, 321 75, 899	45, 424 6, 126	5.01
5. 03	00560 PURCHASING RECEIVING AND STORES	628, 054	53, 859	0	82, 797	0	5. 03
5. 04	00590 ADMINISTRATIVE AND GENERAL	19, 717, 229	177, 548	90, 075	272, 943	73, 759	5.04
6. 00 7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT	1, 830, 502 2, 376, 975	773, 089 46, 444	0	1, 188, 461 71, 397	420, 156 95, 337	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	149, 460	12, 676	0	19, 486	650	ı
9. 00	00900 HOUSEKEEPI NG	3, 898, 326	53, 048	9, 219	81, 550	4, 222	9. 00
	01000 DI ETARY	672, 521	48, 117	9, 531	73, 969	9, 982	
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	757, 472 3, 490, 106	113, 790 19, 635	0	174, 927 30, 184	0 598	11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	6, 288, 647	90, 352	0	138, 897	77, 094	ı
	01500 PHARMACY	2, 620, 748	31, 169	0	47, 916	93, 831	1
	01700 SOCIAL SERVICE 01080 TRANSPORTATION	252, 984	0	0	0	0	
18. 00	INPATIENT ROUTINE SERVICE COST CENTERS	322, 828	0	0	0	0	18. 00
	03000 ADULTS & PEDIATRICS	10, 921, 173	791, 125	0	1, 216, 193	325, 275	30.00
	03100 INTENSIVE CARE UNIT	3, 419, 454	130, 090	0	199, 986	19, 925	
	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	998, 340 449, 592	38, 331 35, 682	0	58, 926 54, 854	0 14, 485	32. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	447, 372	33, 002	<u> </u>	34, 034	14, 403	43.00
	05000 OPERATING ROOM	3, 442, 739	367, 011	0	564, 202	851, 878	1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	2, 447, 732	31, 981	0	49, 164	2, 507 75, 993	
	05400 RADI OLOGY-DI AGNOSTI C	2, 915, 060 4, 433, 493	186, 218 230, 596	0	286, 271 354, 492	834, 939	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 255, 609	124, 196	0	190, 925	37, 169	ł
	05900 CARDI AC CATHETERI ZATI ON	970, 008	31, 664	0	48, 676	318, 977	1
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	5, 442, 187 391, 299	46, 482 0	0	71, 456 0	0	60.00 63.00
65. 00	06500 RESPIRATORY THERAPY	1, 491, 839	27, 912	0	42, 909	39, 465	ł
66. 00	06600 PHYSI CAL THERAPY	1, 501, 602	1, 521	61, 554	2, 338	10, 178	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	516, 370 161, 355	1, 521 1, 521	61, 554 61, 554	2, 338 2, 338	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	987, 970	4, 424	01, 554	6, 801	113, 488	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 013, 313	0	0	0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENT	7, 772, 214	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICES	4, 005, 916	0	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	251, 116	Ö	37, 523	o	0	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C 09002 SLEEP LAB	0 656, 818	0 1, 990	0 70, 557	0 3, 059	0 742	
	09100 EMERGENCY	5, 669, 059	197, 614	70, 557	303, 789	67, 089	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
112 00	SPECIAL PURPOSE COST CENTERS	1					112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	132, 057, 693	3, 955, 456	470, 924	5, 728, 464	3, 539, 289	113.00
	NONREI MBURSABLE COST CENTERS		07 7007 1007	1707721	0,720,101	0,00,720,	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	279, 881	0	34, 714	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 RETAIL PHARMACY	0	0	0 23, 119	0	0	192. 00 192. 01
	19202 MARKETI NG	543, 088	o	15, 004	0		192.01
192. 03	19203 BACK AND NECK	253, 685	o	231, 454	0	16, 650	192. 03
200.00						^	200. 00 201. 00
201. 00 202. 00		133, 134, 347	3, 955, 456	0 775, 215	5, 728, 464	3, 555, 939	
	, (2, 700, 100	, 210	2, .20, .01	-, 555, 767	,

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Ti me Prepared: 5/39/2018 11:42 am

				'	0 12/31/2017	5/29/2018 11:	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AND STORES	Subtotal	
		4. 00	5. 01	5. 02	5. 03	5A. 03	
	GENERAL SERVICE COST CENTERS	•			1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 MOB						1. 01
1. 02	00102 I NTEREST						1. 02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	7, 490, 592					4.00
5. 01	00540 NONPATI ENT TELEPHONES	0	129, 568				5. 01
5. 02	00550 DATA PROCESSING	0	0	4, 796, 326			5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	0	0	C			5. 03
5. 04	00590 ADMINISTRATIVE AND GENERAL	423, 548	4, 074	150, 805		20, 911, 876	5. 04
6.00	00600 MAI NTENANCE & REPAI RS	110, 316	2, 269	84, 011		4, 408, 813	6. 00
7. 00	00700 OPERATION OF PLANT	81, 098	2, 023	74, 885	I I	2, 748, 164	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	C	.,	183, 767	8. 00
9. 00	00900 HOUSEKEEPI NG	159, 871	6, 090	225, 432	1	4, 438, 737	9. 00
10.00	01000 DI ETARY	50, 630	1, 635	60, 516	1	927, 004	10.00
11. 00	01100 CAFETERI A	119, 866	3, 866	143, 103	I I	1, 313, 267	11.00
13. 00	01300 NURSING ADMINISTRATION	427, 663	4, 452	164, 786		4, 137, 441	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	46, 983	1, 220	45, 177		6, 688, 599	14.00
15. 00	01500 PHARMACY	355, 310	4, 506	166, 792		3, 321, 751	15. 00
17. 00	01700 SOCI AL SERVI CE	38, 302	696	25, 760		317, 742	17.00
18. 00	01080 TRANSPORTATI ON	40, 300	1, 561	57, 798	8 0	422, 487	18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 509, 016	26, 922	996, 547		15, 828, 235	30.00
31. 00	03100 INTENSIVE CARE UNIT	420, 611	6, 044	223, 749		4, 433, 072	31.00
32. 00	02060 NEONATAL INTENSIVE CARE UNIT	150, 966	1, 820			1, 317, 573	32.00
43. 00	04300 NURSERY	64, 703	990	36, 633	1, 983	658, 922	43.00
FO 00	ANCILLARY SERVICE COST CENTERS	420 101	(022	252.020	121 025	/ 02/ /10	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	429, 191 369, 802	6, 833 5, 327	252, 939 197, 212		6, 036, 618 3, 109, 029	50. 00 51. 00
51.00	1 1			197, 212			1
54.00	05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	341, 923	5, 231			4, 014, 683	52.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	626, 463 121, 593	10, 569 1, 630	391, 253 60, 322		6, 902, 852 1, 792, 092	54. 00 55. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	107, 668	1, 533	56, 762	1	1, 742, 042	59.00
60.00	06000 LABORATORY	107, 008	5, 735	212, 293		5, 778, 153	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	3, 733	212, 270	1	408, 409	63.00
65.00	06500 RESPIRATORY THERAPY	228, 562	3, 514	130, 094	,	1, 968, 885	65.00
66. 00	06600 PHYSI CAL THERAPY	224, 431	3, 285	121, 615		1, 931, 017	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	79, 556	1, 011	37, 410		699, 849	67.00
68. 00	06800 SPEECH PATHOLOGY	24, 895	306	11, 327		263, 316	•
69. 00	06900 ELECTROCARDI OLOGY	121, 476	1, 878	69, 513	1	1, 306, 719	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	121, 470	1, 0, 0	07, 313		3, 145, 070	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0			8, 112, 060	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0			4, 005, 916	73.00
76. 00	03950 OTHER ANCI LLARY SERVI CES	0	0	ď	1	4, 003, 710	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	36, 721	699	25, 889		352, 254	76. 97
, 0, ,,	OUTPATIENT SERVICE COST CENTERS	00/121	97.1	20,007	000	002,201	70.77
90.00	09000 CLI NI C	0	0	С	ol	0	90.00
	09002 SLEEP LAB	0	0	Č	803	733, 969	
91.00	09100 EMERGENCY	743, 057	12, 952	479, 471		7, 498, 939	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, 10, 00,	.2, ,02	.,,,,,,	20,700	0	92.00
,2.00	SPECIAL PURPOSE COST CENTERS						72.00
113. 00	11300 I NTEREST EXPENSE						113.00
118. 00		7, 454, 521	128, 671	4, 763, 123	764, 710	131, 666, 581	1
	NONREI MBURSABLE COST CENTERS	.,,	.==,	., .,		,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 265	428	15, 857	0	345, 145	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	l	ol		192.00
	1 19201 RETAIL PHARMACY	o	0		ol	23, 119	
	19202 MARKETI NG	ol	o		ol	558, 092	•
	19203 BACK AND NECK	21, 806	469	17, 346	ol ol	541, 410	
200.00		,]	·	200.00
201.00		О	o	c	ol		201.00
202.00		7, 490, 592	129, 568	4, 796, 326	764, 710	133, 134, 347	
		· · ·		•			

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Ti me Prepared: 5/39/2018 11:42 am

				1.	0 12/31/2017	5/29/2018 11:	
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·	E AND GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 04	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 MOB						1.01
1. 02	00102 NTEREST						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATI ENT TELEPHONES						5.01
5. 02 5. 03	00550 DATA PROCESSING						5. 02 5. 03
5. 03	00560 PURCHASING RECEIVING AND STORES 00590 ADMINISTRATIVE AND GENERAL	20, 911, 876					5.03
6. 00	00600 MAINTENANCE & REPAIRS	821, 551	5, 230, 364				6.00
7. 00	00700 OPERATION OF PLANT	512, 101	91, 147	3, 351, 412			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	34, 244	24, 876				8.00
9. 00	00900 HOUSEKEEPI NG	827, 128	104, 108		237, 110		9.00
10. 00	01000 DI ETARY	172, 741	94, 431	61, 581	Ö	102, 491	1
11. 00	01100 CAFETERI A	244, 718	223, 316		_	242, 376	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	770, 983	38, 534			41, 822	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 246, 374	177, 319			192, 453	14.00
15.00	01500 PHARMACY	618, 985	61, 171	39, 891	0	66, 392	15.00
17.00	01700 SOCIAL SERVICE	59, 209	0	0	0	0	17. 00
18.00	01080 TRANSPORTATION	78, 727	0	0	0	0	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	2, 949, 483	1, 552, 611	1, 012, 496	139, 369	1, 685, 129	30.00
31.00	03100 I NTENSI VE CARE UNI T	826, 072	255, 307			277, 097	
32. 00	02060 NEONATAL INTENSIVE CARE UNIT	245, 521	75, 226			81, 647	32.00
43. 00	04300 NURSERY	122, 786	70, 027	45, 666	0	76, 004	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 124, 882	720, 271	469, 707	21, 795	781, 748	50.00
51.00	05100 RECOVERY ROOM	579, 346	62, 763			68, 120	51.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	748, 108	365, 459			396, 652 491, 178	52. 00 54. 00
55. 00	05500 RADI OLOGY-DI AGNOSTI C	1, 286, 298 333, 944	452, 552 243, 739			264, 543	55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	288, 701	62, 141	40, 524		67, 445	•
60.00	06000 LABORATORY	1, 076, 718	91, 222	59, 488		99, 008	60.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	76, 104	0	0 7, 100	0	0	63.00
65. 00	06500 RESPIRATORY THERAPY	366, 888	54, 778	1	0	-	65.00
66. 00	06600 PHYSI CAL THERAPY	359, 832	2, 985	1, 947	0	3, 240	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	130, 412	2, 985		O	3, 240	67.00
68.00	06800 SPEECH PATHOLOGY	49, 067	2, 985		0	3, 240	68.00
69.00	06900 ELECTROCARDI OLOGY	243, 498	8, 682	5, 662	0	9, 423	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	586, 062	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 511, 626	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	746, 474	0	0	0	0	73.00
76. 00	03950 OTHER ANCI LLARY SERVI CES	0	0	0		0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	65, 640	0	0	15	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			_			
90.00	09000 CLINIC	0	0				90.00
	09002 SLEEP LAB	136, 770	3, 906				90.02
	09100 EMERGENCY	1, 397, 375	387, 823	252, 909	58, 753	420, 924	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	20, 638, 368	E 220 244	2 251 412	250 110	E 127 041	113.00
110.00	NONREI MBURSABLE COST CENTERS	20, 030, 300	5, 230, 364	3, 351, 412	259, 110	5, 437, 864	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	64, 315	0	0	٥	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	04, 313	0				192.00
	19201 RETAIL PHARMACY	4, 308	0	0	0		192.01
	2 19202 MARKETI NG	103, 997	0	0			192.01
	19203 BACK AND NECK	100, 888	n	l 0	n n		192. 03
200.00		,	3				200.00
201.00		o	0	0	o		201.00
202.00		20, 911, 876	5, 230, 364	3, 351, 412	259, 110	5, 437, 864	202.00
				•		•	

Peri od: Worksheet B From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/29/2018 11:42 am

				10	12/31/2017	5/29/2018 11:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10. 00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00101 MOB						1. 01
	00102 I NTEREST						1. 02
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00540 NONPATI ENT TELEPHONES						5. 01
	00550 DATA PROCESSING						5.02
	00560 PURCHASING RECEIVING AND STORES 00590 ADMINISTRATIVE AND GENERAL						5.03
	00600 MAINTENANCE & REPAIRS						5. 04 6. 00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY	1, 358, 248					10.00
	01100 CAFETERI A	0	2, 169, 307				11.00
13.00	01300 NURSING ADMINISTRATION	0	88, 100	5, 102, 009			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	24, 153	0	8, 444, 532		14.00
	01500 PHARMACY	0	89, 172	13, 267	16, 436	4, 227, 065	15.00
	01700 SOCIAL SERVICE	0	13, 772		0	0	17.00
	01080 TRANSPORTATI ON	0	30, 901	0	0	0	18. 00
-	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	1, 025, 337	532, 785		466, 662	61, 052	30.00
	03100 I NTENSI VE CARE UNI T	199, 167	119, 623		146, 867	20, 154	
	02060 NEONATAL INTENSIVE CARE UNIT	43, 408	36, 022		20, 147	1, 654 0	
	04300 NURSERY ANCILLARY SERVICE COST CENTERS	90, 336	19, 585	76, 881	22, 040	U	43.00
	05000 OPERATING ROOM	0	135, 229	336, 777	1, 354, 111	40, 834	50.00
	05100 RECOVERY ROOM	ő	105, 436		58, 954	1, 372	51.00
	05200 DELIVERY ROOM & LABOR ROOM	o	103, 533		114, 877	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	209, 176		233, 944	20, 449	
	05500 RADI OLOGY-THERAPEUTI C	0	32, 250	34, 188	7, 197	355	55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	30, 347	55, 959	155, 758	6, 856	59.00
	06000 LABORATORY	0	113, 498	0	0	0	60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	-	190, 177	0	63.00
	06500 RESPI RATORY THERAPY	0	69, 552		51, 016	0	65.00
	06600 PHYSI CAL THERAPY	0	65, 019		49, 943	43	
	06700 OCCUPATI ONAL THERAPY	0	20, 001	0	993	533	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	6, 056		225	780	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	37, 164 0		12, 989 1, 464, 509	780	69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		3, 777, 390	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	Ö	0	Ö	0, ,,,,,	3, 921, 572	
	03950 OTHER ANCILLARY SERVICES	o	0		o	0	
	07697 CARDIAC REHABILITATION	0	13, 841	0	3, 399	25	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	0	0	90.00
	09002 SLEEP LAB	0	0	-	8, 927	0	90. 02
	09100 EMERGENCY	0	256, 340	786, 665	287, 971	151, 386	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS			I			112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 358, 248	2, 151, 555	5, 102, 009	8, 444, 532	4, 227, 065	113.00
	NONREI MBURSABLE COST CENTERS	1, 330, 240	2, 151, 555	5, 102, 009	0, 444, 552	4, 227, 003	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 478	0	ol	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	o	0,		0		192. 00
	19201 RETAIL PHARMACY	ol	0	l o	ol		192. 01
	19202 MARKETI NG	o	0	O	o		192. 02
	19203 BACK AND NECK	О	9, 274	0	0	0	192. 03
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	_ 0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 358, 248	2, 169, 307	5, 102, 009	8, 444, 532	4, 227, 065	202. 00

Heal th Financial Systems

IU HEALTH WEST HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0158

Period:
From 01/01/2017
To 12/31/2017

Part I
Date/Time Prepared:
5/29/2018 11: 42 am

OTHER GENERAL
SERVICE
TRANSPORTATIO
N

SOCIAL
SERVICE
N

Total
Residents
Cost & Post
Stepdown
Adjustments

		Cost Center Description	SOCI AL SERVI CE	OTHER GENERAL SERVICE TRANSPORTATIO N	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	CENED	AL CERVILLE COCT CENTERS	17. 00	18. 00	24. 00	25. 00	26. 00	
1. 00 1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00	00100 00101 00102 00200 00400 00540 00550 00560 00590 00600 00700 00800	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT MOB INTEREST NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES DATA PROCESSING PURCHASING RECEIVING AND STORES ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING						1. 00 1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00	01100 01300 01400 01500 01700 01080	DI ETARY CAFETERIA NURSI NG ADMINI STRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE TRANSPORTATION	390, 723 0					10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00
30. 00		ADULTS & PEDIATRICS	294, 955	38, 339	27, 734, 345	ol	27, 734, 345	30.00
31.00	1	INTENSIVE CARE UNIT	57, 294	10, 481	6, 992, 299	Ö	6, 992, 299	31.00
32.00	1	NEONATAL INTENSIVE CARE UNIT	12, 487	2, 932	2, 060, 119	0	2, 060, 119	
43. 00		NURSERY LARY SERVICE COST CENTERS	25, 987	2, 224	1, 210, 458	UU	1, 210, 458	43.00
50.00	05000	OPERATING ROOM	0	'	11, 094, 693	0	11, 094, 693	50. 00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	16, 133	4, 505, 236	0	4, 505, 236	
54.00		RADI OLOGY-DI AGNOSTI C	0	13, 490 61, 215	6, 394, 838 10, 082, 444	o	6, 394, 838 10, 082, 444	
55. 00		RADI OLOGY-THERAPEUTI C	0	25, 231	2, 895, 660	o	2, 895, 660	
59.00		CARDI AC CATHETERI ZATI ON	0	28, 391	2, 285, 423	0	2, 285, 423	
60. 00 63. 00		LABORATORY BLOOD STORING, PROCESSING, & TRANS.	0	35, 789 1, 212	7, 253, 876 675, 902	0	7, 253, 876 675, 902	60. 00 63. 00
65.00		RESPIRATORY THERAPY	0	6, 303	2, 612, 597	o	2, 612, 597	65.00
66.00	06600	PHYSI CAL THERAPY	0	4, 720	2, 418, 746	0	2, 418, 746	
67.00		OCCUPATIONAL THERAPY	0	1, 426	861, 386	0	861, 386	67.00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	718 17, 278	327, 554 1, 678, 934	0	327, 554 1, 678, 934	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 161	5, 204, 802	Ö	5, 204, 802	
72. 00		IMPL. DEV. CHARGED TO PATIENT	0	38, 271	13, 439, 347	0	13, 439, 347	72. 00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS OTHER ANCILLARY SERVICES	0	35, 223 0	8, 709, 185 0	0	8, 709, 185 0	1
	1	CARDI AC REHABILI TATION	0		-	0	437, 272	
	OUTPA	TIENT SERVICE COST CENTERS		·				
90. 00 90. 02		CLINIC SLEEP LAB	0	0 6, 050	0 898, 411	0	0 898, 411	90. 00 90. 02
91.00		EMERGENCY	0	102, 709	11, 601, 794	0	11, 601, 794	•
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		,	,	0		92.00
110.00		AL PURPOSE COST CENTERS						110 00
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	390, 723	532, 115	131, 375, 321	o	131, 375, 321	113. 00 118. 00
	NONRE	MBURSABLE COST CENTERS	0,0,,20	3327 3	.0.,0.0,02.	91		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	417, 938	0	417, 938	
		PHYSICIANS' PRIVATE OFFICES RETAIL PHARMACY	0		0 27, 427	0	0 27, 427	192. 00 192. 01
		MARKETI NG	0	Ö	662, 089	Ö	662, 089	
		BACK AND NECK	0	o	651, 572	O	651, 572	
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers	^	0	0	0		200. 00 201. 00
202.00		TOTAL (sum lines 118 through 201)	390, 723	532, 115	-	0	133, 134, 347	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 11: 42 am

