INDIANA UNIVERSITY HEALTH BEDFORD

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1328 Worksheet S Peri od. From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: То 5/28/2019 12:16 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/28/2019 Time: 12:16 pm use only 2. [] Manually submitted cost report] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 **[**

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. [use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF 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 OF 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 INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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. [X] 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. MI CHAEL CRAI G (Si gned) Officer or Administrator of Provider(s) CHIEF FINANCIAL OFFICER Title

(Dated when report is electronically signed.)

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	145, 096	-402, 036	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	418	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	145, 514	-402, 036	0	0	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I	I NDI ANA UNI DENTI FI CATI ON DA				15-1328	Peri od:		u of For Workshe		
							From 01/0 To 12/3	01/2018 01/2018	Date/Ti		
	1.00	2	00		3.00			4.00	5/28/20	019 12:	16 p
	Hospital and Hospital Health Care Co	mplex Address:									
))	Street: 2900 WEST SIXTEENTH STREET City: BEDFORD	PO Box: State: I	N 7	ip Code	· 17101	Cour	nty: LAWREN	CE.			1.
, 	City. Debrokb	Component Na		CCN	CBSA	Provi de			ent Syst	em (P,	2.
			N	umber	Number	r Type	Certifie		, 0, or		4
		1.00		2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	XI X 8.00	-
	Hospital and Hospital-Based Componen	t Identification:									
)	Hospi tal	INDIANA UNIVERSI HEALTH BEDFORD	TY 1	51328	99915	1	10/01/20	05 N	0	0	3.
)	Subprovider - IPF										4
)	Subprovider - IRF										5.
))	Subprovider - (Other) Swing Beds - SNF	IU HEALTH BEDFOR	D - 1	5Z328	99915		10/01/20	05 N	0	0	6.
	Ū.	SWING BED		02020	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10/01/20				
))	Swing Beds - NF Hospital-Based SNF										8.
	Hospi tal -Based NF										10.
00	Hospital-Based OLTC										11.
	Hospital-Based HHA Separately Certified ASC										12.
	Hospi tal -Based Hospi ce										14.
	Hospital-Based Health Clinic - RHC										15.
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16
0	Renal Dialysis										18
0	Other										19
							Fro		Tc 2.0		-
	Cost Reporting Period (mm/dd/yyyy)						01/01	/2018	12/31		20
00	Type of Control (see instructions)						2	2			21.
						1.00	2.	00	3.	00	
	Inpatient PPS Information	ournontly and i	1	ato 6		N					
00	Does this facility qualify and is it disproportionate share hospital adju:					IN					22.
	§412.106? In column 1, enter "Y" fo	r yes or "N" for	no. Is thi	s							
	facility subject to 42 CFR Section §- hospital?) In column 2, enter "Y" for			ment							
)1	Did this hospital receive interim un			for this	5	Ν	Ν	I			22.
	cost reporting period? Enter in colu										
	the portion of the cost reporting per Enter in column 2, "Y" for yes or "N										
	reporting period occurring on or afte	er October 1. (se	e instruct	tions)							
)2	Is this a newly merged hospital that					Ν	Ν	1			22.
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N				·)						
	cost reporting period prior to Octob	er 1. Enter in co	olumn 2, "א	Y" for y							
	or "N" for no, for the portion of the October 1.	e cost reporting	period on	or afte	er						
)3	Did this hospital receive a geograph					Ν	N	I	N	I	22.
	rural as a result of the OMB standard										
	adopted by CMS in FY2015? Enter in conformation of the cost reportion										
	in column 2, "Y" for yes or "N" for i	no for the portio	on of the d	cost							
	reporting period occurring on or afte Does this hospital contain at least				.						
	counted in accordance with 42 CFR 412										
~	yes or "N" for no.										
0	Which method is used to determine Me below? In column 1, enter 1 if date o				- 3		3 N	1			23.
	if date of discharge. Is the method o	of identifying th	ne days in	this co							
	reporting period different from the reporting period? In column 2, enter										
	peperting period: In corumn z, enter	i i i oi yes or	In-State	In-St	ate	Out-of	Out-of	Medi ca	aid 0	ther	
			Medi cai d	Medi c	aid	State	State	HMO da	ays Med	di cai d	
			paid days	eligi unpa		Medicaid aid days	Medicaid eligible		0	days	
				day:		and days	unpai d				
			1.00	2.0		3.00	4.00	5.00		5.00	-
				0	0	0	0		0	C	
00	If this provider is an IPPS hospital, in-state Medicaid paid days in colum										24.
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in colu	n 1, in-state umn 2,) 24.
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in colu out-of-state Medicaid paid days in co	n 1, in-state umn 2, olumn 3,) 24.
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in colu	n 1, in-state umn 2, olumn 3, d days in column									24.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC			1/2018	Part Date/ 5/28/	Time Pre 2019 12:	epared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	iys M	Other edi cai d days	
5.00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.0
5.00	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0		unal C		of Coord	
					1. (of Geogr .00	-
6. 00	Enter your standard geographic classification (not wa		at the beg	inning of t		2			26. (
7.00 5.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	ige) status 2" for ri cation in d	ural. If ap column 2.	pl i cabl e,		2			27.0
5.00	effect in the cost reporting period.								00.
					Begi nr 1. (di ng: 00	-
5.00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb				~ ~	36.
7.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		of period	s MDH statu	s	0			37.
7. 01	is in effect in the cost reporting period.	e MDH trans	sitional pa	yment in					37.
3. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	of MDH sta	atus. Ifli	ne 37 is					38.
	enter subsequent dates.					N		(/)	-
					Y/			Y/N 00	-
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or he mileage	(iii)? Ent requiremen	er in colum ts in	in			N	39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	⁻"Y" for y					N	40.
						1. 00	XVI I 2. 0		-
	Prospective Payment System (PPS)-Capital								
5. 00 5. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					N	N N	N	45.
7 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	. L, Pt. II	I and Wkst	. L-1, Pt.	I through	N		N	47.
7.00 3.00	Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment Teaching Hospitals	•		5		N N	N N	N N	47.
5.00 7.00	Is this a hospital involved in training residents in or "N" for no.				2	N			56. 57.
. 00	<pre>If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II</pre>	yes or "N" h of this o ", complete	' for no in cost report e Worksheet	column 1. ing period?	lf column 1 ' Enter "Y"				57.
. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		s as	N			58.
. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	WKST. D-2,	Pt. I. NAHE 413.8 Y/N	35 Worksh Line	e #	Qual i	Through fication ion Code	1