					5/29/2018 11:	42 am
			CAPITAL REL	ATED COSTS		
Cost Center Description	Directly Assigned New Capital	NEW BLDG & FLXT	MOB	INTEREST	NEW MVBLE EQUIP	
	Related Costs					
CENEDAL CEDIMOS COCT CENTEDO	0	1. 00	1. 01	1. 02	2. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 02 00107 MOD 1. 02 00102 NTEREST						1.01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 O0400 EMPLOYEE BENEFITS DEPARTMENT	o	0	69, 357	o	0	4.00
5. 01 00540 NONPATIENT TELEPHONES	o	7, 365		11, 321	45, 424	5. 01
5. 02 00550 DATA PROCESSING	0	49, 372		75, 899	6, 126	5. 02
5.03 00560 PURCHASING RECEIVING AND STORES	0	53, 859	0	82, 797	0	5. 03
5.04 00590 ADMINISTRATIVE AND GENERAL	0	177, 548	90, 075	272, 943	73, 759	5. 04
6. 00 00600 MAI NTENANCE & REPAI RS	0	773, 089	0	1, 188, 461	420, 156	6.00
7. 00 00700 OPERATION OF PLANT	0	46, 444	0	71, 397	95, 337	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	12, 676 53, 048	9, 219	19, 486 81, 550	650	8. 00 9. 00
10. 00 01000 DI ETARY		48, 117	9, 531	73, 969	4, 222 9, 982	10.00
11. 00 01100 CAFETERI A	l ő	113, 790	7, 331	174, 927	7, 732	11.00
13. 00 01300 NURSING ADMINISTRATION	o	19, 635	ő	30, 184	598	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	90, 352	0	138, 897	77, 094	14.00
15. 00 01500 PHARMACY	o	31, 169	0	47, 916	93, 831	15.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
18. 00 01080 TRANSPORTATION	0	0	0	0	0	18. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		701 105		1 21/ 102	225 275	20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT	0	791, 125 130, 090	0	1, 216, 193 199, 986	325, 275 19, 925	30. 00 31. 00
32. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	38, 331		58, 926	19, 925	32.00
43. 00 04300 NURSERY	l ő	35, 682		54, 854	14, 485	43.00
ANCILLARY SERVICE COST CENTERS	, -,		· · · · · · · · · · · · · · · · · · ·	,		
50.00 05000 OPERATING ROOM	0	367, 011	0	564, 202	851, 878	50.00
51.00 05100 RECOVERY ROOM	0	31, 981	0	49, 164	2, 507	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	186, 218	0	286, 271	75, 993	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	230, 596	0	354, 492	834, 939	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	124, 196	0	190, 925	37, 169 318, 977	55. 00 59. 00
60. 00 06000 LABORATORY		31, 664 46, 482		48, 676 71, 456	310, 977	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		40, 402	0	71, 430	0	63.00
65. 00 06500 RESPI RATORY THERAPY	o	27, 912	Ö	42, 909	39, 465	65.00
66. 00 06600 PHYSI CAL THERAPY	o	1, 521	61, 554	2, 338	10, 178	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 521	61, 554	2, 338	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	1, 521	61, 554	2, 338	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	4, 424	0	6, 801	113, 488	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	73.00
76. 00 03950 OTHER ANCI LLARY SERVICES	l ő	0		o	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	O	0	37, 523	o	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 02 09002 SLEEP LAB	0	1, 990	70, 557	3, 059	742	90.02
91. 00 09100 EMERGENCY	0	197, 614	0	303, 789	67, 089	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 726, 343	470, 924	5, 728, 464	3, 539, 289	
NONREI MBURSABLE COST CENTERS	-	27 . 227 2 . 2		27 1227 12 1	2,221,221	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	34, 714	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192. 01 19201 RETAIL PHARMACY	0	0	23, 119	0		192. 01
192. 02 19202 MARKETI NG	0	0	15, 004	0		192.02
192. 03 19203 BACK AND NECK	0	0	231, 454	0	16, 650	192.03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	0		0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	0	3, 726, 343	_	5, 728, 464	3, 555, 939	
(Sam 11185 116 thi Sugn 201)	· ~	5, . 20, 0 10		-, , 20, 104	5, 555, 757	,

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Cost Center Description	Subtotal	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AND	
	2A	DEPARTMENT 4. 00	5. 01	5. 02	STORES 5. 03	
GENERAL SERVICE COST CENTERS	ZA	4.00	3.01	5. 02	3.03	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 MOB						1. 01
1. 02 00102 I NTEREST						1. 02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	69, 357	69, 357				4.00
5. 01 00540 NONPATI ENT TELEPHONES	64, 110	0	64, 110			5. 01
5. 02 00550 DATA PROCESSING	131, 397	0	0	131, 397		5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES	136, 656	0	0	0	136, 656	5. 03
5. 04 00590 ADMINISTRATIVE AND GENERAL	614, 325	3, 922	2, 016	4, 131	339	5. 04
6. 00 00600 MAI NTENANCE & REPAI RS	2, 381, 706	1, 021	1, 123	2, 302	2	6. 00
7. 00 00700 OPERATION OF PLANT	213, 178	751	1, 001	2, 051	1	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	32, 812	0	0	0	267	8.00
9. 00 00900 HOUSEKEEPI NG	148, 039	1, 480	3, 013	6, 176	175	9.00
10. 00 01000 DI ETARY	141, 599	469	809	1, 658	18	10.00
11. 00 01100 CAFETERI A	288, 717	1, 110	1, 913	3, 920	43	11.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	50, 417	3, 960 435	2, 203 604	4, 514	3 41	13. 00 14. 00
15. 00 01500 PHARMACY	306, 343 172, 916	3, 290	2, 229	1, 238 4, 569	264	15.00
17. 00 01700 SOCIAL SERVICE	172, 910	3, 240	344	706	0	17.00
18. 00 01080 TRANSPORTATI ON		373	773	1, 583	0	18. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	373	770	1,000		10.00
30. 00 03000 ADULTS & PEDIATRICS	2, 332, 593	13, 972	13, 318	27, 301	7, 503	30.00
31.00 03100 INTENSIVE CARE UNIT	350, 001	3, 894	2, 991	6, 130	2, 361	31.00
32.00 02060 NEONATAL INTENSIVE CARE UNIT	97, 257	1, 398	901	1, 846	324	32.00
43. 00 04300 NURSERY	105, 021	599	490	1, 004	354	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 783, 091	3, 974	3, 381	6, 929	21, 771	50.00
51. 00 05100 RECOVERY ROOM	83, 652	3, 424	2, 636	5, 403	948	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	548, 482	3, 166	2, 588	5, 305	1, 847	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 420, 027	5, 800	5, 230	10, 719	3, 761	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 59. 00 05900 CARDI AC CATHETERI ZATI ON	352, 290 399, 317	1, 126 997	806 759	1, 653 1, 555	116 2, 504	55. 00 59. 00
60. 00 06000 LABORATORY	117, 938	997	2, 838	5, 816	2,504	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	117, 730	0	2, 030	3, 010	3, 058	63.00
65. 00 06500 RESPIRATORY THERAPY	110, 286	2, 116	1, 739	3, 564	820	65. 00
66. 00 06600 PHYSI CAL THERAPY	75, 591	2, 078	1, 626	3, 332	803	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	65, 413	737	500	1, 025	16	67.00
68. 00 06800 SPEECH PATHOLOGY	65, 413	231	151	310	4	68. 00
69. 00 06900 ELECTROCARDI OLOGY	124, 713	1, 125	929	1, 904	209	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	23, 546	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	60, 729	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICES	0	0	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	37, 523	340	346	709	55	76. 97
OUTPATIENT SERVICE COST CENTERS		0		0	0	00.00
90. 00 09000 CLINI C	74 240	0	0	0	-	90.00
90. 02 09002 SLEEP LAB 91. 00 09100 EMERGENCY	76, 348 568, 492	6, 880	6, 409	13, 135	144 4, 630	90. 02 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 300, 492	0, 000	0, 409	13, 133	4, 630	92.00
SPECIAL PURPOSE COST CENTERS	0					72.00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 465, 020	69, 023	63, 666	130, 488	136, 656	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 714	132	212	434	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
192. 01 19201 RETAIL PHARMACY	23, 119	0	0	0		192. 01
192. 02 19202 MARKETI NG	15, 004	0	0	0		192. 02
192. 03 19203 BACK AND NECK	248, 104	202	232	475	0	192. 03
200.00 Cross Foot Adjustments	0	_	_	_	_	200.00
201.00 Negative Cost Centers	12 705 041	40.357	(4 110	121 207		201.00
202.00 TOTAL (sum lines 118 through 201)	13, 785, 961	69, 357	64, 110	131, 397	136, 656	12U2. UU

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	Cost Center Description	ADMI NI STRATI V		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		E AND GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 04	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 MOB						1. 01
1.02	00102 I NTEREST						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00590 ADMINISTRATIVE AND GENERAL	624, 733					5. 04
6. 00	00600 MAI NTENANCE & REPAI RS	24, 544	2, 410, 698				6.00
7. 00	00700 OPERATION OF PLANT	15, 299	42, 010				7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 023	11, 466				8.00
9. 00	00900 HOUSEKEEPI NG		47, 984			237, 133	9.00
		24, 710				-	1
10.00	01000 DI ETARY	5, 161	43, 524			4, 469	10.00
11.00	01100 CAFETERI A	7, 311	102, 927			10, 569	1
13. 00	01300 NURSING ADMINISTRATION	23, 033	17, 760			1, 824	13.00
	01400 CENTRAL SERVICES & SUPPLY	37, 235	81, 727			8, 392	14.00
15. 00	01500 PHARMACY	18, 492	28, 194			2, 895	
17. 00	01700 SOCIAL SERVICE	1, 769	0	0	0	0	17. 00
18.00	01080 TRANSPORTATI ON	2, 352	0	0	0	0	18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	88, 104	715, 605	82, 867	25, 223	73, 486	30.00
31.00	03100 INTENSIVE CARE UNIT	24, 679	117, 672	13, 626	0	12, 084	31.00
32.00	02060 NEONATAL INTENSIVE CARE UNIT	7, 335	34, 672	4, 015	80	3, 560	32.00
43.00	04300 NURSERY	3, 668	32, 276	3, 737	o	3, 314	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	33, 606	331, 976	38, 442	3, 945	34, 090	50.00
51.00	05100 RECOVERY ROOM	17, 308	28, 928			2, 971	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22, 350	168, 442			17, 297	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	38, 428	208, 583			21, 419	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	9, 977	112, 340			11, 536	•
59. 00	05900 CARDI AC CATHETERI ZATI ON	8, 625	28, 641			2, 941	•
60.00	06000 LABORATORY	32, 167	42, 045			4, 318	•
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	2, 274	42, 043			4, 310	63.00
			-		-		1
65.00	06500 RESPI RATORY THERAPY	10, 961	25, 247			2, 593	65.00
66.00	06600 PHYSI CAL THERAPY	10, 750	1, 376			141	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	3, 896	1, 376			141	67.00
68. 00	06800 SPEECH PATHOLOGY	1, 466	1, 376	•		141	1
69. 00	06900 ELECTROCARDI OLOGY	7, 275	4, 002			411	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 509	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	45, 160	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	22, 301	0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICES	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 961	0	0	3	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 02	09002 SLEEP LAB	4, 086	1, 800	208	363	185	90.02
91.00	09100 EMERGENCY	41, 747	178, 749	20, 699	10, 634	18, 356	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					,	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 NTEREST EXPENSE						113.00
118. 00		616, 562	2, 410, 698	274, 291	46, 896	237, 133	
110.00	NONREI MBURSABLE COST CENTERS	010,002	2, 110, 070	271,271	10, 070	207, 100	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 921	0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	19201 RETAIL PHARMACY	129	0				192.00
	19201 RETAIL PHARMACY		0	· -	-		192.01
		3, 107	0	1			
	19203 BACK AND NECK	3, 014	0	0		0	192.03
200.00			_	_		_	200.00
201. 00	Negative Cost Centers	0	0	1 0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	624, 733	2, 410, 698	274, 291	46, 896	237, 133	202 22

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		Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	
			10. 00	11. 00	N 13. 00	SUPPLY 14. 00	15. 00	
	CENED	AL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
1. 00		NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101							1. 01
1. 02	1	INTEREST						1. 02
2. 00	1	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		NONPATIENT TELEPHONES						5. 01
5.02	00550	DATA PROCESSING						5. 02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04		ADMINISTRATIVE AND GENERAL						5. 04
6. 00		MAINTENANCE & REPAIRS						6. 00
7. 00		OPERATION OF PLANT						7. 00
8.00		LAUNDRY & LINEN SERVICE						8.00
9.00	1	HOUSEKEEPI NG	202 747					9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	202, 747	120 120				10.00 11.00
13.00		NURSING ADMINISTRATION	0	428, 429 17, 399				13.00
14. 00		CENTRAL SERVICES & SUPPLY	0	4, 770		450, 249		14.00
15. 00	1	PHARMACY	0	17, 611		876	254, 921	15.00
17. 00	1	SOCI AL SERVI CE	0	2, 720		0	0	17. 00
18. 00	1	TRANSPORTATI ON	ol	6, 103		o	0	18. 00
		IENT ROUTINE SERVICE COST CENTERS	- '		·	- 1		
30.00		ADULTS & PEDIATRICS	153, 053	105, 225	51, 854	24, 881	3, 682	30. 00
31.00	03100	INTENSIVE CARE UNIT	29, 730	23, 625	11, 604	7, 831	1, 215	31.00
32.00		NEONATAL INTENSIVE CARE UNIT	6, 479	7, 114		1, 074	100	32. 00
43.00		NURSERY	13, 485	3, 868	1, 856	1, 175	0	43.00
		LARY SERVICE COST CENTERS			T			
50.00		OPERATING ROOM	0	26, 707		72, 198	2, 463	
51.00	1	RECOVERY ROOM	0	20, 823		3, 143	83	
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	20, 447		6, 125	1 222	52.00
55. 00		RADI OLOGY-DI AGNOSTI C	0	41, 311 6, 369		12, 473 384	1, 233 21	54. 00 55. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	5, 993		8, 305	413	
60.00		LABORATORY	0	22, 415		0, 303	0	60.00
63.00	1	BLOOD STORING, PROCESSING, & TRANS.	o	0		10, 140	0	63. 00
65.00	1	RESPI RATORY THERAPY	0	13, 736	1	2, 720	0	65.00
66.00	06600	PHYSI CAL THERAPY	0	12, 841	0	2, 663	3	66.00
67.00	06700	OCCUPATI ONAL THERAPY	0	3, 950	0	53	32	67.00
68.00	06800	SPEECH PATHOLOGY	0	1, 196	0	12	0	68. 00
69. 00		ELECTROCARDI OLOGY	0	7, 340	887	693	47	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	_	78, 084	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENT	0	0	0	201, 408	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	236, 497	73.00
76.00	1	OTHER ANCILLARY SERVICES	0	0	-	0	0	76.00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	U	2, 734	0	181	2	76. 97
90. 00		CLINIC	0	0	0	0	0	90.00
90.00	1	SLEEP LAB	0	0	_	476	0	
91. 00		EMERGENCY	0	50, 626		15, 354	9, 130	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	o l	00,020	10, 771	10,001	7, 100	92.00
72.00		AL PURPOSE COST CENTERS			l l			72.00
113.00		INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	202, 747	424, 923	123, 170	450, 249	254, 921	
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 674	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	O	0	0	0		192. 00
		RETAIL PHARMACY	0	0	0	0		192. 01
		MARKETI NG	0	0	0	0		192. 02
		BACK AND NECK	0	1, 832	0	0		192. 03
200.00		Cross Foot Adjustments		^				200. 00 201. 00
201. 00 202. 00		Negative Cost Centers TOTAL (sum lines 118 through 201)	202, 747	0 428, 429	- 1	450, 249	254, 921	
202.00	1	TOTAL (Sum Times The through 201)	202, 141	720, 727	123, 170	430, 247	204, 721	1202.00

| Period: | Worksheet B | From 01/01/2017 | Part II | To | 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0158

				T-	o 12/31/2017	Date/Time Pre	
			OTHER GENERAL			5/29/2018 11:	42 alli
			SERVI CE				
	Cost Center Description	SOCI AL	TRANSPORTATIO	Subtotal	Intern &	Total	
		SERVI CE	N		Residents		
					Cost & Post Stepdown		
					Adjustments		
		17. 00	18. 00	24. 00	25. 00	26. 00	
	ERAL SERVICE COST CENTERS						
	OO NEW CAP REL COSTS-BLDG & FIXT						1.00
	01 MOB						1.01
	02 INTEREST 00 NEW CAP REL COSTS-MVBLE EQUIP						1. 02 2. 00
	OO EMPLOYEE BENEFITS DEPARTMENT						4.00
	40 NONPATI ENT TELEPHONES						5. 01
5. 02 005	DATA PROCESSING						5. 02
1	660 PURCHASING RECEIVING AND STORES						5. 03
1	90 ADMINISTRATIVE AND GENERAL						5.04
	OO MAINTENANCE & REPAIRS OO OPERATION OF PLANT						6. 00 7. 00
	OO LAUNDRY & LINEN SERVICE						8.00
1	HOUSEKEEPI NG						9.00
	000 DI ETARY						10.00
	OO CAFETERI A						11.00
	NURSING ADMINISTRATION						13.00
	OO CENTRAL SERVICES & SUPPLY						14.00
	000 PHARMACY 000 SOCI AL SERVI CE	5, 894					15. 00 17. 00
	080 TRANSPORTATION	0,074	11, 184				18.00
	ATIENT ROUTINE SERVICE COST CENTERS		1.17.101				10.00
	000 ADULTS & PEDIATRICS	4, 450	833		0	3, 723, 950	
1	00 INTENSIVE CARE UNIT	864	228		0	608, 535	
1	060 NEONATAL INTENSIVE CARE UNIT	188		· ·	0	170, 608	
	OO NURSERY	392	48	171, 287	0	171, 287	43.00
	OOO OPERATING ROOM	0	1, 581	2, 372, 284	0	2, 372, 284	50.00
51. 00 051	OO RECOVERY ROOM	0	351		0	184, 201	51.00
	DELIVERY ROOM & LABOR ROOM	0	293		0	825, 497	
	OO RADI OLOGY-DI AGNOSTI C	0	1, 331		0	1, 802, 863	
1	000 RADI OLOGY-THERAPEUTI C 000 CARDI AC CATHETERI ZATI ON	0	549 617	· ·	0	511, 575 465, 335	
	OO LABORATORY	0	778	· ·	0	233, 184	
1	000 BLOOD STORING, PROCESSING, & TRANS.	0	26	· ·	o	15, 498	
65. 00 065	000 RESPI RATORY THERAPY	0	137	176, 843	0	176, 843	65.00
	000 PHYSI CAL THERAPY	0	103	· ·	0	111, 466	
	OO OCCUPATIONAL THERAPY	0	31		0	77, 329	1
	000 SPEECH PATHOLOGY 000 ELECTROCARDI OLOGY	0	16 376		0	70, 475 150, 374	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	199	· ·	o	119, 338	1
	OO IMPL. DEV. CHARGED TO PATIENT	0	832	· ·	- 1	308, 129	
	OO DRUGS CHARGED TO PATIENTS	0	766	259, 564	0	259, 564	73.00
	50 OTHER ANCILLARY SERVICES	0			0	0	
	97 CARDI AC REHABI LI TATI ON	0	46	43, 900	0	43, 900	76. 97
	PATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	002 SLEEP LAB	0	132		o	83, 742	
	OO EMERGENCY	0	1, 847			965, 679	
	OO OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	CIAL PURPOSE COST CENTERS						
	SUPTOTALS (SUM OF LINES 1 through 117)	5, 894	11 104	10 451 454	0	10 451 454	113.00
118. 00 NON	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	5, 894	11, 184	13, 451, 656	U	13, 451, 656	1118.00
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	39, 087	0	39. 087	190. 00
192. 00 192	00 PHYSICIANS' PRIVATE OFFICES	0	o	0	o		192. 00
	01 RETAIL PHARMACY	0	0	23, 248	О	23, 248	
	02 MARKETI NG	0	0	18, 111	0		192.02
192. 03 192 200. 00	OS BACK AND NECK	0	0	253, 859 0	0	253, 859	192. 03 200. 00
200.00	Cross Foot Adjustments Negative Cost Centers	n	n	0	0		200.00
202.00	TOTAL (sum lines 118 through 201)	5, 894	11, 184	13, 785, 961	o	13, 785, 961	
'	, , , , , , , , , , , , , , , , , , , ,		,	,	-1		•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0158

					To	12/31/2017	Date/Time Pre 5/29/2018 11:	
				CAPI TAL REI	LATED COSTS		372772010 11.	42 aiii
		Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	MOB (MOB SQUARE FEET)	INTEREST (SQUARE FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1. 00	1. 01	1. 02	2. 00	4. 00	
		AL SERVICE COST CENTERS						
1. 00 1. 01 1. 02 2. 00 4. 00	00101 00102 00200 00400	INTEREST NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	312, 051 18, 075 0	32, 291 0 2, 889	293, 976 0	3, 192, 906 0	45, 241, 067	1. 00 1. 01 1. 02 2. 00 4. 00
5. 01 5. 02 5. 03	00550 00560	NONPATIENT TELEPHONES DATA PROCESSING PURCHASING RECEIVING AND STORES	581 3, 895 4, 249	0 0	3, 895 4, 249	40, 787 5, 501 0	0 0	5. 01 5. 02 5. 03
5. 04 6. 00 7. 00 8. 00 9. 00	00600 00700 00800	ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING	14, 007 60, 990 3, 664 1, 000 4, 185	3, 752 0 0 0 384	60, 990 3, 664 1, 000	66, 229 377, 261 85, 604 584 3, 791	2, 558, 106 666, 276 489, 810 0 965, 574	5. 04 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 13. 00 14. 00 15. 00	01000 01100 01300 01400	DI ETARY CAFETERI A NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY PHARMACY	3, 796 8, 977 1, 549 7, 128 2, 459	397 0 0 0 0	3, 796 8, 977 1, 549 7, 128	8, 963 0 537 69, 223 84, 252	305, 788 723, 956 2, 582, 961 283, 766 2, 145, 965	10. 00 11. 00 13. 00 14. 00 15. 00
17. 00 18. 00	01700 01080	SOCIAL SERVICE TRANSPORTATION IENT ROUTINE SERVICE COST CENTERS	0 0	0	0	0 0	231, 335 243, 401	17. 00 18. 00
30. 00 31. 00 32. 00 43. 00	03100 02060 04300	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT NURSERY	62, 413 10, 263 3, 024 2, 815	0 0 0 0	10, 263 3, 024	292, 067 17, 891 0 13, 006	9, 114, 098 2, 540, 369 911, 792 390, 789	30. 00 31. 00 32. 00 43. 00
50. 00 51. 00 52. 00	05000 05100	LARY SERVICE COST CENTERS OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	28, 954 2, 523 14, 691	0	2, 523	764, 907 2, 251 68, 235	2, 592, 188 2, 233, 494 2, 065, 112	50. 00 51. 00 52. 00
54. 00 55. 00 59. 00 60. 00	05400 05500 05900 06000	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C CARDI AC CATHETERI ZATI ON LABORATORY	18, 192 9, 798 2, 498 3, 667	0 0 0 0	18, 192 9, 798 2, 498 3, 667	749, 698 33, 374 286, 412 0	3, 783, 649 734, 384 650, 285 0	54. 00 55. 00 59. 00 60. 00
63. 00 65. 00 66. 00 67. 00 68. 00	06500 06600 06700 06800	BLOOD STORING, PROCESSING, & TRANS. RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0 2, 202 120 120 120	0 0 2, 564 2, 564 2, 564	2, 202 120 120 120	0 35, 436 9, 139 0 0	0 1, 380, 449 1, 355, 495 480, 495 150, 360	63. 00 65. 00 66. 00 67. 00 68. 00
69. 00 71. 00 72. 00 73. 00 76. 00	07100 07200 07300	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENTS IMPL. DEV. CHARGED TO PATI ENT DRUGS CHARGED TO PATI ENTS OTHER ANCI LLARY SERVI CES	349 0 0 0	0 0 0 0	0 0	101, 902 0 0 0 0	733, 682 0 0 0 0	
76. 97 90. 00	OUTPA	CARDIAC REHABILITATION TIENT SERVICE COST CENTERS CLINIC	0	1, 563	0	0	221, 787	76. 97 90. 00
90. 02 91. 00 92. 00	09002 09100 09200 SPECI	SLEEP LAB EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS	157 15, 590	2, 939 0	157	666 60, 240	4, 487, 847	90. 02 91. 00 92. 00
113.00	D	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	312, 051	19, 616	293, 976	3, 177, 956	45, 023, 213	113. 00 118. 00
192. 00 192. 01	19000 19200 19201	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES RETAIL PHARMACY	0 0 0	1, 446 0 963	0	0 0 0	0	192. 00 192. 01
	19203	MARKETING BACK AND NECK Cross Foot Adjustments Negative Cost Centers	0	625 9, 641		0 14, 950	0 131, 700	192. 02 192. 03 200. 00 201. 00
202.00		Cost to be allocated (per Wkst. B, Part I)	3, 955, 456	775, 215		3, 555, 939	7, 490, 592	202. 00
203.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	12. 675672	24. 007154	19. 486162	1. 113700	0. 165571 69, 357	204. 00
205.00	7	Unit cost multiplier (Wkst. B, Part					0. 001533	∠U5. UU

Health Financial Systems		IU HEALTH WEST HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der C		Peri od:	Worksheet B-1		
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 11:		
	Cost Center Description	NEW BLDG &	MOB	INTEREST	NEW MVBLE	EMPLOYEE		
		FI XT	(MOB SQUARE	(SQUARE FEET)		BENEFI TS		
		(SQUARE FEET)	FEET)		(DOLLAR	DEPARTMENT		
					VALUE)	(GROSS		
						SALARI ES)		
		1.00	1. 01	1. 02	2. 00	4. 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
COST ALLOCATION - STATISTICAL BASIS IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0158

					To	12/31/2017	Date/Time Pre 5/29/2018 11:	
		Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	Reconciliatio	ADMI NI STRATI V	12 (3
			TELEPHONES (FTES)	PROCESSING (FTES)	RECEIVING AND STORES	n	E AND GENERAL (ACCUM.	
			(11123)	(LILS)	(PURCHASED		COST)	
					REQ)			
	CENED	AL SERVICE COST CENTERS	5. 01	5. 02	5. 03	5A. 04	5. 04	
1. 00		NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101	•						1. 01
1. 02	1	I NTEREST						1.02
2. 00 4. 00	1	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 01	1	NONPATI ENT TELEPHONES	74, 105					5. 01
5. 02		DATA PROCESSING	0	74, 105				5. 02
5. 03		PURCHASING RECEIVING AND STORES	0	0	,	00 011 07/	440 000 474	5.03
5. 04 6. 00		ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS	2, 330 1, 298	2, 330 1, 298		-20, 911, 876 0	112, 222, 471 4, 408, 813	5. 04 6. 00
7. 00		OPERATION OF PLANT	1, 157	1, 157		o	2, 748, 164	7.00
8.00		LAUNDRY & LINEN SERVICE	0	0		0	183, 767	8. 00
9.00		HOUSEKEEPI NG	3, 483	3, 483		0	4, 438, 737	9.00
10. 00 11. 00		DI ETARY CAFETERI A	935 2, 211	935 2, 211		0	927, 004 1, 313, 267	1
13. 00		NURSI NG ADMI NI STRATI ON	2, 546	2, 546		0	4, 137, 441	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	698	698	5, 231	0	6, 688, 599	
15.00		PHARMACY	2, 577	2, 577		0	3, 321, 751	1
17. 00 18. 00		SOCIAL SERVICE TRANSPORTATION	398 893	398 893		0	317, 742 422, 487	17. 00 18. 00
10.00		IENT ROUTINE SERVICE COST CENTERS	073	073	<u> </u>	<u>0</u>	422, 407	10.00
30.00	1	ADULTS & PEDIATRICS	15, 397	15, 397		0	15, 828, 235	
31.00		INTENSIVE CARE UNIT	3, 457	3, 457		0	4, 433, 072	1
32. 00 43. 00		NEONATAL INTENSIVE CARE UNIT NURSERY	1, 041 566	1, 041 566		0	1, 317, 573 658, 922	
10.00		LARY SERVICE COST CENTERS	000	300	10, 010	<u> </u>	000, 722	10.00
50.00		OPERATING ROOM	3, 908	3, 908		0	6, 036, 618	
51. 00 52. 00	1	RECOVERY ROOM	3, 047	3, 047		0	3, 109, 029	
54.00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	2, 992 6, 045	2, 992 6, 045		0	4, 014, 683 6, 902, 852	
55. 00	1	RADI OLOGY-THERAPEUTI C	932	932		Ö	1, 792, 092	
59. 00		CARDI AC CATHETERI ZATI ON	877	877		0	1, 549, 301	
60. 00 63. 00	1	LABORATORY BLOOD STORING, PROCESSING, & TRANS.	3, 280	3, 280 0		0	5, 778, 153 408, 409	
65.00		RESPIRATORY THERAPY	2, 010	2, 010		0	1, 968, 885	
66. 00		PHYSI CAL THERAPY	1, 879	1, 879		Ō	1, 931, 017	1
67.00	1	OCCUPATIONAL THERAPY	578	578		0	699, 849	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	175 1, 074	175 1, 074		0	263, 316 1, 306, 719	
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 0,4		0	3, 145, 070	
72.00	1	IMPL. DEV. CHARGED TO PATIENT	0	0		0	8, 112, 060	
73.00		DRUGS CHARGED TO PATIENTS	0	0		0	4, 005, 916	1
76. 00 76. 97		OTHER ANCILLARY SERVICES CARDIAC REHABILITATION	400	0 400		0	0 352, 254	
70. 77		TIENT SERVICE COST CENTERS	400	400	0, 773	<u> </u>	332, 234	70.77
90.00	09000	CLINIC	0	0	0	0	0	90.00
90. 02	1	SLEEP LAB	7 400	7 400	18, 368	0	733, 969	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	7, 408	7, 408	592, 518	0	7, 498, 939	91.00 92.00
72.00		AL PURPOSE COST CENTERS						72.00
	1	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	73, 592	73, 592	17, 488, 925	-20, 911, 876	110, 754, 705	118.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	245	245	0	0	345, 145	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	1	Ö		192.00
		RETAIL PHARMACY	0	0	0	0	23, 119	
		MARKETI NG BACK AND NECK	0 268	0 268	0	0	558, 092 541, 410	
200.00		Cross Foot Adjustments	200	200	l	o _l	541, 410	200.00
201.00		Negative Cost Centers						201.00
202.00)	Cost to be allocated (per Wkst. B,	129, 568	4, 796, 326	764, 710		20, 911, 876	202. 00
203.00		Part I) Unit cost multiplier (Wkst. B, Part I)	1. 748438	64. 723379	0. 043725		0. 186343	203 00
204.00	1	Cost to be allocated (per Wkst. B,	64, 110	131, 397			624, 733	
		Part II)						
205. 00		Unit cost multiplier (Wkst. B, Part	0. 865124	1. 773119	0. 007814		0. 005567	205. 00
206. 00								206. 00
		(per Wkst. B-2)						

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				rom 01/01/2017		
				Γο 12/31/2017		
					5/29/2018 11:	
Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	Reconciliatio	ADMI NI STRATI V	
	TELEPHONES	PROCESSI NG	RECEIVING AND	n	E AND GENERAL	
	(FTES)	(FTES)	STORES		(ACCUM.	
			(PURCHASED		COST)	
			REQ)			
	5. 01	5. 02	5. 03	5A. 04	5. 04	
207.00 NAHE unit cost multiplier (Wkst. D,		-				207.00
Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2017 Provi der CCN: 15-0158

				o 12/31/2017	Date/Time Pre 5/29/2018 11:	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	42 aiii
	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(TOTAL PATIENT DAYS)	
	,		LAUNDRY)		,	
GENERAL SERVICE COST CENTERS	6. 00	7.00	8.00	9. 00	10. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 MOB						1.01
1. 02 00102 NTEREST 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 02 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04 00590 ADMI NI STRATI VE AND GENERAL						5. 04
6. 00 00600 MAI NTENANCE & REPAI RS	210, 254	204 500				6.00
7. 00 00700 0PERATI ON OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	3, 664 1, 000	206, 590 1, 000	i			7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	4, 185	4, 185	0	201, 405		9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	3, 796 8, 977	3, 796 8, 977	l .	3, 796 8, 977	30, 477 0	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 549	l '	l .		0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	7, 128	7, 128	0	7, 128	0	14.00
15. 00 01500 PHARMACY 17. 00 01700 SOCI AL SERVI CE	2, 459	2, 459 0	i	2, 459 0	0	15. 00 17. 00
18. 00 01/00 30CTAL SERVICE 18. 00 01080 TRANSPORTATION	0			_	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	62, 413 10, 263		1		23, 007 4, 469	30. 00 31. 00
32. 00 02060 NEONATAL INTENSIVE CARE UNIT	3, 024	3, 024	l .		974	32.00
43. 00 04300 NURSERY	2, 815		1	2, 815	2, 027	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	28, 954	20.054	7/ 025	20.054	0	FO 00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	28, 954	28, 954 2, 523	1	28, 954 2, 523	0	50. 00 51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	14, 691	14, 691	0	14, 691	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	18, 192 9, 798	18, 192	1		0	54. 00 55. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 498		1		0	59.00
60. 00 06000 LABORATORY	3, 667	3, 667	0		0	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 65. 00 06500 RESPIRATORY THERAPY	2, 202	0 2, 202	_	0 2, 202	0	63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	120	l '	1	120	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	120	120	0	120	0	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	120 349	l e	1	120 349	0	68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ł		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03950 OTHER ANCI LLARY SERVI CES	0	0	0	0	0	73. 00 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C 90. 02 09002 SLEEP LAB	157		7, 071	157	0	90. 00 90. 02
91. 00 09100 EMERGENCY	15, 590	l .			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	210, 254	206, 590	914, 634	201, 405	30, 477	
NONREI MBURSABLE COST CENTERS						400.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0		0	0		190. 00 192. 00
192. 01 19201 RETAIL PHARMACY	0		Ö	0	0	192. 01
192. 02 19202 MARKETI NG	0	0	0	0		192.02
192.03 19203 BACK AND NECK 200.00 Cross Foot Adjustments	0	0	0	0	0	192. 03 200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	5, 230, 364	3, 351, 412	259, 110	5, 437, 864	1, 358, 248	202. 00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	24. 876407	16. 222528	0. 283294	26. 999647	44. 566329	203. 00
204.00 Cost to be allocated (per Wkst. B,	2, 410, 698	ł	1		202, 747	
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	11 14544	1 227707	0.051272	1 177204	6. 652459	205 00
205.00 Unit cost multiplier (Wkst. B, Part	11. 465646	1. 327707	0. 051273	1. 177394	0. 052459	200.00
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)	<u> </u>					_57.00

Heal th	Fi nar	cial Systems	IU HEALTH WES	ST_HOSPITAL		In Lie	u of Form CMS-	2552-1 <u>0</u>
COST A	LLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2017	Worksheet B-1	
						To 12/31/2017		
		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/29/2018 11: SOCIAL	42 am
		cost center bescription	(FTES)	ADMI NI STRATI O	SERVICES &	(COSTED	SERVI CE	
				N	SUPPLY	REQUIS.)	(TOTAL	
				(DIRECT NURS FTES)	(PURCHASED REQ)		PATIENT DAYS)	
			11. 00	13. 00	14. 00	15.00	17. 00	
		AL SERVICE COST CENTERS				1		
1. 00 1. 01	00100	NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01	1	INTEREST						1.01
2. 00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02		NONPATIENT TELEPHONES DATA PROCESSING						5. 01 5. 02
5. 02		PURCHASING RECEIVING AND STORES						5.03
5.04	00590	ADMINISTRATIVE AND GENERAL						5. 04
6.00		MAINTENANCE & REPAIRS						6.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00		HOUSEKEEPI NG						9.00
10.00		DI ETARY						10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	62, 691					11.00
14. 00		CENTRAL SERVICES & SUPPLY	2, 546 698		1	2		14.00
15. 00		PHARMACY	2, 577	78				15. 00
17.00		SOCIAL SERVICE	398		1	0 0	30, 477	1
18. 00		TRANSPORTATION I ENT ROUTINE SERVICE COST CENTERS	893	0		0 0	0	18.00
30.00		ADULTS & PEDIATRICS	15, 397	12, 628	960, 18	62, 365	23, 007	30.00
31.00		INTENSIVE CARE UNIT	3, 457		1	·	4, 469	1
32. 00 43. 00		NEONATAL INTENSIVE CARE UNIT NURSERY	1, 041 566		1	·	l .	1
43.00		LARY SERVICE COST CENTERS	300	452	45, 34	8 0	2, 027	43.00
50.00	05000	OPERATING ROOM	3, 908	1, 980	2, 786, 16	2 41, 712	0	50.00
51.00		RECOVERY ROOM	3, 047	2, 723		· ·	0	
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	2, 992 6, 045				0	
55. 00		RADI OLOGY-THERAPEUTI C	932				Ö	
59. 00		CARDI AC CATHETERI ZATI ON	877	329	1		0	
60. 00 63. 00	1	LABORATORY BLOOD STORING, PROCESSING, & TRANS.	3, 280 0	0	1	0 0	0	60.00
65.00		RESPIRATORY THERAPY	2, 010		1		0	
66.00		PHYSI CAL THERAPY	1, 879	0	102, 76	0 44	0	
67.00		OCCUPATIONAL THERAPY	578		_, -,		0	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	175 1, 074		46 26, 72		0	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			Ö	1
	1	IMPL. DEV. CHARGED TO PATIENT	0	0	1 ' '		0	
73. 00 76. 00		DRUGS CHARGED TO PATIENTS OTHER ANCILLARY SERVICES	0	1		0 4, 005, 915	0	
		CARDI AC REHABI LI TATI ON	400		6, 99	3 26	1	1
	OUTPA	TIENT SERVICE COST CENTERS						1
		CLI NI C SLEEP LAB	0	0	10.24	0	0	
90. 02 91. 00		EMERGENCY	7, 408	4, 625	18, 36 592, 51		0	
		OBSERVATION BEDS (NON-DISTINCT PART)	77 100	1,7 02 0	37273.	1017012	J	92.00
440.00		AL PURPOSE COST CENTERS		T	1	T	I	
113. 00 118. 00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	62, 178	29, 996	17, 375, 13	4, 317, 978	30 477	113. 00 118. 00
110.00		IMBURSABLE COST CENTERS	02, 176	27, 770	17, 375, 13	4, 317, 970	30, 477	1118.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	245	0	1	0 0		190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	1	0 0		192. 00 192. 01
		RETAIL PHARMACY MARKETING	0	0	1	0 0		192.01
		BACK AND NECK	268	Ö		0 0		192. 03
200.00		Cross Foot Adjustments						200.00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 169, 307	5, 102, 009	8, 444, 53	4, 227, 065	390, 723	201.00
202.00		Part I)	2, 107, 307	3, 102, 009	0, 444, 53	4, 221, 000	370, 723	202.00
203.00	1	Unit cost multiplier (Wkst. B, Part I)	34. 603165		l .		l	•
204.00)	Cost to be allocated (per Wkst. B, Part II)	428, 429	123, 170	450, 24	9 254, 921	5, 894	204.00
205. 00)	Unit cost multiplier (Wkst. B, Part	6. 833979	4. 106214	0. 02591	3 0. 059037	0. 193392	205.00
		11)						
206. 00	,	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
	T.	(F-: 5 L)	İ	l .	I	TI.	ı	1