ealth Financial System OSPITAL AND HOSPITAL H	EALTH CARE COMPLEX IDENTIFICATION DA		HEALTH BEDFOR Provider CC	CN: 15-1328 P	eriod: rom 01/01/2018		pared
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	1
	l receive FTE slots under ACA ter "Y" for yes or "N" for no in				0.00	0.00	61.0
column 1. (see i 1.01 Enter the averag FTEs from the ho							61. (
i nstructions) 1.02 Enter the curren FTE count (exclu	t year total unweighted primary care ding OB/GYN, general surgery FTEs, FTEs added under section 5503 of						61. (
and/or general s	uctions) ine FTE count for primary care urgery residents, which is used for liance with the 75% test. (see						61. (
surgery allopath	of unweighted primary care/or ic and/or osteopathic FTEs in the						61. (
1.05 Enter the differ and/or general s primary care and	orting period. (see instructions). ence between the baseline primary urgery FTEs and the current year's /or general surgery FTE counts (line						61.0
1.06 Enter the amount used for cap rel	61.03). (see instructions) of ACA §5503 award that is being ief and/or FTEs that are nonprimary surgery. (see instructions)						61. (
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
I.10 Of the FTEs in I	ine 61.05, specify each new program		1.00	2.00	3.00	4.00	61.
specialty, if an for each new pro column 1, the pr program code. En unweighted count FTE unweighted c 1.20 Of the FTEs in I program specialt residents for ea instructions) En Enter in column 3, the IME FTE u	y, and the number of FTE residents gram. (see instructions) Enter in ogram name. Enter in column 2, the ter in column 3, the IME FTE Enter in column 4, the direct GME				0.00	0.00	61.:
						1.00	
	ffecting the Health Resources and Ser						
your hospital re 2.01 Enter the number during in this c	of FTE residents that your hospital ceived HRSA PCRE funding (see instruct of FTE residents that rotated from a cost reporting period of HRSA THC proc	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.(62.(
3.00 Has your facilit	<u>Is that Claim Residents in Nonprovide</u> y trained residents in nonprovider se N" for no in column 1. If yes, comple	ettings	during this co	67. (see instru	uctions)	N	63.
				Unweighted FTEs Nonprovider Site	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of	the ACA Base Year FTE Residents in No	onnrovi	ler Settings-	1.00 This base year	2.00	3.00	
4.00 Enter in column in the base year resident FTEs at settings. Enter resident FTEs th	ns on or after July 1, 2009 and befor 1, if line 63 is yes, or your facilit period, the number of unweighted nor tributable to rotations occurring in in column 2 the number of unweighted at trained in your hospital. Enter ir ided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. med residents y care provider imary care a 3 the ratio	0. 00	-		64.(