Health Financial Systems	IU HEALTH WE	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od: From 01/01/2017	Worksheet B-1	
				To 12/31/2017		
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	SOCI AL	
	(FTES)	ADMI NI STRATI O	SERVICES &	(COSTED	SERVI CE	
		N	SUPPLY	REQUIS.)	(TOTAL	
		(DI RECT	(PURCHASED		PATIENT DAYS)	
		NURS FTES)	REQ)			
	11. 00	13. 00	14.00	15. 00	17. 00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/29/2018 11: 42 am Provider CCN: 15-0158 OTHER GENERAL SERVI CE Cost Center Description TRANSPORTATI 0 Ν (GROSS CHARGES) 18. 00 GENERAL SERVICE COST CENTERS

00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 MOB 00102 INTEREST 00200 NEW CAP REL COSTS-MVBLE EQUIP 1.01 1.01 1.02 1.02

2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00590 ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01700 SOCIAL SERVICE 01080 TRANSPORTATION INPATIENT ROUTINE SERVICE COST CENTERS	826, 783, 250	2.00 4.00 5.01 5.02 5.03 5.04 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 17.00
30.00	03000 ADULTS & PEDIATRICS	59, 532, 047	30.00
31. 00	03100 NTENSI VE CARE UNI T	16, 274, 935	31.00
32.00	02060 NEONATAL INTENSIVE CARE UNIT	4, 553, 512	32.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	3, 452, 915	43.00
50. 00	05000 OPERATING ROOM	112, 920, 812	50.00
51. 00	05100 RECOVERY ROOM	25, 050, 903	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	20, 947, 172	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	95, 054, 004	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	39, 179, 330	55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	44, 085, 348	59.00
60.00	06000 LABORATORY	55, 573, 595	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 881, 992	63.00
65.00	06500 RESPI RATORY THERAPY	9, 787, 135	65.00
66.00	06600 PHYSI CAL THERAPY	7, 329, 365	66.00
67.00	06700 OCCUPATI ONAL THERAPY	2, 214, 057	67.00
68. 00	06800 SPEECH PATHOLOGY	1, 115, 058	68. 00
69. 00	06900 ELECTROCARDI OLOGY	26, 829, 236	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 224, 983	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	59, 426, 524	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	54, 694, 232	73.00
76. 00 76. 97	03950 OTHER ANCILLARY SERVICES 07697 CARDIAC REHABILITATION	2 257 747	76. 00 76. 97
70. 97	OUTPATIENT SERVICE COST CENTERS	3, 257, 747	70.97
90. 00	09000 CLINIC	O	90.00
90. 02	09002 SLEEP LAB	9, 394, 036	90.02
91. 00	09100 EMERGENCY	160, 004, 312	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, , .	92.00
	SPECIAL PURPOSE COST CENTERS		
113.00	11300 I NTEREST EXPENSE		113. 00
118.00		826, 783, 250	118. 00
	NONREI MBURSABLE COST CENTERS		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	192. 00
	19201 RETAIL PHARMACY	0	192. 01
	19202 MARKETI NG	0	192. 02
	19203 BACK AND NECK	0	192. 03 200. 00
200. 00 201. 00			200.00
201.00		532, 115	201.00
202. UC	Part I)	JSZ, 115	202.00
203.00		0. 000644	203. 00
204.00		11, 184	204.00
	Part II)	,	
205.00	1 1 /	0. 000014	205.00
206.00	NAHE adjustment amount to be allocated		206.00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0158		Worksheet B-1
			From 01/01/2017	
			To 12/31/2017	
	1			5/29/2018 11:42 am
	OTHER GENERAL			
	SERVI CE			
Cost Center Description	TRANSPORTATI 0			
	N			
	(GROSS			
	CHARGES)			
	18. 00			
207.00 NAHE unit cost multiplier (Wkst. D,		· ·		207. 00
Parts III and IV)				

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Peri od:	Worksheet C
		From 01/01/2017	
		To 10/01/0017	Data /Tima Dranarad.

				o 12/31/2017	Date/Time Pre 5/29/2018 11:	pared: 42 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	27, 734, 345		27, 734, 345		27, 734, 345	
31.00 03100 INTENSIVE CARE UNIT	6, 992, 299		6, 992, 299	0	6, 992, 299	31.00
32.00 02060 NEONATAL NTENSIVE CARE UNIT	2, 060, 119		2, 060, 119	0	2, 060, 119	32.00
43. 00 04300 NURSERY	1, 210, 458		1, 210, 458	0	1, 210, 458	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	11, 094, 693		11, 094, 693	0	11, 094, 693	50.00
51.00 05100 RECOVERY ROOM	4, 505, 236		4, 505, 236	0	4, 505, 236	
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 394, 838		6, 394, 838	0	6, 394, 838	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 082, 444		10, 082, 444	0	10, 082, 444	
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 895, 660		2, 895, 660	0	2, 895, 660	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 285, 423		2, 285, 423	0	2, 285, 423	
60. 00 06000 LABORATORY	7, 253, 876		7, 253, 876		7, 253, 876	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	675, 902		675, 902	0	675, 902	63.00
65. 00 06500 RESPI RATORY THERAPY	2, 612, 597	0	2, 612, 597		2, 612, 597	
66. 00 06600 PHYSI CAL THERAPY	2, 418, 746	0	2, 418, 746	0	2, 418, 746	
67. 00 06700 OCCUPATI ONAL THERAPY	861, 386	0	861, 386	0	861, 386	
68. 00 06800 SPEECH PATHOLOGY	327, 554	0	327, 554	0	327, 554	
69. 00 06900 ELECTROCARDI OLOGY	1, 678, 934		1, 678, 934		1, 678, 934	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 204, 802		5, 204, 802	0	5, 204, 802	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 439, 347		13, 439, 347	0	13, 439, 347	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 709, 185		8, 709, 185	0	8, 709, 185	
76. 00 03950 OTHER ANCI LLARY SERVI CES	0		C	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	437, 272		437, 272	. 0	437, 272	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		C	1	0	90.00
90. 02 09002 SLEEP LAB	898, 411		898, 411	I	898, 411	90. 02
91. 00 09100 EMERGENCY	11, 601, 794		11, 601, 794		11, 601, 794	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 237, 874		3, 237, 874		3, 237, 874	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	134, 613, 195	0	134, 613, 195		134, 613, 195	
201.00 Less Observation Beds	3, 237, 874		3, 237, 874	· •	3, 237, 874	
202.00 Total (see instructions)	131, 375, 321	0	131, 375, 321	0	131, 375, 321	202. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-	10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Period: Worksheet C	_

From 01/01/2017 To 12/31/2017 Part I Date/Time Prepared: 5/29/2018 11:42 am Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 50, 799, 729 50, 799, 729 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 274, 935 16, 274, 935 31.00 02060 NEONATAL INTENSIVE CARE UNIT 4, 553, 512 4, 553, 512 32.00 32.00 43.00 04300 NURSERY 3, 452, 915 3, 452, 915 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 38, 121, 169 74, 799, 643 112, 920, 812 0.098252 0.000000 50.00 51.00 05100 RECOVERY ROOM 5, 560, 888 19, 490, 015 25, 050, 903 0.179843 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.305284 52.00 14, 872, 065 6, 075, 107 20. 947. 172 0.000000 52.00 75, 975, 268 05400 RADI OLOGY-DI AGNOSTI C 95, 054, 004 0.106071 0.000000 54.00 19, 078, 736 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 609, 715 38, 569, 615 39, 179, 330 0.073908 0.000000 55.00 59.00 05900 CARDIAC CATHETERIZATION 18, 721, 868 25, 363, 480 44, 085, 348 0.051841 0.000000 59.00 31, 224, 157 55, 573, 595 0. 130527 60.00 06000 LABORATORY 24, 349, 438 0.000000 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 1, 261, 244 620, 748 1, 881, 992 0.359142 0.000000 63.00 06500 RESPIRATORY THERAPY 4, 774, 279 9, 787, 135 0. 266942 65.00 5, 012, 856 0.000000 65.00 06600 PHYSI CAL THERAPY 0. 330008 0.000000 66.00 3, 192, 867 4, 136, 498 7, 329, 365 66,00 06700 OCCUPATI ONAL THERAPY 67 00 1, 581, 581 632, 476 2, 214, 057 0.389053 0.000000 67 00 06800 SPEECH PATHOLOGY 755, 655 359, 403 1, 115, 058 0. 293755 0.000000 68.00 68.00 11, 779, 533 69.00 06900 ELECTROCARDI OLOGY 15, 049, 703 26, 829, 236 0.062579 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 5, 673, 375 8, 551, 608 14, 224, 983 0.365892 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 37, 071, 456 22, 355, 068 59, 426, 524 0. 226151 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 35, 566, 625 19, 127, 607 54, 694, 232 0.159234 0.000000 73.00 76.00 03950 OTHER ANCILLARY SERVICES 0.000000 0.000000 76.00 07697 CARDIAC REHABILITATION 76. 97 39, 420 3, 218, 327 3<u>, 257, 747</u> 0. 134225 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 09002 SLEEP LAB 5.533 9, 388, 503 9.394.036 0.095636 0.000000 90.02 90.02 09100 EMERGENCY 29, 480, 647 160, 004, 312 0.072509 91.00 91.00 130, 523, 665 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 511, 745 8, 220, 573 8, 732, 318 0.370792 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 LNTEREST EXPENSE 113 00 200.00 Subtotal (see instructions) 328, 327, 507 498, 455, 743 826, 783, 250 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 328, 327, 507 498, 455, 743 826, 783, 250 202.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/29/2018 11:42 am

			10 12/31/201/	5/29/2018 11: 42 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u> </u>	
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32.00 02060 NEONATAL INTENSIVE CARE UNIT				32.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 098252			50.00
51.00 05100 RECOVERY ROOM	0. 179843			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 305284			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 106071			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 073908			55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 051841			59.00
60. 00 06000 LABORATORY	0. 130527			60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 359142			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 266942			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 330008			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 389053			67.00
68.00 06800 SPEECH PATHOLOGY	0. 293755			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 062579			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 365892			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 226151			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 159234			73.00
76. 00 03950 OTHER ANCI LLARY SERVI CES	0. 000000			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 134225			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 02 09002 SLEEP LAB	0. 095636			90. 02
91. 00 09100 EMERGENCY	0. 072509			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 370792			92.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST 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 WEST HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Peri od: Worksheet C
		From 01/01/2017 Part

				o 12/31/2017	Date/Time Pre 5/29/2018 11:	pared: 42 am
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	27, 734, 345		27, 734, 345		27, 734, 345	
31.00 03100 INTENSIVE CARE UNIT	6, 992, 299		6, 992, 299	0	6, 992, 299	
32.00 02060 NEONATAL NTENSIVE CARE UNIT	2, 060, 119		2, 060, 119	0	2, 060, 119	32.00
43. 00 04300 NURSERY	1, 210, 458		1, 210, 458	0	1, 210, 458	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	11, 094, 693		11, 094, 693	0	11, 094, 693	50.00
51.00 05100 RECOVERY ROOM	4, 505, 236		4, 505, 236			
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 394, 838		6, 394, 838	0	6, 394, 838	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 082, 444		10, 082, 444	0	10, 082, 444	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 895, 660		2, 895, 660	0	2, 895, 660	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 285, 423		2, 285, 423	0	2, 285, 423	59.00
60. 00 06000 LABORATORY	7, 253, 876		7, 253, 876	0	7, 253, 876	60.00
63.00 O6300 BLOOD STORING, PROCESSING, & TRANS.	675, 902		675, 902	0	675, 902	
65. 00 06500 RESPIRATORY THERAPY	2, 612, 597	0	2, 612, 597	0	2, 612, 597	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 418, 746	0	2, 418, 746	0	2, 418, 746	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	861, 386	0	861, 386	0	861, 386	67.00
68.00 06800 SPEECH PATHOLOGY	327, 554	0	327, 554	0	327, 554	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 678, 934		1, 678, 934	0	1, 678, 934	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 204, 802		5, 204, 802	0	5, 204, 802	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 439, 347		13, 439, 347	0	13, 439, 347	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 709, 185		8, 709, 185	0	8, 709, 185	73.00
76. 00 03950 OTHER ANCI LLARY SERVI CES	0		0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	437, 272		437, 272	0	437, 272	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		0	0	0	90.00
90. 02 09002 SLEEP LAB	898, 411		898, 411	0	898, 411	90.02
91. 00 09100 EMERGENCY	11, 601, 794		11, 601, 794	0	11, 601, 794	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 237, 874		3, 237, 874		3, 237, 874	92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	134, 613, 195	0	134, 613, 195	0	134, 613, 195	200.00
201.00 Less Observation Beds	3, 237, 874		3, 237, 874		3, 237, 874	201.00
202.00 Total (see instructions)	131, 375, 321	0	131, 375, 321	0	131, 375, 321	202.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-	10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Period: Worksheet C	_

From 01/01/2017 To 12/31/2017 Part I Date/Time Prepared: 5/29/2018 11:42 am Title XIX Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 50, 799, 729 50, 799, 729 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 274, 935 16, 274, 935 31.00 02060 NEONATAL INTENSIVE CARE UNIT 4, 553, 512 4, 553, 512 32.00 32.00 43.00 04300 NURSERY 3, 452, 915 3, 452, 915 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 38, 121, 169 74, 799, 643 112, 920, 812 0.098252 0.000000 50.00 51.00 05100 RECOVERY ROOM 5, 560, 888 19, 490, 015 25, 050, 903 0.179843 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.305284 52.00 14, 872, 065 6, 075, 107 20. 947. 172 0.000000 52.00 75, 975, 268 05400 RADI OLOGY-DI AGNOSTI C 95, 054, 004 0.106071 0.000000 54.00 19, 078, 736 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 609, 715 38, 569, 615 39, 179, 330 0.073908 0.000000 55.00 59.00 05900 CARDIAC CATHETERIZATION 18, 721, 868 25, 363, 480 44, 085, 348 0.051841 0.000000 59.00 31, 224, 157 55, 573, 595 0. 130527 60.00 06000 LABORATORY 24, 349, 438 0.000000 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 1, 261, 244 620, 748 1, 881, 992 0.359142 0.000000 63.00 06500 RESPIRATORY THERAPY 4, 774, 279 9, 787, 135 0. 266942 65.00 5, 012, 856 0.000000 65.00 06600 PHYSI CAL THERAPY 0. 330008 0.000000 66.00 3, 192, 867 4, 136, 498 7, 329, 365 66,00 06700 OCCUPATI ONAL THERAPY 67 00 1, 581, 581 632, 476 2, 214, 057 0.389053 0.000000 67 00 06800 SPEECH PATHOLOGY 755, 655 359, 403 1, 115, 058 0. 293755 0.000000 68.00 68.00 11, 779, 533 69.00 06900 ELECTROCARDI OLOGY 15, 049, 703 26, 829, 236 0.062579 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 5, 673, 375 8, 551, 608 14, 224, 983 0.365892 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 37, 071, 456 22, 355, 068 59, 426, 524 0. 226151 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 35, 566, 625 19, 127, 607 54, 694, 232 0.159234 0.000000 73.00 76.00 03950 OTHER ANCILLARY SERVICES 0.000000 0.000000 76.00 07697 CARDIAC REHABILITATION 76. 97 39, 420 3, 218, 327 3<u>, 257, 747</u> 0. 134225 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 09002 SLEEP LAB 5.533 9, 388, 503 9.394.036 0.095636 0.000000 90.02 90.02 09100 EMERGENCY 29, 480, 647 160, 004, 312 0.072509 91.00 91.00 130, 523, 665 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 511, 745 8, 220, 573 8, 732, 318 0.370792 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 LNTEREST EXPENSE 113 00 200.00 Subtotal (see instructions) 328, 327, 507 498, 455, 743 826, 783, 250 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 328, 327, 507 498, 455, 743 826, 783, 250 202.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 11:42 am

Cost Center Description PPS Inpatient Ratio	
Rati o	
11.00	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
	0. 00
31. 00 03100 I NTENSI VE CARE UNI T 31	1.00
32.00 02060 NEONATAL INTENSIVE CARE UNIT 32	2. 00
43. 00 04300 NURSERY 43	3. 00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATING ROOM 0. 098252 50	0. 00
51. 00 05100 RECOVERY ROOM 0. 179843 51	1.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 305284 52	2. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0. 106071 54	1.00
55. 00 05500 RADI 0LOGY-THERAPEUTI C 0. 073908 55	5. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 051841 59	9. 00
60. 00 06000 LABORATORY 0. 130527 60	0. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 0. 359142 63	3. 00
65. 00 06500 RESPI RATORY THERAPY 0. 266942 65	5. 00
66. 00 06600 PHYSI CAL THERAPY 0. 330008 66	5. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 389053 67	7. 00
68. 00 06800 SPEECH PATHOLOGY 0. 293755 68	3. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 062579 69	9. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.365892 71	1.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 226151 72	2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 159234 73	3. 00
	5. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 134225 76	5. 97
OUTPATIENT SERVICE COST CENTERS	
	0. 00
90. 02 09002 SLEEP LAB 0. 095636 90	0. 02
	1.00
	2. 00
SPECIAL PURPOSE COST CENTERS	
	3. 00
	0. 00
	1.00
202.00 Total (see instructions)	2. 00

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

			'	0 12/31/201/	5/29/2018 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operati ng	Capi tal	Operati ng	
	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
	Part I, col.	Part II col.	Capital Cost		Reducti on	
	26)	26)	(col. 1 -		Amount	
			col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	11, 094, 693				0	
51. 00 05100 RECOVERY ROOM	4, 505, 236				0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	6, 394, 838				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 082, 444	1, 802, 863			0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 895, 660				0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 285, 423	465, 335			0	59. 00
60. 00 06000 LABORATORY	7, 253, 876				0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	675, 902	15, 498			0	63.00
65. 00 06500 RESPI RATORY THERAPY	2, 612, 597	176, 843			0	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 418, 746				0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	861, 386				0	67.00
68. 00 06800 SPEECH PATHOLOGY	327, 554	70, 475			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 678, 934	150, 374	1, 528, 560	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 204, 802	119, 338	5, 085, 464	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 439, 347	308, 129	13, 131, 218	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 709, 185	259, 564	8, 449, 621	0	0	73.00
76. 00 03950 OTHER ANCI LLARY SERVICES	0	0	C	0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	437, 272	43, 900	393, 372	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		-	0	
90. 02 09002 SLEEP LAB	898, 411	83, 742			0	70.02
91. 00 09100 EMERGENCY	11, 601, 794	965, 679	10, 636, 115	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 237, 874	434, 756	2, 803, 118	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	96, 615, 974					200. 00
201.00 Less Observation Beds	3, 237, 874					201. 00
202.00 Total (line 200 minus line 201)	93, 378, 100	8, 777, 276	84, 600, 824	0	0	202. 00

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

Provider CCN: 15-0158
Period: Worksheet C
From 01/01/2017
To 12/31/2017
Date/Time Prepared:

					10 12/31/2017	5/29/2018 11: 42 am
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to		
		Operati ng	Part I,	Charge Ratio)	
		Cost	column 8)	(col. 6 /		
		Reducti on		col. 7)		
		6. 00	7. 00	8. 00		
	CILLARY SERVICE COST CENTERS	11 004 (00	110 000 010		- 0	
	OOO OPERATING ROOM	11, 094, 693				50.00
	OO RECOVERY ROOM	4, 505, 236				51.00
	200 DELIVERY ROOM & LABOR ROOM	6, 394, 838				52. 00
	RADI OLOGY-DI AGNOSTI C	10, 082, 444				54.00
	RADI OLOGY-THERAPEUTI C	2, 895, 660				55.00
	200 CARDI AC CATHETERI ZATI ON	2, 285, 423				59.00
	000 LABORATORY	7, 253, 876				60.00
	BOO BLOOD STORING, PROCESSING, & TRANS.	675, 902				63.00
	000 RESPI RATORY THERAPY	2, 612, 597				65.00
	000 PHYSI CAL THERAPY	2, 418, 746				66.00
	OO OCCUPATIONAL THERAPY	861, 386				67. 00
	300 SPEECH PATHOLOGY	327, 554				68. 00
	POO ELECTROCARDI OLOGY	1, 678, 934				69. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 204, 802				71.00
	200 IMPL. DEV. CHARGED TO PATIENT	13, 439, 347				72.00
	BOO DRUGS CHARGED TO PATIENTS	8, 709, 185	54, 694, 232			73.00
	050 OTHER ANCILLARY SERVICES	0	0	0. 00000		76.00
	97 CARDI AC REHABI LI TATI ON	437, 272	3, 257, 747	0. 13422	25	76. 97
	PATIENT SERVICE COST CENTERS					
90. 00 090		0	0	0. 00000		90.00
	002 SLEEP LAB	898, 411				90. 02
	00 EMERGENCY	11, 601, 794				91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 237, 874	8, 732, 318	0. 37079	92	92.00
	CLIAL PURPOSE COST CENTERS					
1	300 INTEREST EXPENSE					113.00
200. 00	Subtotal (sum of lines 50 thru 199)	96, 615, 974				200.00
201. 00	Less Observation Beds	3, 237, 874	l e			201. 00
202.00	Total (line 200 minus line 201)	93, 378, 100	751, 702, 159			202. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2017	Worksheet D Part I	
				To 12/31/2017	Date/Time Pre	
					5/29/2018 11:	42 am_
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col . 26)		col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	T	T	ı			
30. 00 ADULTS & PEDIATRICS	3, 723, 950		0,,20,,0			1
31.00 INTENSIVE CARE UNIT	608, 535	l e	608, 53			
32.00 NEONATAL INTENSIVE CARE UNIT	170, 608	l e	170, 60			
43. 00 NURSERY	171, 287		171, 28	7 2, 027	84. 50	43.00
200.00 Total (lines 30 through 199)	4, 674, 380		4, 674, 38	0 33, 518		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	9, 642	1, 378, 420			l	30.00
31.00 INTENSIVE CARE UNIT	2, 151	292, 902			ļ	31.00
32.00 NEONATAL INTENSIVE CARE UNIT	0	0			ļ	32.00
43. 00 NURSERY	0	0			I	43.00
200.00 Total (lines 30 through 199)	11, 793	1, 671, 322				200. 00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLAR	Y SERVICE CAPITAL COSTS	Provi der CCN: 15-0158	From 01/01/2017	Worksheet D Part II Date/Time Prepared

APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPITA	L C0515	Provider C		From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/29/2018 11:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 372, 284				304, 029	50.00
51. 00 05100 RECOVERY ROOM	184, 201	25, 050, 903	•	· · ·	· ·	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	825, 497		•		· ·	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 802, 863			· · ·		
55. 00 05500 RADI OLOGY-THERAPEUTI C	511, 575		•			
59. 00 05900 CARDI AC CATHETERI ZATI ON	465, 335			· · ·	· ·	59. 00
60. 00 06000 LABORATORY	233, 184			· · ·	40, 232	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	15, 498		1		5, 520	
65. 00 06500 RESPI RATORY THERAPY	176, 843		1	· · ·	· ·	
66. 00 06600 PHYSI CAL THERAPY	111, 466					
67. 00 06700 OCCUPATI ONAL THERAPY	77, 329				· ·	
68. 00 06800 SPEECH PATHOLOGY	70, 475	1, 115, 058	0. 06320	3 437, 985	27, 682	68. 00
69. 00 06900 ELECTROCARDI OLOGY	150, 374	26, 829, 236	0. 00560	5 6, 001, 393	33, 638	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	119, 338	14, 224, 983	0. 00838	9 1, 897, 086	15, 915	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	308, 129	59, 426, 524	0. 00518	5 16, 228, 674	84, 146	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	259, 564	54, 694, 232	0. 00474	6 14, 367, 383	68, 188	73.00
76. 00 03950 OTHER ANCI LLARY SERVI CES	0	0	0. 00000	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	43, 900	3, 257, 747	0. 01347	6 15, 983	215	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0. 00000		0	90.00
90. 02 09002 SLEEP LAB	83, 742	9, 394, 036	0. 00891	4 5, 533	49	90. 02
91. 00 09100 EMERGENCY	965, 679	160, 004, 312	0.00603	5 13, 092, 830		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	434, 756	8, 732, 318	0. 04978	7 220, 122		
200.00 Total (lines 50 through 199)	9, 212, 032	751, 702, 159	·	100, 542, 475	1, 030, 800	200.00

Health Financial Cystems	III UEALTU WE	CT HOODITAL		ملاها	u of Form CMC	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	IU HEALTH WES ASS THROUGH COS		F	Period: From 01/01/2017 To 12/31/2017		epared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
•	School	School	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	C	0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0	1 0	0	0	31.00
32.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	1	0	0	32.00
43. 00 04300 NURSERY	0	0	1	0	Ö	
200.00 Total (lines 30 through 199)	0	0	1	o o		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4, 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	26, 048	0.00	9, 642	30.00
31. 00 03100 INTENSIVE CARE UNIT		0	4, 469			
32.00 02060 NEONATAL INTENSIVE CARE UNIT		0	974			1
43. 00 04300 NURSERY		Ö				
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	Inpati ent	-			,	
, and the second	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 02060 NEONATAL INTENSIVE CARE UNIT	l o					32.00
43. 00 04300 NURSERY	l o					43.00
200.00 Total (lines 30 through 199)	0					200.00

31. 00 32. 00 43. 00 200. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	NCILLARY SERVICE OTHER PASS Provider CCN: 15-0158	
		F 01 /01 /0017 D+ 11/

From 01/01/2017 Part IV To 12/31/2017 Date/Time Prepared: 5/29/2018 11:42 am THROUGH COSTS

					3/29/2010 11.	42 alli
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
	0	0		0	0	50.00
	0	0		0	0	51.00
I I	0	0		0	0	52.00
	0	0		0	0	54.00
I I	0	0		0	0	55.00
I I	0	0		0	0	59.00
	0	0		0	0	60.00
The state of the s	0	0		0	0	63.00
	0	0		0	0	65.00
	0	0		0	0	66.00
	0	0		0	0	67.00
	0	0		0	0	68. 00
	0	0		0	0	69. 00
	0	0		0	0	71.00
	0	0		0	0	72.00
	0	0		0	0	73.00
	0	0		0	0	76. 00
	0	0		0	0	76. 97
	0	0		0	0	
	0	0		0	0	90. 02
	0	0		0 0	0	91.00
	0			O	0	92.00
0 Total (lines 50 through 199)	0	0		0 C	0	200. 00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 073950 OTHER ANCI LLARY SERVI CES 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 00 05100 RECOVERY ROOM 00 05200 DELI VERY ROOM 00 05400 RADI OLOGY-DI AGNOSTI C 00 05500 RADI OLOGY-THERAPEUTI C 00 05900 CARDI AC CATHETERI ZATI ON 00 06300 LABORATORY 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY 00 06700 OCCUPATI ONAL THERAPY 00 06800 SPECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 00 07300 DRUGS CHARGED TO PATI ENTS 00 073950 OTHER ANCI LLARY SERVI CES 00 07697 CARDI AC REHABI LI TATI ON 00 0UTPATI ENT SERVI CE COST CENTERS 00 09000 CLI NI C 00 09000 SLEEP LAB 00 09100 EMERGENCY 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 00	Non Physician Anesthetist Cost School Post-Stepdown Adjustments	Anesthetist Cost Post-Stepdown Adjustments	Non Physician Anesthetist Cost Post-Stepdown Adjustments Cost Post-Stepdown Adjustments Cost Post-Stepdown Adjustments Cost Post-Stepdown Adjustments Cost Post-Stepdown Adjustments Cost Centers Cost Cen	Non Physician Anesthetist Cost School Post-Stepdown Adjustments School Post-Stepdown Adjustments Allied Health Allied Health Post-Stepdown Adjustments Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health Allied Health A

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	NCILLARY SERVICE OTHER PASS Provider CCN: 15-0158	
		F 01 /01 /0017 D+ 11/

From 01/01/2017 | Part IV To 12/31/2017 | Date/Time Prepared: THROUGH COSTS 5/29/2018 11:42 am Title XVIII Hospi tal Cost Center Description All Other Total Cost Ratio of Cost Total Total Charges Outpati ent Medi cal (sum of col 1 to Charges (from Wkst. Educati on (col. 5 ÷ through col Cost (sum of C, Part I, Cost 4) col . 2, 3 and col. 8) col. 7) 4. 00 5.00 6.00 7. 00 8. 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 112, 920, 812 0.000000 50 00 51.00 05100 RECOVERY ROOM 25, 050, 903 0.000000 51.00 0000000000000000 05200 DELIVERY ROOM & LABOR ROOM 0 0 20, 947, 172 0.000000 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 95, 054, 004 0 0 0.000000 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55.00 39, 179, 330 55.00 59.00 05900 CARDIAC CATHETERIZATION 0 44, 085, 348 0.000000 59.00 60.00 06000 LABORATORY 0 55, 573, 595 0.000000 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 63.00 0 1, 881, 992 0.000000 63.00 65.00 06500 RESPIRATORY THERAPY 0 9, 787, 135 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 7, 329, 365 0.000000 66.00 2, 214, 057 67.00 06700 OCCUPATI ONAL THERAPY 0 0.000000 67.00 06800 SPEECH PATHOLOGY 0 1, 115, 058 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 26, 829, 236 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 14, 224, 983 0.000000 71.00 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 72 00 0 59, 426, 524 0.000000 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 54, 694, 232 0.000000 73.00 03950 OTHER ANCILLARY SERVICES 0 0 0 0.000000 76.00 76.00 07697 CARDIAC REHABILITATION 3, 257, 747 0.000000 76.97 76.97 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0.000000 90.00 0 0 0 0 90. 02 09002 SLEEP LAB 0 9, 394, 036 0.000000 0 90.02 0 91. 00 09100 EMERGENCY 0 160, 004, 312 0.000000 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 8, 732, 318 0.000000

751, 702, 159

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems IU HEALTH WEST H				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017		
				To 12/31/2017		
					5/29/2018 11:	42 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col 6 ÷		Costs (col	8	Costs (col 9	

		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	14, 472, 047	0	11, 645, 573	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	2, 240, 270	0	3, 983, 935	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	39, 532	0	24, 436	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	8, 516, 438	0	17, 563, 555	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	275, 224	0	13, 373, 374	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	7, 597, 049	0	6, 887, 656	0	59. 00
60. 00 06000 LABORATORY	0. 000000	9, 588, 117	0	3, 173, 072	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	670, 341	0	192, 933	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2, 398, 338	0	1, 601, 181	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 623, 767	0	191, 682	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	854, 363	0	30, 318	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	437, 985	0	7, 562	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	6, 001, 393	0	7, 071, 433	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 897, 086	0	2, 083, 150		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	16, 228, 674	0	6, 137, 227	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	14, 367, 383	0	3, 566, 827	0	73.00
76. 00 03950 OTHER ANCILLARY SERVICES	0. 000000	0	0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	15, 983	0	1, 152, 515	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 02 09002 SLEEP LAB	0. 000000	5, 533	0	2, 280, 755	0	90. 02
91. 00 09100 EMERGENCY	0. 000000	13, 092, 830	0	19, 338, 831	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	220, 122		2, 319, 684		92.00
200.00 Total (lines 50 through 199)		100, 542, 475	0	102, 625, 699	0	200. 00
					•	•

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0158 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/29/2018 11:42 am Title XVIII Hospi tal Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.098252 11, 645, 573 1, 144, 201 50.00 05100 RECOVERY ROOM 3, 983, 935 0 0.179843 51.00 0 51.00 716, 483 05200 DELIVERY ROOM & LABOR ROOM 0.305284 0 52.00 24, 436 7, 460 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.106071 17, 563, 555 0 1, 862, 984 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.073908 13, 373, 374 0 988, 399 55.00 0 59 00 05900 CARDIAC CATHETERIZATION 0.051841 6, 887, 656 0 357, 063 59 00 0 0 60.00 06000 LABORATORY 0.130527 3, 173, 072 414, 172 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0. 359142 192, 933 0 69, 290 63.00 0 0 06500 RESPIRATORY THERAPY 1, 601, 181 427, 422 65.00 0.266942 65.00 0 06600 PHYSI CAL THERAPY 0.330008 66.00 191, 682 63, 257 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.389053 30, 318 0 11, 795 67.00 06800 SPEECH PATHOLOGY 0. 293755 7, 562 0 0 68.00 2, 221 68.00 0 06900 ELECTROCARDI OLOGY 7,071,433 0 69 00 0.062579 442 523 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 365892 2,083,150 762, 208 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 226151 6, 137, 227 0 0 1, 387, 940 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0. 159234 39, 764 567, 960 73.00 3, 566, 827 03950 OTHER ANCILLARY SERVICES 0 76 00 0.000000 76 00 0 0 07697 CARDIAC REHABILITATION 0 76.97 0.134225 1, 152, 515 154, 696 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 0 09002 SLEEP LAB 90.02 0.095636 2, 280, 755 0 218, 122 90.02 91.00 09100 EMERGENCY 0.072509 19, 338, 831 0 1, 402, 239 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.370792 2, 319, 684 0 860, 120 92.00 200.00 0 200.00 Subtotal (see instructions) 102, 625, 699 39, 764 11, 860, 555 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00

102, 625, 699

0

39, 764

11, 860, 555 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu of	Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0158		sheet D
			From 01/01/2017 Part	

				From 01/01/2017 To 12/31/2017		
		Title	: XVIII	Hospi tal	PPS	
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
, and the second	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0	1			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1			55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1			59. 00
60. 00 06000 LABORATORY	0	0	1			60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	1			63.00
65. 00 06500 RESPIRATORY THERAPY	0	0)			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0)			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 332				73.00
76. 00 03950 OTHER ANCI LLARY SERVICES	0	0	1			76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0)			76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
90. 02 09002 SLEEP LAB	0	0				90. 02
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	6, 332				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	6, 332				202. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2017	Worksheet D Part I	
				Γο 12/31/2017	Date/Time Pre	
		Ti +I	e XIX	Hospi tal	5/29/2018 11: PPS	42 am_
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	Auj ustilient	Related Cost		col . 4)	
	B, Part II,		(col . 1 -		COI. 4)	
	col . 26)		col . 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 723, 950	0	3, 723, 950	26, 048	142. 96	30.00
31.00 INTENSIVE CARE UNIT	608, 535		608, 535	4, 469	136. 17	31.00
32.00 NEONATAL INTENSIVE CARE UNIT	170, 608		170, 608	974	175. 16	32.00
43. 00 NURSERY	171, 287		171, 28	2, 027	84. 50	43.00
200.00 Total (lines 30 through 199)	4, 674, 380		4, 674, 380	33, 518		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)	-			
INDATIONE DOUTING CODULOG COCE CONTEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	240	25 507	I			1 20 00
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT	249					30.00
	111	15, 115				31.00
32.00 NEONATAL INTENSIVE CARE UNIT 43.00 NURSERY	40	,	•			32. 00 43. 00
43.00 NURSERY 200.00 Total (lines 30 through 199)	925 1, 325					200.00
200. 00 Total (Titles 30 till ough 199)	1, 325	135,881	I			₁ 200.00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017		nared:
				10 12/31/2017	5/29/2018 11:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T		T	-T		
50. 00 05000 OPERATING ROOM	2, 372, 284					
51.00 05100 RECOVERY ROOM	184, 201	25, 050, 903	•			
52.00 05200 DELIVERY ROOM & LABOR ROOM	825, 497				· ·	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 802, 863					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	511, 575				-	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	465, 335					59.00
60. 00 06000 LABORATORY	233, 184					60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	15, 498					
65. 00 06500 RESPIRATORY THERAPY	176, 843	9, 787, 135	0. 01806	9 79, 958	1, 445	65.00
66. 00 06600 PHYSI CAL THERAPY	111, 466					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	77, 329	2, 214, 057				67.00
68.00 06800 SPEECH PATHOLOGY	70, 475	1, 115, 058	0.06320	3 4, 894	309	68. 00
69. 00 06900 ELECTROCARDI OLOGY	150, 374	26, 829, 236	0. 00560	5 79, 317	445	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	119, 338	14, 224, 983	0. 00838	9 27, 043	227	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	308, 129	59, 426, 524	0. 00518	5 139, 451	723	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	259, 564	54, 694, 232	0.00474	6 468, 688	2, 224	73.00
76.00 03950 OTHER ANCILLARY SERVICES	0	0	0.00000	0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	43, 900	3, 257, 747	0. 01347	6 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90. 02 09002 SLEEP LAB	83, 742	9, 394, 036	0. 00891	4 0	0	90. 02
91. 00 09100 EMERGENCY	965, 679	160, 004, 312	0. 00603	5 259, 733	1, 567	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	434, 756	8, 732, 318	0. 04978	7 6, 132	305	92.00
200.00 Total (lines 50 through 199)	9, 212, 032	751, 702, 159		2, 082, 748	23, 975	200. 00