			Fr	riod: om 01/01/2018	Worksheet S-2 Part I	
			To	12/31/2018	Date/Time Pre 5/28/2019 12:	pared 16 pm
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTES	FTEs in	$(\operatorname{col} \cdot 3 + \operatorname{col} \cdot$	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	1
0.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility 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)						
			Unweighted	Unwei ghted	Ratio (col. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current	/ear FTE Residents i	n Nonprovider Settir				
beginning on or after July 1, 201 .00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1)	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. (
(column 1 divided by (column 1 +		structions)				
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col 3/	/
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
.00 Enter in column 1, the program	Program Name	Program Code	FTĔs Nonprovi der	FTEsin	(col. 3 + col. 4)) 5.00	_
COD Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	U U		FTĔs Nonprovider Site 3.00	FTES in Hospital 4.00 0.00	(col. 3 + col. 4)) 5.00 0.000000	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00 25	2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.000000 0.000000 0.0000000	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00 25 vchiatric Facility (2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.000000 0.000000 0.0000000	-
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	1.00 1.00 2S ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac ≥ 112.424 (d)(1)(iii) sate which program y	2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most b. (see ing 0.	(col . 3 + col . 4)) 5.00 0.000000 0.000000 0.0000000	
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	1.00 1.00 2S ychiatric Facility (the facility have a effore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y y PPS habilitation Facilit	2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 intain an IPF subp sing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most b. (see ing 0.	(col . 3 + col . 4)) 5.00 0.000000 0 2.00 3.00 0 0 0 2.00 3.00	_