Heal th Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10							
INPATIENT ROUTINE SERVICE COST CENTERS Swing-Bed Adjustment Amount (see all instructions) minus col. 4) As a col. 4) As a col. 4) As a col. 40	Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-	2552-10
Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustment Nursing School Post-Stepdown Adjustment Nursing School Post-Stepdown Nursing School Post-Stepdown School Post-Stepdown Nursing School Po	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C				
Nursing School Post-Stepdown Adjustments						Part III	norod:
Nursing School Post-Stepdown Adjustments					10 12/31/2017	5/29/2018 11:	42 am
NPATIENT ROUTINE SERVICE COST CENTERS			Ti tl	e XIX	Hospi tal		
NPATIENT ROUTINE SERVICE COST CENTERS Adjustments Adjustments Education	Cost Center Description	Nursi ng	Nursi ng	Allied Health	n Allied Health	All Other	
Adjustments			School		n Cost	Medi cal	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2A 2.00 3.0		Post-Stepdown		Adjustments		Educati on	
NPATI ENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 31.00		1A	1. 00	2A	2. 00	3. 00	
31.00							1
32.00		0	C		0		
A3.00		0	C		0		
Total (lines 30 through 199)		0	C		0		
Swing-Bed Adjustment Amount (see instructions) Swing-Bed Adjustment Amount (see instructions) Swing-Bed Adjustment Amount (see instructions) Swing-Bed Adjustment Amount (see instructions) Swing-Bed Adjustment (sum of cols. 1 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 1 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 1 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 1 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 1 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 1 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 1 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 1 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 2 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 2 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 2 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 2 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 3 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 3 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 3 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 3 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 3 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 4 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4 through 3, minus col. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of cols. 4) Swing-Bed Adjustment (sum of col		0	C		0		
Adjustment Amount (see instructions) NPATIENT ROUTINE SERVICE COST CENTERS 1 through 3, minus col. 4) 4.00 5.00 6.00 7.00 8.00		0	C		0 0		200.00
Amount (see instructions) 1 through 3, minus col. 4) 4.00 5.00 6.00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 0 0 26,048 0.00 249 30.00 31.00 03100 INTENSI VE CARE UNI T 0 4,469 0.00 111 31.00 32.00 0266 NEONATAL INTENSI VE CARE UNI T 0 974 0.00 40 32.00 43.00 04300 NURSERY 0 2,027 0.00 925 43.00 200.00 Total (lines 30 through 199) 1 Inpatient Program Pass-Through Cost (col. 7 x col. 8)	Cost Center Description						
INPATIENT ROUTINE SERVICE COST CENTERS				Days	`	Program Days	
NPATIENT ROUTINE SERVICE COST CENTERS					col. 6)		
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 0 0 26,048 0.00 249 30.00				/ 00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS 0 0 26,048 0.00 249 30. 00 31. 00	INDATIENT DOUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
31. 00				26.04	0 00	240	20 00
32. 00 02060 NEONATAL INTENSIVE CARE UNIT 0 974 0. 00 40 32. 00 43. 00 04300 NURSERY 0 2, 027 0. 00 925 43. 00 04300		0					
43.00 04300 NURSERY 0 2,027 0.00 925 43.00 200.00 0 33,518 0 0.00 0 0 0 0 0 0 0			۲				
Total (lines 30 through 199) 0 33,518 1,325 200.00			۲				
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8)			Ì				
Program Pass-Through Cost (col. 7 x col. 8)		Inpatient		5 00,01	<u> </u>	1,020	200.00
Pass-Through Cost (col. 7 x col. 8)	5051 5011C1 55501 pt 1511						
Cost (col. 7 x col. 8)							
9.00		x col. 8)					
INDATIONE POLITIME CERVILOE COCE CENTERS		9. 00					

30.00

30. 00 31. 00 32. 00 43. 00 200. 00

30. 00 | 03000 | ADULTS & PEDI ATRI CS | 31. 00 | 03100 | INTENSI VE CARE UNI T | 32. 00 | 02060 | NEONATAL | INTENSI VE CARE UNI T | 43. 00 | 04300 | NURSERY | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 1

Total (lines 30 through 199)

200.00

Health Financial Systems IU HEALTH WEST HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0158 In Lieu of Form CMS-2552-10

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To | 12/31/2017 | Date/Time Prepared: THROUGH COSTS

			'	12/31/2017	5/29/2018 11:	42 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS		1	1			
50. 00 05000 OPERATI NG ROOM	0	0		0	0	
51. 00 05100 RECOVERY ROOM	0	0		0	0	51.00
52.00 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
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
76. 00 03950 OTHER ANCI LLARY SERVICES	0	0	(0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
OUTPATIENT SERVICE COST CENTERS				_		
90. 00 09000 CLI NI C	0	0	(0	0	,
90. 02 09002 SLEEP LAB	0	0	(0	0	90. 02
91. 00 09100 EMERGENCY	0	0	(0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
200.00 Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0	
TUDOUCH COSTS		From 01/01/2017 Part IV

THROUG	H COSTS			1	From 01/01/2017 Fo 12/31/2017	5/29/2018 11:	pared: 42 am_
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of col 1		(from Wkst.	to Charges	
		Educati on	through col.	Cost (sum of		(col. 5 ÷	
		Cost	4)	col . 2, 3 and	col. 8)	col. 7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	T	_	1			
	05000 OPERATI NG ROOM	0	0	(112, 920, 812	0. 000000	
	05100 RECOVERY ROOM	0	0	(25, 050, 903		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	9	20, 947, 172		1
	05400 RADI OLOGY-DI AGNOSTI C	0	0	9	95, 054, 004	0.000000	
	05500 RADI OLOGY-THERAPEUTI C	0	0	9	39, 179, 330		
	05900 CARDI AC CATHETERI ZATI ON	0	0	9	44, 085, 348		1
	06000 LABORATORY	0	0		55, 573, 595		1
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		1, 881, 992	0.000000	
	06500 RESPIRATORY THERAPY	0	0		9, 787, 135		65.00
	06600 PHYSI CAL THERAPY	0	0		7, 329, 365		1
	06700 OCCUPATI ONAL THERAPY	0	0		2, 214, 057	0.000000	
	06800 SPEECH PATHOLOGY	0	0		1, 115, 058		
	06900 ELECTROCARDI OLOGY	0	0		26, 829, 236		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		14, 224, 983		
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		59, 426, 524		
	07300 DRUGS CHARGED TO PATIENTS	0	0		54, 694, 232	0.000000	
	03950 OTHER ANCI LLARY SERVI CES	0	0		0 057 747	0.000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(3, 257, 747	0. 000000	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		0			0.000000	00 00
	09000 CLINIC	0	0		0 204 024	0.000000	
	09002 SLEEP LAB	0	0		9, 394, 036		
	09100 EMERGENCY	0	0		160, 004, 312		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		8, 732, 318	l .	1
200. 00	Total (lines 50 through 199)	0	0	(751, 702, 159		200. 00

Heal th Financ	ial Systems			ΙU	HEALTH	WEST	HOSPI TAL			In Lieu	of Form CMS-2552-10
APPORTI ONMEN	OF INPATIEN	T/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER	PASS	Provi der	CCN:	15-0158	Peri od:	Worksheet D
THROUGH COST	:									From 01/01/2017	Part IV

	H COSTS	RVICE UTHER PASS	Provider Co		Period: From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre 5/29/2018 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8		Outpatient Program Pass-Through Costs (col. 9	
		col. 7)	10.00	x col. 10)	12.00	x col. 12)	
	ANCILLARY SERVICE COST CENTERS	9. 00	10. 00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0. 000000	179, 944		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	179, 944			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	153, 859			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	221, 288		0 0	o o	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	34, 003		o o	Ō	59.00
60.00	06000 LABORATORY	0. 000000	373, 356		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	9, 190		0 0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	79, 958		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	28, 106		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	4, 719		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	4, 894		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	79, 317		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	27, 043		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	139, 451		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	468, 688		0	0	73.00
	03950 OTHER ANCILLARY SERVICES	0. 000000	0		0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 000000	0		0	1	
	09002 SLEEP LAB	0. 000000	0		0	0	90.02
91.00	09100 EMERGENCY	0. 000000	259, 733		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	6, 132		0	0	92.00
200. 00	Total (lines 50 through 199)	1	2, 082, 748		0 0	l 0	200. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0	158 Peri od: From 01/01/2017	Worksheet D-1
		To 12/31/2017	Date/Time Prepared: 5/29/2018 11:42 am
	Title XVIII	Hospi tal	PPS

ABT - ALL PROVIDER COMPONENTS 1.00					5/29/2018 11:	42 am
			Title XVIII	Hospi tal	PPS	
New York Properties New York Properties		Cost Center Description				
MATLERT DAYS		DART I ALL DROW DED COMPONENTS			1. 00	
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 26,048 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 26,048 2.00 1.00 2						
1.00 Injection days (including private room days, excluding swing-bed and newborn days) 20,048 2.00 3.00 Private room days (secluding swing-bed and observation bed days). If you have only private room days 23,007 4.00 5.00	1 00		s excluding newborn)		26 048	1 00
2.00 On rot complete this line. On a complete may (excluding swing-bed and observation bed days) If you have only private room days. On a complete this line. On a complete may (excluding swing-bed and observation bed days) On a complete may (excluding swing-bed and observation bed days) On a complete may (excluding swing-bed swi						
do not complete this line.				rivate room days		•
Sami-private room days (excluding swing-bed and observation bed days) Sami-private room days (and days) (a	0.00		<i>γογ. γοα</i> ανο ο <i>γ</i> ρ.	. rate room dayor	Ü	0.00
Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) reporting period (in the cost reporting period (in the 1 on this period year, enter 0 on this line) reporting period (in calendar year, enter 0 on	4.00		ed days)		23, 007	4.00
10 10 10 10 10 10 10 10	5.00			er 31 of the cost	0	5.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total saving-bod NF type inpatient days (including private room days) through December 31 of the cost open days and period NF type inpatient days (including private room days) after December 31 of the cost of the cost including private room days) after December 31 of the cost open days including private room days applicable to the Program (excluding swing-bed and neaborn days) is including private room days applicable to the Program (excluding swing-bed and neaborn days) saving-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 horses of the cost reporting period (if calendar year, enter 0 on this line) and the cost reporting period (if calendar year, enter 0 on this line) and the cost reporting period (if calendar year, enter 0 on this line) and the cost reporting period (if calendar year, enter 0 on this line) and the cost reporting period (if calendar year, enter 0 on this line) and the cost reporting period (if calendar year, enter 0 on this line) and the cost of the cost reporting period (if calendar year, enter 0 on this line) and the cost reporting period (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and the cost (if calendar year, enter 0 on this line) and th		3				
Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost 0 7.00	6. 00		om days) after December	31 of the cost	0	6.00
reporting period 10.00 Total inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Soling-bed SNP type inpatient days applicable to title XVIII only (including private room days) 11.00 Soling-bed SNP type inpatient days applicable to title XVIII only (including private room days) 11.00 Soling-bed SNP type inpatient days applicable to title XVIII only (including private room days) after 0 becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Soling-bed SNP type inpatient days applicable to title XVIII only (including private room days) after 0 becomes 31 of the cost reporting period (alendar year, enter 0 on this line) 13.00 Soling-bed SNP type inpatient days applicable to titles V or XIX only (including private room days) after 0 becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13.00 after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 miles (including transvery days (if line V X) only) 0 15.00 miles (if a colendar year, enter 0 on this line) 0 15.00 miles (if line V X) only) 0 15.00 miles (if a colendar year, enter 0 on this line) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) only) 0 15.00 miles (if line V X) 0 15.00 miles (if line V X) 0 15.00 miles (if line V X) 0 15.00 miles (if line V X) 0 15.00 miles (if line V X) 0 15.00 miles (if line V X) 0 15.00 miles						
1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and period days) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 1.00 Swing-bed SNF type inpatient days applicable to little XVIII only (including private room days) after 1.00 Swing-bed SNF type inpatient days applicable to little XVIII only (including private room days) after 1.00 Swing-bed SNF type inpatient days applicable to little XVIII only (including private room days) after 1.00 Swing-bed SNF type inpatient days applicable to little XVIII only (including private room days) 1.00 1	7.00		m days) through December	31 of the cost	0	7.00
reporting period (if "calendar year, enter 0 on this line) 10.00 Sinj-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Soft-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Soft-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Soft-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) 11.00 Soft-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period to titles V or XIX only (including private room days) 12.00 Including Private room days applicable to titles V or XIX only (including private room days) 13.00 are reported for the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Medical rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including room of the cost reporting period (including swing-bed days) 18.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including swing-bed NF services applicable to services after December 31 of the cost reporting period (including swing-bed NF services applicable to services after December 31 of the cost reporting period (line of NF services) 18.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of NF services) 18.00 North of the cost reporting period (line of NF services) 18.00 North of the cost reporting period (line of NF services) 18.00 North of the cost reporting period (line of NF services) 18.00 North of the cost reporting peri	0 00		m days) after December 3	11 of the cost	0	9 00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0.00	8.00		ill days) after beceilber s	of the cost	U	0.00
newborn days 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 10.	9 00		o the Program (excluding	swing-bed and	9 642	9 00
through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 14.00 Medically necessary private room days applicable on the Vivo XIX only (including private room days) 0 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 15.00 15.00 North on the Vivo XIX only) 0 15.00 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only) 0 15.00 North on the Vivo XIX only 0 15	7. 00		o tho riegiam (exercanne	, oming boa and	7, 0.12	7.00
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26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27,734,345 27.00 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 32.00 Average private room per diem charge (line 29 + line 3) 0.00 33.00 Average semi-private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27,734,345 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 10,266,223 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	23.00		31 of the cost reporting	g perrou (Trile o	O	25.00
27. 00 Common Co	26.00	/			0	26.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 Pri vate room charges (excluding swing-bed charges) 0 29.00 30.00 Semi-pri vate room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0 .0000000 31.00 Average pri vate room per diem charge (line 29 ÷ line 3) 0 .00 32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 0 .00 33.00 Average per diem pri vate room charge differential (line 32 minus line 33)(see instructions) 0 .00 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 0 .00 Average per diem private room cost differential (line 3 x line 35) 0 .00 Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 345) DART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 88.00 Adjusted general inpatient routine service cost (line 9 x line 38) 0 Program general inpatient routine service cost (line 9 x line 38) 0 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			(line 21 minus line 26)		27, 734, 345	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 345) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost differential (line 27, 734, 345) 30.00 Average per diem private room cost differential (line 27, 734, 345) 30.00 Average per diem private room cost differential (line 27, 734, 345) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 32 minus line 33)						
30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 29 ÷ line 3) 4.00 Average semi-private room charge differential (line 30 ± line 4) 30.00 Average per diem private room cost differential (line 32 ± line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 × line 31) 30.00 Average per diem private room cost differential (line 34 × line 31) 30.00 Average per diem private room cost differential (line 3 × line 35) 30.00 Average per diem private room cost differential (line 3 × line 35) 30.00 Average per diem private room cost differential (line 3 × line 35) 30.00 Average per diem private room cost differential (line 3 × line 35) 30.00 Average per diem private room cost differential (line 27, 734, 345) 30.00 Average per diem private room cost differential (line 27, 734, 345) 30.00 Average per diem private room cost differential (line 3 × line 35) 30.00 Average per diem private room cost differential (line 27, 734, 345) 30.00 Average per diem private room cost differential (line 27, 734, 345) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 27, 734, 345) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 27, 734, 345) 31.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 27, 734, 345) 32.00 Average per diem private room cost differential (line 3 × line 31) 33.00 Average per diem private room cost differential (line 3 × line 31) 34.00 Average per diem private room cost differential (line 3 × line 31) 35.00 Average per diem private room cost differential (line 3 × line 31) 36.00 Average per diem private room cost differential (line 3 × line 31) 37.00 Average per diem private room cost differential (line 3	28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 33.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 345) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.0000000000000000000000000000000000						1
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 345) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Average semi-private room per diem charge (line 30 ÷ line 32 minus line 33) (see instructions) 0.00 34.00 35.00 36.00 37.00 General inpatient routine service cost and private room cost differential (line 27, 734, 345) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	÷ line 28)			1
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 345) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 27, 734, 345) 37.00 Eneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 345) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 27, 734, 345) 37.00 Eneral inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 27, 734, 345) 37.00 Eneral inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 27, 734, 345) 38.00 Average per diem private room cost differential (line 27, 734, 345) 38.00 Average per diem private room cost differential (line 27, 734, 345) 37.00 Eneral inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x						1
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 345 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			nue lino 22)(coo instru	stione)		
36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 345 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 27, 734, 345 27, 734, 345 37.00 10, 266, 223 39.00 40.00				, ti ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27,734,345 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,064.74 38.00 Program general inpatient routine service cost (line 9 x line 38) 10,266,223 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,064.74 38.00 Program general inpatient routine service cost (line 9 x line 38) 10,266,223 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	and private room cost di	fferential (line		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,064.74 38.00 Program general inpatient routine service cost (line 9 x line 38) 10,266,223 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	00				,,,,,,,,	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,064.74 38.00 Program general inpatient routine service cost (line 9 x line 38) 10,266,223 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 10, 266, 223 39.00 40.00			USTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		Adjusted general inpatient routine service cost per diem (see	instructions)		1, 064. 74	38. 00
			*			
41.00 lotal Program general inpatient routine service cost (line 39 + line 40) 10,266,223 41.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		10, 266, 223	41.00

Heal th	Financial Systems	IU HEALTH WEST	T HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2017	Worksheet D-1	
					To 12/31/2017	Date/Time Pre	
			Title	× XVIII	Hospi tal	5/29/2018 11: PPS	42 am_
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(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	0	0	0.0	0 0	0	42.00
43.00	INTENSIVE CARE UNIT	6, 992, 299	4, 469	1, 564. 6	2, 151	3, 365, 498	43.00
44.00	NEONATAL INTENSIVE CARE UNIT	2, 060, 119	974	2, 115. 1	1 0	0	44.00
46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					14, 345, 019	48. 00
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	1 through 48)(see instructi	ons)		27, 976, 740	49. 00
50.00	Pass through costs applicable to Program inpa	itient routine :	servi ces (fro	m Wkst. D, su	m of Parts I and	1, 671, 322	50.00
E4 00					C D	4 000 000	E4 00
51. 00	Pass through costs applicable to Program inpal and IV)	itrent andiliar	y services (r	rom wkst. D,	sum or Parts II	1, 030, 800	51.00
52.00	Total Program excludable cost (sum of lines 5					2, 702, 122	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		lated, non-ph	ysician anesti	netist, and	25, 274, 618	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
56.00	Target amount (line 54 x line 55)					0.00	56.00
57.00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	ortina period (endi na 1996.	updated and c	ompounded by the	0.00	58. 00 59. 00
	market basket	0 .	o .	•			
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines					0. 00 0	60. 00 61. 00
011.00	which operating costs (line 53) are less than	expected costs					01100
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Dece	mhar 31 of th	a cost raport	ing period (See	0	64. 00
04.00	instructions)(title XVIII only)	· ·		·			04.00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s after Decembe	er 31 of the	cost reporting	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line d	64 plus line	65)(title XVI	II only). For	0	66. 00
<i>(</i> 7, 00	CAH (see instructions)	. cocto through	Doggmbox 21	of the cost 5	onorting ported	0	47.00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through	December 31	or the cost re	eporting period	U	67.00
68. 00	Title V or XIX swing-bed NF inpatient routine	costs after De	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 r	outine costs (line 67 + lin	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	,		•)		70. 00 71. 00
72.00	Program routine service cost (line 9 x line 7	'1)		ŕ			72.00
73. 00 74. 00	Medically necessary private room cost applica Total Program general inpatient routine servi					-	73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient r			•	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi don rocon	de)			78. 00 79. 00
80.00	Total Program routine service costs for compa				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limit		\				81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82. 00 83. 00
84.00	Program inpatient ancillary services (see ins	structions)					84.00
85. 00 86. 00	Utilization review - physician compensation (Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	/				
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per d		line 2)			3, 041 1, 064. 74	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	,			3, 237, 874	

Health Financial Systems	IU HEALTH WES	ST 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 5/29/2018 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	3, 723, 950	27, 734, 345	0. 13427	2 3, 237, 874	434, 756	90.00
91.00 Nursing School cost	0	27, 734, 345	0.00000	0 3, 237, 874	0	91.00
92.00 Allied health cost	0	27, 734, 345	0.00000	0 3, 237, 874	0	92.00
93.00 All other Medical Education	0	27, 734, 345	0. 00000	0 3, 237, 874	0	93. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0158	Peri od: From 01/01/2017	Worksheet D-1	
		To 12/31/2017	Date/Time Prepared: 5/29/2018 11:42 am	
	Ti tle XIX	Hospi tal	PPS	

Inpatient days (including private room days, excluding swing-bed and newborn days) 26,048 2,007				10 12/01/2017	5/29/2018 11:	42 am
PART 1 - ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	PPS	
HARTIENT DAYS		Cost Center Description				
IMPATEENT DAYS		DADT I ALL DROW DED COMPONENTS			1. 00	
Impatient days (Including private room days and swing-bed and newborn) 26,048 1.0						
Inpatient days (Including private room days, excluding swing-bed and newborn days) 2,048 2,0			s excluding newborn)		26 048	1.00
9.00 private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SWT type inpatient days (including private room days) through December 31 of the cost reporting period. 6.00 Total swing-bed SWT type inpatient days (including private room days) after December 31 of the cost reporting period the following private room days) after December 31 of the cost reporting period the flype inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SWT type inpatient days applicable to titles XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 14.00 Medically necessary private room days applicable to titles XVIII only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SWF services applicable t						
do not complete this line. OS Bellin-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) OS December 31 of the cost reporting period (if cal endar year, enter 0 on this line) OS December 31 of the cost reporting period (if cal endar year, enter 0 on this line) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the cost reporting period (see instructions) OS December 31 of the				rivate room days		3.00
Semi_private room days (excluding swing-bed and observation bed days) 23,007 4.0	0.00		<i>γογ. γου</i> α <i>το σ γ</i> ρ.	. rate . com dayo,	ŭ	0.00
5.00 Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Swing-bed NF type inpatient days applicable to titles XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.01 Total period (if calendar year, enter 0 on this line) 9.02 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9.04 At 0.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9.04 At 0.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9.05 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9.06 At 10 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9.07 Ioun period (if calendar year, enter 0 on this line) 9.08 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 9.09 Swing-bed NF type	4.00		ed days)		23, 007	4.00
1.00 Cotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	5.00			er 31 of the cost	0	5.00
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reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 31.00 Average per idem private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 34 x line 31) 20.00 Average per diem private room cost differential (line 34 x line 31) 20.00 Average per diem private room cost differential (line 34 x line 31)	19. 00		s through December 31 of	the cost	0.00	19.00
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x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.734,345 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 34.00 Average semi-private room per diem charge (line 30 + line 4) 35.00 Average per diem private room cost differential (line 34 x line 31) 24.00 Variage per diem private room cost differential (line 34 x line 31) 25.00 Variage per diem private room cost differential (line 34 x line 31)	23. 00		31 of the cost reportir	na period (line 6	0	23. 00
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x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27, 734, 345 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 34 x line 31)						
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27. 734, 345 27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31)	24 00				0	24 00
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30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 30.00 31.00 32.00 32.00 32.00 32.00 33.00 33.00 33.00 33.00 Average per diem private room cost differential (line 34 x line 31)			d and observation bed ch	narges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 31.00 0.000000 0.	29. 00	Private room charges (excluding swing-bed charges)		0 ,	0	29. 00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 32.00 32.00 32.00 33.00 32.00 33.00	30.00					30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 33.00 34.00 35.00			÷ line 28)			1
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00						
35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.0			nua lina 22) (asa inatau	+! ana)		
				ctions)		
00.00 printing to room obstruction that adjustment (time or a fine 00)						
, , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , ,	and private room cost di	fferential (line		
27 minus line 36)	00				,,,,,,,,	
PART II - HOSPITAL AND SUBPROVIDERS ONLY						[
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
			•			
						40.00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 265,120 41.0	-1 1.00	Trotal Trogram general impatrent routine service cost (TINE 39	1 11116 40 <i>)</i>		200, 120	1 41.00

	Financial Systems	IU HEALTH WEST				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der Co		Period: From 01/01/2017	Worksheet D-1	
					o 12/31/2017		
			Ti tl	e XIX	Hospi tal	5/29/2018 11: PPS	42 alli
					Program Cost		
		I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		1.00	Days 2.00	÷ col. 2) 3.00	4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	1, 210, 458	2, 00				42.00
	Intensive Care Type Inpatient Hospital Units	, , , , , , ,	,	-			
43.00	INTENSIVE CARE UNIT	6, 992, 299	4, 469				
44. 00 45. 00	i i	2, 060, 119	974	2, 115. 11	40	84, 604	44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	ct D 2 col 2	lino 200)			1. 00 320, 297	48. 00
	Total Program inpatient costs (sum of lines			ons)		1, 396, 076	•
	PASS THROUGH COST ADJUSTMENTS			,		, , , , , ,	
50.00	Pass through costs applicable to Program inp	atient routine s	servi ces (fror	m Wkst. D, sum	of Parts I and	135, 881	50.00
51. 00		ationt ancillary	u sorvi cos (fi	rom Wket D s	um of Darts II	23, 975	51.00
31.00	and IV)	atrent andiriary	y services (ii	I OIII WKSt. D, S	um or Farts II	23, 473	31.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				159, 856	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anesth	etist, and	1, 236, 220	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	55. 00
56.00	Target amount (line 54 x line 55)			it E4t		0	
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (i	line 56 minus	IIne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	portina period e	endi na 1996. u	updated and co	mpounded by the	1	
	market basket			•	,		
60.00	, ,				*h h	0.00	1
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see		3 (TITIES 54 X	00), 01 1% 01	the target		
62.00	62.00 Relief payment (see instructions)						62.00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00		ts through Decer	mber 31 of the	e cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line d	64 plus line 0	65)(title XVII	l only) For	0	66. 00
00.00	CAH (see instructions)		o. p. 40	00)(11110 /////			00.00
67. 00	9 1	e costs through	December 31 o	of the cost re	porting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	a costs after De	ecember 31 of	the cost reno	rting period		68. 00
00.00	(line 13 x line 20)	e costs arter be	ecember 31 or	the cost repo	iting period		00.00
69. 00						0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI					ı	70.00
70.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	•		•			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line			_,			72.00
73. 00	Medically necessary private room cost applic		•				73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II column		74. 00 75. 00
75.00	26, line 45)	Toutine Service	COSTS (TIOIII I	WOLKSHEET D, F	art II, Corumii		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi der record	46)			78. 00 79. 00
80.00	Total Program routine service costs for comp	, ,		,	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi				•		81.00
82.00	Inpatient routine service cost limitation (I						82. 00 83. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		>)				83.00
85.00	Utilization review - physician compensation		ns)				85.00
86.00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					2.044	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			3, 041 1, 064. 74	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•	/			3, 237, 874	1

Health Financial Systems	IU HEALTH WES	ST 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 5/29/2018 11:	pared: 42 am_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	3, 723, 950	27, 734, 345	0. 13427	2 3, 237, 874	434, 756	90.00
91.00 Nursing School cost	0	27, 734, 345	0.00000	0 3, 237, 874	0	91.00
92.00 Allied health cost	0	27, 734, 345	0.00000	0 3, 237, 874	0	92.00
93.00 All other Medical Education	0	27, 734, 345	0. 00000	3, 237, 874	0	93. 00

INPATIENT ANCILLARY SEF	RVICE COST APPORTIONMENT	Provi de	r CCN: 15-0158	Peri od:	Worksheet D-3	3
				From 01/01/2017 To 12/31/2017		
		Ti	tle XVIII	Hospi tal	PPS	
Cost Center	Description		Ratio of Co	st Inpatient	I npati ent	
			To Charges	9	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	E SERVICE COST CENTERS					
30. 00 03000 ADULTS & PE				20, 217, 502		30.00
31.00 03100 INTENSIVE (7, 921, 559		31.00
	NTENSIVE CARE UNIT			0		32.00
43. 00 04300 NURSERY						43.00
ANCILLARY SERVIC					1	
50. 00 05000 OPERATING F			0. 0982			
51. 00 05100 RECOVERY RO			0. 1798			
52. 00 05200 DELIVERY RO			0. 3052			
54. 00 05400 RADI OLOGY-I			0. 1060			
55. 00 05500 RADI OLOGY-1			0. 0739			
59. 00 05900 CARDI AC CAT	THETERI ZATI ON		0. 0518			
60. 00 06000 LABORATORY			0. 1305			
	NG, PROCESSING, & TRANS.		0. 3591			
65. 00 06500 RESPI RATOR			0. 2669			
66. 00 06600 PHYSI CAL TH			0. 3300			
67. 00 06700 OCCUPATI ONA			0. 3890			
68. 00 06800 SPEECH PATH			0. 2937	·		
69. 00 06900 ELECTROCARI			0. 0625			
	PPLIES CHARGED TO PATIENTS		0. 3658			
	CHARGED TO PATI ENT		0. 2261			
73. 00 07300 DRUGS CHARG			0. 1592			
76. 00 03950 OTHER ANCI L			0.0000		·	
76. 97 07697 CARDI AC REI			0. 1342	225 15, 983	2, 145	76. 9
OUTPATIENT SERVI	UE CUST CENTERS		0.0000	200		
90. 00 09000 CLINIC			0.0000		ļ	1
90. 02 09002 SLEEP LAB			0.0956			
91. 00 09100 EMERGENCY	L DEDC (NON DICTINGT DART)		0. 0725			
	N BEDS (NON-DISTINCT PART)		0. 3707	792 220, 122		

14, 345, 019 200. 00 201. 00 202. 00

100, 542, 475 0 100, 542, 475

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)

200. 00 201. 00 202. 00

	ALTH WEST HOSPITAL			u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	nared:
			10 12/31/2017	5/29/2018 11:	42 am
	Titl∈	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			494, 333		30.00
31.00 03100 INTENSIVE CARE UNIT			286, 014		31.00
32.00 02060 NEONATAL INTENSIVE CARE UNIT			182, 443		32.00
43. 00 04300 NURSERY			117, 875		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 09825		17, 680	
51. 00 05100 RECOVERY ROOM		0. 17984		2, 350	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 30528		•	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 10607		•	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 07390		0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 05184		1, 763	59.00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 13052			
		0. 35914 0. 26694		•	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 33000		•	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38905			
68. 00 06800 SPEECH PATHOLOGY	+	0. 36903		1, 630	
69. 00 06900 ELECTROCARDI OLOGY	+	0. 29373		4, 964	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 36589		•	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 22615		31, 537	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 22813		•	
76. 00 03950 OTHER ANCI LLARY SERVICES		0. 13923		74,031	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 13422		0	76. 97
OUTPATIENT SERVICE COST CENTERS		0. 13422	<u>J</u> 0	0	70. 77
90. 00 09000 CLINI C		0. 00000	ol o	0	90.00
00 03 00000 SLEED LAB	1	0.00000		_	

0.095636

0. 072509

0. 370792

o

259, 733

2, 082, 748 2, 082, 748

6, 132

90.02

91.00

0

2, 274 92. 00

320, 297 200. 00 201. 00 202. 00

18, 833

200. 00 201. 00 202. 00

90. 02 09002 SLEEP LAB

91. 00 09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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)

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0158	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 11:42 am

		Title XVIII	Hospi tal	5/29/2018 11: PPS	42 am
		IT LIE XVIII	nospi tai	113	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1 (see	15, 592, 192	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurrinstructions)	5, 446, 802	1. 02		
1. 03	DRG for federal specific operating payment for Model 4 BPCl f 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			158, 411 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	rting period (see instru	ıcti ons)	0 118. 19	3. 00 4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)				5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)			0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA \S 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slunder § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lininstructions)	es (8, 8,01 and 8,02) (see	0. 00	9. 00
	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recor	ds		10.00 11.00
12. 00	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye	ar ended on or after Sep	tember 30, 1997,	0. 00 0. 00	1
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital clo	sure		0.00	17. 00
18.00	Adjusted rolling average FTE count			0.00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19. 00
	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42			0	
	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$.	ent cap slots under 42 (FR 412.105	0. 00	
	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see		24. 00 25. 00
	instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	1
	IME payments adjustment factor. (see instructions)			0. 000000	1
	IME add-on adjustment amount (see instructions)		0	ł	
			0	1	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
30 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	tions)	2. 83	30.00
	Percentage of Medicaid patient days (see instructions)	arrent days (See Thistitud	iti ulis)	2. 83 16. 70	•
	Sum of lines 30 and 31			19. 53	1
	Allowable disproportionate share percentage (see instructions)		5. 44	1
	Disproportionate share adjustment (see instructions)	,		286, 131	1
	, , , , , , , , , , , , , , , , , , , ,		'	, .0.	

ALCUI	Financial Systems IU HEALTH WES ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0158	Period: From 01/01/2017 To 12/31/2017	5/29/2018 11:	epared
		Title XVIII	Hospital	PPS On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				١
5. 00	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		5, 977, 483, 147 0. 000145005	6, 766, 695, 164 0. 000312558	
5. 02		nter zero on this line) (se			1
5. 03 6. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35	5. 03)	648, 295 1, 181, 387	533, 092	35. 0 36. 0
0. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I excludin		ugh 46) 0		40.0
1. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41.0
1. 01	Total ESRD Medicare covered and paid discharges excluding M an 685. (see instructions)	MS-DRGs 652, 682, 683, 684	1 0		41.0
2. 00 3. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)		0.00		42. (43. (
4. 00	Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		44.
5. 00	Average weekly cost for dialysis treatments (see instruction		0. 00		45.
5. 00 7. 00	Total additional payment (line 45 times line 44 times line	41. 01)	22 444 023		46. 47.
3. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	22, 664, 923 0		47.
				Amount	
2 00				1. 00	10
9.00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I		1	22, 664, 923 1, 873, 082	1
1. 00	Exception payment for inpatient program capital (Wkst. L, P			0	1
2. 00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52.
3. 00	Nursing and Allied Health Managed Care payment			0	1
1.00	Special add-on payments for new technologies			2, 071	1
4. 01 5. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	. 60)		0	
5. 00	Cost of physicians' services in a teaching hospital (see in	•		0	1
7. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	1
3. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)	0 ,	0	58.
9. 00	Total (sum of amounts on lines 49 through 58)			24, 540, 076	
0.00	Primary payer payments			0	
1.00 2.00	Total amount payable for program beneficiaries (line 59 min Deductibles billed to program beneficiaries	nus line 60)		24, 540, 076	
3. 00	1			2, 503, 760 71, 393	
	Allowable bad debts (see instructions)			390, 149	
5. 00				253, 597	
5. 00		nstructi ons)		34, 472	
7. 00				22, 218, 520	67.
3. 00	Credits received from manufacturers for replaced devices fo			0	
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96	5).(For SCH see instruction	ns)	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1 .
0. 50	Rural Community Hospital Demonstration Project (§410A Demon		instructions)	0	1
). 87). 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	1
	Pioneer ACO demonstration payment adjustment amount (see in				70.
). 89	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
0. 89 0. 90	HSP bonus payment HRR adjustment amount (see instructions)			Ö	1
	This bonds payment like adjustment amount (see Thistructions)				
). 90				0	70.
). 90). 91	Bundled Model 1 discount amount (see instructions)			0 185, 708 -136, 917	70.

Heal th	Financial Systems IU HEALTH WEST	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der (CCN: 15-0158	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/29/2018 11:	
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or at			0	0	70. 97
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				65, 723	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			22, 201, 588	71.00
71. 01	Sequestration adjustment (see instructions)				444, 032	71. 01
71 02	Domonstration payment adjustment amount after sequestration				0	71 02

70. 96	Low volume adjustment for rederal fiscal year (yyyy) (Enter in column 0	0	0	70.96
70.07	the corresponding federal year for the period prior to 10/1)			
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 97
70.00	the corresponding federal year for the period ending on or after 10/1)			70.00
70. 98	Low Volume Payment-3		0	
70. 99	HAC adjustment amount (see instructions)		65, 723	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22, 201, 588	1
71. 01	Sequestration adjustment (see instructions)		444, 032	•
71. 02			0	
72.00	Interim payments		21, 594, 542	
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		163, 014	74.00
	73)			
75. 00	Protested amounts (nonallowable cost report items) in accordance with		412, 780	75.00
	CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91. 00			0	91.00
	· · · · · · · · · · · · · · · · · · ·		_	
	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	1.1		0	93.00
94.00	j . , , , , , , , , , , , , , , , , , ,		0.00	ł
	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96. 00
			On/After 10/1	
	HSP Bonus Payment Amount	1. 00	2. 00	
100.00			0	100.00
100.00	HSP bonus amount (see instructions)	0	U	1100.00
101 00	HVBP Adjustment for HSP Bonus Payment	0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions)	0. 0000000000		1
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
	HRR Adjustment for HSP Bonus Payment			
	HRR adjustment factor (see instructions)	0.0000	0. 0000	1
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustmen			
200.00	extstyle Is this the first year of the current 5-year demonstration period under the 21	st		200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.			ļ
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in first year of th	e current 5-year demons	trati on	
	peri od)			
	Medicare target amount			204.00
	Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209. 00
	Reserved for future use			210.00
	Total adjustment to Medicare IPPS payments (see instructions)			211. 00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00	Low-volume adjustment (see instructions)			213.00
	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimburse	ment)		218. 00
	(line 212 minus line 213) (see instructions)	·		
		,		

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2017 Part A Exhi bit 4 To 12/31/2017 Date/Ti me Prepared: 5/29/2018 11: 42 am Provider CCN: 15-0158

							5/29/2018 11:	42 am
		W/S E Dort A	Amounts (from		XVIII	Hospi tal	PPS Total (Col 2	
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments		0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	15, 592, 192	0	15, 592, 192		15, 592, 192	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	5, 446, 802	0		5, 446, 802	5, 446, 802	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	O	0		0	0	1. 04
2. 00	October 1 Outlier payments for discharges (see instructions)	2. 00	158, 411	0	124, 085	34, 325	158, 410	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
F 00	Indirect Medical Education Adj		0.000000	0.000000	0.000000	0.000000		F 00
5. 00 6. 00	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21. 00 22. 00	0. 000000	0.000000	0.000000	0. 000000	0	5. 00 6. 00
6. 01	instructions) IME payment adjustment for	22. 00	0	0	0	0	0	6. 01
0.01	managed care (see instructions)		J		Ŭ	0	0	0.01
7 00	Indirect Medical Education Adj					0.000000		7 00
7. 00 8. 00	IME payment adjustment factor (see instructions) IME adjustment (see	27. 00 28. 00	0. 000000	0.000000		0. 000000	0	7. 00 8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
0.0.	for managed care (see instructions)	20.0.		C		J	J	0.0.
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Disproportionate Share Adjustm							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0544	0. 0544	0. 0544	0. 0544		10.00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	286, 131	0	212, 054	74, 077	286, 131	11. 00
11. 01	Uncompensated care payments Additional payment for high pe	36.00 rcentage of ES	1, 181, 387 RD beneficiary	0 di scharges	648, 295	533, 092	1, 181, 387	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0		0	0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	22, 664, 923 0	0	16, 576, 627 0	6, 088, 296 0	22, 664, 923 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	22, 664, 923	0	16, 576, 627	6, 088, 296	22, 664, 923	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 873, 082	0	1, 406, 498	466, 584	1, 873, 082	16. 00
17. 00	Special add-on payments for new technologies	54. 00	2, 071	0	2, 071	0	2, 071	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 01 17. 02

111 45	Financial Customs		III UEALTU WEG	CT LIOCDI TAI		la li a		2552 10
	Financial Systems LUME CALCULATION EXHIBIT 4		IU HEALTH WES	Provi der C		Period: From 01/01/2017 To 12/31/2017	u of Form CMS-: Worksheet E Part A Exhibi Date/Time Pre 5/29/2018 11:	t 4 pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	
19. 00	SUBTOTAL			0	17, 985, 19	6, 554, 880	24, 540, 076	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Capital DRG other than outlier		1, 706, 436	0	1, 262, 74	0 443, 696		
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0		0 0	0	
21.00	Capital DRG outlier payments	2. 00	97, 877	0	92, 87	0 5, 007	97, 877	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0.0000		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0	0	23.00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0403	0. 0403	0. 040	0. 0403		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	68, 769	0	50, 88	8 17, 881	68, 769	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 873, 082	0	1, 406, 49	8 466, 584	1, 873, 082	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.00000			27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96				0	0	28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	o	29. 00

100.00

Pt. A, line)
100.00 Transfer low volume adjustments to Wkst. E, Pt. A.

 Heal th Financial
 Systems
 IU HEALTH WEST
 HOSPITAL

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provide
 Provider CCN: 15-0158 Peri od: Worksheet E From 01/01/2017 Part A Exhi bit 5 To 12/31/2017 Date/Time Prepared:

					10 12/31/2017	5/29/2018 11:	
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00					1.00
1. 01	DRG amounts other than outlier payments for	1. 01	15, 592, 192	15, 592, 19:	2	15, 592, 192	1. 01
	discharges occurring prior to October 1	4 00			ooo	ooo	
1. 02	DRG amounts other than outlier payments for	1. 02	5, 446, 802		5, 446, 802	5, 446, 802	1. 02
1 02	discharges occurring on or after October 1	1 02	0	,		_	1 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	\)	0	1.03
	1						
1. 04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
1.01	for Model 4 BPCI occurring on or after	1.01					1.01
	October 1						
2.00	Outlier payments for discharges (see	2. 00	158, 411	124, 08!	34, 326	158, 411	2.00
	instructions)					•	
2. 01	Outlier payments for discharges for Model 4	2. 02	0		0	0	2. 01
	BPCI						
3.00	Operating outlier reconciliation	2. 01	0		0	0	3.00
4.00	Managed care simulated payments	3. 00	0	(0	0	4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
,	(see instructions)						,
6.00	IME payment adjustment (see instructions)	22. 00	0		0		6.00
6. 01	IME payment adjustment for managed care (see	22. 01	0	·	0	0	6. 01
	instructions) Indirect Medical Education Adjustment for the	Add on for S	oction 122 of	the MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000		0.00000		7.00
7.00	instructions)	27.00	0.00000	0.00000	0.00000		7.00
8. 00	IME adjustment (see instructions)	28. 00	0	(0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0		0	0	8. 01
	care (see instructions)						
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	(0	0	9.00
9. 01	Total IME payment for managed care (sum of	29. 01	0	(0	0	9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33. 00	0. 0544	0. 054	0. 0544		10. 00
44.00	(see instructions)	0.4.00	00/ 404	040.05	74 077	00/ 404	44.00
11. 00	Disproportionate share adjustment (see	34. 00	286, 131	212, 05	74, 077	286, 131	11. 00
11. 01	instructions) Uncompensated care payments	36. 00	1, 181, 387	648, 29	533, 092	1, 181, 387	11. 01
11.01	Additional payment for high percentage of ESI		di scharges	040, 27	0 000,092	1, 101, 307	11.01
12. 00	Total ESRD additional payment (see	46. 00	0		0	0	12.00
. 2. 00	instructions)	10.00					12.00
13.00	Subtotal (see instructions)	47. 00	22, 664, 923	16, 576, 62	6, 088, 297	22, 664, 923	13.00
14.00	Hospital specific payments (completed by SCH	48. 00	0		0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15.00	Total payment for inpatient operating costs	49. 00	22, 664, 923	16, 576, 62	6, 088, 297	22, 664, 923	15. 00
	(see instructions)						
16. 00		50. 00	1, 873, 082	1, 406, 498	466, 584	1, 873, 082	16. 00
47.00	Wkst. L, Pt. I, if applicable)	E4 00	0.074	0.07		0.074	47.00
17.00		54. 00	2, 071	2, 07	0	2, 0/1	17.00
17. 01	Net organ acquisition cost	49.00	_	ļ ,		_	17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	1	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment	93. 00	0	,	0	0	18. 00
10.00	amount (see instructions)	73.00			1		10.00
19.00	SUBTOTAL			17, 985, 19	6, 554, 881	24, 540, 076	19.00
			ı	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5, 55 1, 561	2.,010,070	

Health Financial Systems	ealth Financial Systems IU HEALTH WEST HOSPITAL				In Lieu of Form CMS-2552-10			
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provi der Co		Period: From 01/01/2017 Fo 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/29/2018 11:	pared:		
		Title	XVIII	Hospi tal	PPS			
	Wkst. L, line	(Amt. from Wkst. L)						
	0	1.00	2.00	3. 00	4. 00			
20.00 Capital DRG other than outlier	1. 00	1, 706, 436	1, 262, 740	443, 696	1, 706, 436	20.00		

						5/29/2018 11:	42 am
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	1, 706, 436	1, 262, 74	0 443, 696	1, 706, 436	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	97, 877	92, 87	5, 007	97, 877	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0403	0. 040	0. 0403		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	68, 769	50, 88	17, 881	68, 769	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 873, 082	1, 406, 49	8 466, 584	1, 873, 082	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1. 00	2. 00	3. 00	4. 00	
27.00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	185, 708	129, 57	2 56, 136	185, 708	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-136, 917	-98, 24	4 -38, 673	-136, 917	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 65, 723		
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0158	From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 11:42 am

			12/01/201/	5/29/2018 11:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6, 332	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		11, 860, 555	2.00
3.00	OPPS payments			12, 944, 518	3.00
4.00	Outlier payment (see instructions)			26, 344	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	5. 00
6.00	Line 2 times line 5	,		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	LV col 13 line 200		0	9.00
10.00	Organ acquisitions	,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 332	
	COMPUTATION OF LESSER OF COST OR CHARGES			0,002	
	Reasonable charges				
12.00	Ancillary service charges			39, 764	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			39, 764	
00	Customary charges			37,731	
15. 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable fo			0	16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(on a chargebasi's	O	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			39, 764	
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds l	ine 11) (see	33, 432	
17.00	instructions)	if it time to exceeds t	1116 11) (366	33, 432	17.00
20. 00	Excess of reasonable cost over customary charges (complete on	lvifline 11 exceeds l	ine 18) (see	0	20. 00
20.00	instructions)	if it time it execess i	1116 10) (366	O	20.00
21. 00	Lesser of cost or charges (see instructions)			6 332	21.00
22. 00	Interns and residents (see instructions)			0, 332	
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		12, 970, 862	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			12, 770, 002	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (fo	ur CAH see instructions	`	2, 549, 040	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			10, 428, 154	1
27.00	instructions)	prus trie sum or rifles z	2 and 25] (366	10, 420, 134	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			10, 428, 154	
31.00	Primary payer payments			2, 263	1
32. 00	Subtotal (line 30 minus line 31)			10, 425, 891	•
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI)	CES)		10, 120, 071	02.00
33 00	Composite rate ESRD (from Wkst. I-5, line 11)	020)		0	33.00
	Allowable bad debts (see instructions)			609, 895	
35. 00	Adjusted reimbursable bad debts (see instructions)			396, 432	
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		261, 248	•
	Subtotal (see instructions)	. 401. 65)		10, 822, 323	
38.00	MSP-LCC reconciliation amount from PS&R			-7	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	(2)		Ü	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	•
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	deci devices (see institu	011 0113)	0	39. 99
40. 00	Subtotal (see instructions)			10, 822, 330	
40. 01	Sequestration adjustment (see instructions)			216, 447	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41. 00	Interim payments			10, 397, 916	
42.00	Tentative settlement (for contractors use only)			0	42.00
43. 00	Balance due provider/program (see instructions)			207, 967	
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	chanter 1	207, 707	
1 1. 00	§115. 2		5ap (5) 1,	O	11.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			Λ	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money				92.00
93. 00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.00
55	1		!	O	

Health Financial Systems IU I ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/29/2018 11: 42 am Provider CCN: 15-0158

					5/29/2018 11:4	42 am
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		21, 594, 542		10, 397, 916	1. 00
2.00	Interim payments payable on individual bills, either		O		o	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provi der		_	T	_	
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	Secretary to Secretary		0		0	3. 05
2 50	Provi der to Program					2 50
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51 3. 52			i o			3. 51 3. 52
3. 52 3. 53			i o			3. 52
3. 53			i o			3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 99
3. 77	3. 50-3. 98)				١	3. 77
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		21, 594, 542		10, 397, 916	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		21, 374, 342		10, 377, 710	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	ļ.				
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					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		163, 014		207, 967	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		21, 757, 556		10, 605, 883	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems IU HEALTH	WEST HOSPITAL	In Lie	u of Form CMS	-2552-10	
CALCUL	From 01/01/2017 Pa					
			To 12/31/2017	Date/Time Pr 5/29/2018 11		
		Title XVIII	Hospi tal	PPS		
				1. 00		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
1. 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL		0.14		1.00	
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3. 00						
4. 00						
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2	· · ·			4. 00 5. 00	
6. 00	Total hospital charity care charges from Wkst. S-10, col				6.00	
7. 00	CAH only - The reasonable cost incurred for the purchase		Wkst. S-2, Pt. I		7. 00	
	line 168	33				
8.00	Calculation of the HIT incentive payment (see instruction	ns)			8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)			30.00	
	Other Adjustment (specify)				31.00	
32. 00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instructio	ns)		32.00	

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: 15-0158

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/29/2018 11: 42 am

——————————————————————————————————————					5/29/2018 11:	42 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	338, 896, 627	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes recei vabl e	781, 984	0	0	1	
4.00	Accounts receivable	30, 131, 751	0	0	0	
5. 00	Other recei vable	-5, 864, 054	0	0	0	
6.00	Allowances for uncollectible notes and accounts receivable		0	0	0	1
7.00	Inventory	1, 521, 470		0	0	
8. 00	Prepai d expenses	832, 880	0	0	0	
9. 00 10. 00	Other current assets			0	0	
11. 00	Due from other funds Total current assets (sum of lines 1-10)	366, 300, 658		0	l .	
11.00	FIXED ASSETS	300, 300, 030	0	0		11.00
12. 00	Land		ol ol	0	0	12.00
13. 00	Land improvements	6, 800, 703		0	1	
14. 00	Accumulated depreciation	-4, 636, 562		0	1	
15. 00	Bui I di ngs	103, 481, 243		0	1	1
16. 00	Accumulated depreciation	-34, 608, 880		0	o	
17. 00	Leasehold improvements	511, 213		0	0	1
18.00	Accumul ated depreciation	-373, 996		0	0	18.00
19.00	Fi xed equi pment		0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	12, 997	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Maj or movable equipment	70, 825, 342	. 0	0	0	23.00
24.00	Accumulated depreciation	-57, 285, 301	0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26.00	Accumul ated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30.00	Total fixed assets (sum of lines 12-29)	84, 726, 759	0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	0	0	0	1	
32. 00	Deposits on Leases	0	0	0	1	1
33.00	Due from owners/officers	0	0	0	0	
34. 00	Other assets	5, 365, 117		0	0	1
35.00	Total other assets (sum of lines 31-34)	5, 365, 117		0	1	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	456, 392, 534	. 0	0	. 0	36.00
37. 00	Accounts payable	10, 027, 456	ol ol	0	0	37.00
38.00	Salaries, wages, and fees payable	4, 481, 885		0	1	
39. 00	Payrol I taxes payable	4, 401, 003		0		
40. 00	Notes and Loans payable (short term)	93, 989, 349		0	o o	1
41. 00	Deferred income	70, 707, 017		0	ol o	
42. 00	Accel erated payments			O		42.00
43. 00	Due to other funds		0	0	0	
44. 00	Other current liabilities	1, 276, 702		0	o	
45.00	Total current liabilities (sum of lines 37 thru 44)	109, 775, 392		0		1
	LONG TERM LIABILITIES		- 1			
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured Loans	0	0	0	0	48.00
49.00	Other long term liabilities	3, 984, 927	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3, 984, 927	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	113, 760, 319	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	342, 632, 215				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0	4	54.00
55.00	Donor created - endowment fund balance - unrestricted			0	4	55.00
56.00	Governing body created - endowment fund balance			0	4	56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 -:	replacement, and expansion			_		
59. 00	Total fund balances (sum of lines 52 thru 58)	342, 632, 215		0	0	1
60.00	Total liabilities and fund balances (sum of lines 51 and	456, 392, 534	0	0	0	60.00
	[59]	I	1		I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet G-1 From 01/01/2017 Provi der CCN: 15-0158

					To 12/31/2017		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TEMP RESTRICTED FUND BALANCE	19, 813 0 0 0 0	291, 437, 252 51, 175, 151 342, 612, 403		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 00 6. 00 7. 00 8. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	1 0 0 0 0	19, 813 342, 632, 216 1 342, 632, 215		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TEMP RESTRICTED FUND BALANCE Total additions (sum of line 4-9)	0	0 0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2017 | Parts | & II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0158

			To	12/31/2017	Date/Time Pre 5/29/2018 11:			
	Cost Center Description	Inpati	ent	Outpati ent	Total	42 aiii		
	333 331 333 F C 31	1.00		2. 00	3. 00			
	PART I - PATIENT REVENUES				2. 22			
	General Inpatient Routine Services							
1.00	Hospi tal	54, 25	2, 644		54, 252, 644	1. 00		
2. 00	UBPROVIDER - IPF		,		. , . , ,	2.00		
3.00	SUBPROVI DER - I RF					3. 00		
4.00	SUBPROVI DER					4.00		
5.00	Swing bed - SNF		0		0	5.00		
6.00	Swing bed - NF		0		0	6.00		
7.00	SKILLED NURSING FACILITY					7.00		
8.00	NURSING FACILITY					8. 00		
9.00	OTHER LONG TERM CARE					9.00		
10.00	Total general inpatient care services (sum of lines 1-9)	54, 25	2, 644		54, 252, 644	10.00		
	Intensive Care Type Inpatient Hospital Services							
11. 00	INTENSIVE CARE UNIT	16, 27	4, 935		16, 274, 935	11.00		
12.00	NEONATAL INTENSIVE CARE UNIT	4, 55	3, 512		4, 553, 512	12.00		
13.00	BURN INTENSIVE CARE UNIT					13.00		
14.00	SURGICAL 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	s 20, 82	8, 447		20, 828, 447	16.00		
	11-15)							
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	75, 08	-		75, 081, 091	17.00		
18. 00	Ancillary services	223, 24		350, 323, 002	573, 571, 493	18. 00		
19. 00	Outpatient services	29, 99		148, 132, 741	178, 130, 666	19. 00		
20.00	RURAL HEALTH CLINIC		0	0	0	20.00		
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00		
22. 00	HOME HEALTH AGENCY					22. 00		
23. 00	AMBULANCE SERVICES					23.00		
24.00	CMHC					24.00		
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00		
26. 00	HOSPI CE			_	_	26. 00		
27. 00	NONALLOWABLE REVENUE		0	0	0	27. 00		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk	kst. 328, 32	7,507	498, 455, 743	826, 783, 250	28. 00		
	G-3, line 1)							
20.00	PART II - OPERATING EXPENSES		1	150 (41 147		20.00		
30.00	Operating expenses (per Wkst. A, column 3, line 200) ROUNDING		0	159, 641, 147		29. 00 30. 00		
	ROUNDING		0					
31. 00 32. 00			0			31. 00 32. 00		
			0			32.00		
33. 00 34. 00			0			34.00		
35.00			0			34. 00 35. 00		
36.00	Total additions (sum of lines 30-35)		U	0		36.00		
37.00			0	U		36.00		
38. 00	DEDUCT (SPECIFY)		0			38.00		
39.00			0			38. 00 39. 00		
40.00			0			40. 00		
41. 00		-	0			40.00		
41.00	Total deductions (sum of lines 37-41)	-	U	0		41.00		
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfer		159, 641, 147		42.00		
45.00	to Wkst. G-3, line 4)	11131 61		137, 041, 147		45.00		
	10 mcst. 0 3, 11116 4)	ı		١				

	Financial Systems	IU HEALTH WEST HOSPITAL		u of Form CMS-	
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0158 Period:		Period: From 01/01/2017	Worksheet G-3	
				Date/Time Pre	pared:
			1	5/29/2018 11:	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part			826, 783, 250	1.00
2. 00	Less contractual allowances and discounts on	patients' accounts		619, 277, 087	
3. 00	Net patient revenues (line 1 minus line 2)			207, 506, 163	1
4. 00	Less total operating expenses (from Wkst. G-2			159, 641, 147	1
5. 00	Net income from service to patients (line 3 m	nus line 4)		47, 865, 016	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8. 00	· ·			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	ts		0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical sup			0	16. 00
17. 00	Revenue from sale of drugs to other than patie			0	17. 00
18. 00	Revenue from sale of medical records and abst			0	18. 00
19. 00				0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and	d 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			3, 310, 135	24.00
25.00	Total other income (sum of lines 6-24)			3, 310, 135	25. 00
26.00	Total (line 5 plus line 25)			51, 175, 151	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and subse	cripts)		0	28.00

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

51, 175, 151 29. 00

28.00

	n Financial Systems	IU HEALTH WEST			u of Form CMS-2	2552-10
CALCUI	LATION OF CAPITAL PAYMENT		Provi der CCN: 15-0158	Peri od: From 01/01/2017 To 12/31/2017		
			Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD				1. 00	
	CAPITAL FEDERAL AMOUNT					1
1. 00	Capital DRG other than outlier				1, 706, 436	1.00
1. 01	Model 4 BPCI Capital DRG other than out	lier			0	
2. 00	Capital DRG outlier payments				97, 877	2.00
2. 01	Model 4 BPCI Capital DRG outlier paymen				0	2. 01
3. 00	Total inpatient days divided by number of		eporting period (see ins	tructi ons)	78. 95	
4. 00	Number of interns & residents (see inst				0. 00	
5.00	Indirect medical education percentage (4	0.00	
5. 00	Indirect medical education adjustment (I. 01) (see instructions)	muitipiy iine 5 by the	e sum of lines I and I.U	i, columns i and	0	6.00
7. 00	Percentage of SSI recipient patient days	s to Medicare Part A p	oatient days (Worksheet	E, part A line	2. 83	7. 00
3. 00	30) (see instructions) Percentage of Medicaid patient days to	total days (see instri	ictions)		16. 70	8.00
9. 00	Sum of lines 7 and 8	total days (see Histit	ictions)		19. 53	
10. 00	Allowable disproportionate share percent	tage (see instructions	5)		4. 03	
11. 00			68, 769			
12. 00	Total prospective capital payments (see	instructions)			1, 873, 082	12.00
					4.00	
	PART II - PAYMENT UNDER REASONABLE COST				1. 00	
1. 00	Program inpatient routine capital cost	(see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cos				0	2.00
3. 00	Total inpatient program capital cost (I				0	3.00
4. 00	Capital cost payment factor (see instru	ctions)			0	4.00
5. 00	Total inpatient program capital cost (I	ine 3 x line 4)			0	5.00
					1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYM					
1. 00	Program inpatient capital costs (see in:				0	
2. 00	Program inpatient capital costs for ext		ces (see instructions)		0	2.00
3.00	Net program inpatient capital costs (li				0	3.00
1.00	Applicable exception percentage (see in: Capital cost for comparison to payments				0.00	
5. 00 6. 00	Percentage adjustment for extraordinary		netructions)		0.00	
7. 00	Adjustment to capital minimum payment lo			x line 6)	0.00	
8. 00	Capital minimum payment level (line 5 pl		,		Ö	8.00
0.00	Current year canital nayments (from Dar		cable)		0	

1. 01	Model 4 BPCI Capital DRG other than outlier	0	1. 01
2. 00	Capital DRG outlier payments	97, 877	2.00
2. 00	Model 4 BPCI Capital DRG outlier payments	97, 077	
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	78. 95	1
4. 00	Number of interns & residents (see instructions)	0. 00	•
5. 00	, ,	0.00	1
	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and	0.00	6.00
6. 00	1.01)(see instructions)	-	
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2. 83	7. 00
8.00	Percentage of Medicaid patient days to total days (see instructions)	16. 70	8.00
9.00	Sum of lines 7 and 8	19. 53	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4. 03	10.00
11. 00	Disproportionate share adjustment (see instructions)	68, 769	11.00
12.00	Total prospective capital payments (see instructions)	1, 873, 082	12.00
		1. 00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	o	3.00
4.00	Capital cost payment factor (see instructions)	o	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	o	5.00
		1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	o	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	o	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	o	5.00
6. 00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	o	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	ol	8.00
9. 00	Current year capital payments (from Part I, line 12, as applicable)	o	1
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	ol	10.00
11. 00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	ol	12.00
13. 00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	ı
14. 00	Carryover of accumulated capital minimum payment level over capital payment for the following period	0	1
11.00	(if line 12 is negative, enter the amount on this line)	ĭ	11.00
15. 00	Current year allowable operating and capital payment (see instructions)	0	15.00
		0	
	Current year exception offset amount (see instructions)	0	1
17.00	pour one your on or see amount (see that detrois)	٥١	