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1328 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: То 12/31/2018 5/28/2019 12:16 pm 1.00 Long Term Care Hospital PPS 80.00 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. ٧ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90 00 ves or "N" for no in the applicable column. $|I\,s\,$ this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 Ν Ν 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 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. 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. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 Υ 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. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ν γ 98.02 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. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 Ν column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Υ 98.06 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. Rural Providers 105.00 Does this hospital qualify as a CAH? Y 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R Ν 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 108.00 Ν CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Respi ratory Physi cal Occupati onal Speech 1 00 2 00 4 00 3 00 109.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, 110.00 Ν complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	LTH BEDFORD rovider CCN: 15-1328	Period: From 01/01/ To 12/31/	2018	Workshe Part I Date/Ti 5/28/20	et S-2 me Pre	epared:
		1.00		2.0)0	
11.00 If this facility qualifies as a CAH, did it participate in the F Health Integration Project (FCHIP) demonstration for this cost r "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is partici Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services.	reporting period? Enter 1 is Y, enter the pating in column 2.	r N				111.00
			1.00	2.00	3.00	1
 Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" is yes, enter the method used (A, B, or E only) in column 2. If 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) be Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for 17.00 Is this facility legally-required to carry mal practice insurance 	column 2 is "E", ente ir long term care (inc ased on the definition yes or "N" for no.	r in column ludes n in CMS	N		0	115. 00 116. 00 117. 00
no.	,					
18.00 Is the malpractice insurance a claims-made or occurrence policy? claim-made. Enter 2 if the policy is occurrence.	Enter 1 if the polic	y is	1			118.00
	Premi ums	Losse	s	Insur	ance	
18.01 List amounts of malpractice premiums and paid losses:	1.00	2.00	0	3. () 118.0 ²
	01,0		0			110.0
18.02 Are malpractice premiums and paid losses reported in a cost cent	er other than the	1.00 N		2.0	00	118.0
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Har §3121 and applicable amendments? (see instructions) Enter in col "N" for no. Is this a rural hospital with < 100 beds that qualif Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	mless provision in AC, umn 1, "Y" for yes or ies for the Outpatien			Ν		119. 0 120. 0
21.00 Did this facility incur and report costs for high cost implantab	le devices charged to	Y				121.0
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.	in §1903(w)(3) of the "Y", enter in column :	e Y 2		5.0	00	122. 0
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for ye	s and "N" for no. If	N				125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter		e				126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter t						127.0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter t	he certification date					128. 0
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter th	e certification date	in				129. (
column 1 and termination date, if applicable, in column 2. 30.00 of this is a Medicare certified pancreas transplant center, enter						130. 0
date in column 1 and termination date, if applicable, in column 31.00 of this is a Medicare certified intestinal transplant center, er	ter the certification					131. 0
date in column 1 and termination date, if applicable, in column 32.00 If this is a Medicare certified islet transplant center, enter t						132. 0
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter t in column 1 and termination date if applicable, in column 2.	he certification date					133. 0
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the OF and termination date, if applicable, in column 2.	0 number in column 1					134. 0
All Providers						
40.00 Are there any related organization or home office costs as defir	and the OMC Durk 1E 1	Y	T	15H0)59	140. 0

	X IDENTIFICATION DATA	RSITY HEALTH BE	er CCN: 1	5-1328			Date/Time Pre	2 epared:
1.00		2.00				3.00	5/28/2019 12:	:16 pm
If this facility is part of a cha	in organization, enter		through	143 the	e name a		of the	
home office and enter the home of			number.					_
141.00 Name: INDIANA UNIVERSITY HEALTH,		e: WPS		Contra	ctor's N	lumber: 0810)1	141.00
42.00 Street: 340 WEST 10TH STREET 43.00 City: INDIANAPOLIS	PO Box: State:	IN		Zip Co	de·	4620	12	142.00
	jotate.			210 00	uc.	4020		145.00
							1.00	
44.00 Are provider based physicians' co	sts included in Worksh	eet A?					Y	144.0
						1.00	2.00	-
45.00 If costs for renal services are c	aimed on Wkst. A. lin	e 74, are the c	osts fo	r		1.00	2.00	145.0
inpatient services only? Enter "Y								
no, does the dialysis facility in	clude Medicare utiliza							
period? Enter "Y" for yes or "N"								
46.00 Has the cost allocation methodolog					l f	N		146. 0
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o		ub. 15-2, chapt	EI 40,	34020)	· ·			
					1			
							1.00	
47.00 Was there a change in the statist							N	147. C
48.00 Was there a change in the order of							N	148.0
49.00Was there a change to the simplif	eu cost finding metho	d? Enter "Y" fo Part A		<u>r "N" f</u> Part B		Title V	N Title XIX	149.0
		1.00		2.00		3.00	4.00	-
Does this facility contain a prov	ider that qualifies fo		from th		cation			
or charges? Enter "Y" for yes or								
55.00Hospi tal		N		Ν		N	N	155. 0
56.00 Subprovider - IPF		N		N		N	N	156.0
57.00 Subprovider - IRF		N		Ν		N	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF		Ν		Ν		Ν	N	158. C
60. 00 HOME HEALTH AGENCY		N		N		N	N	160. 0
61. 00 CMHC				N		N	N	161.0
							1.00	
Multicampus				1	Course (N	1/5 0
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that na	s one or more c	ampuses	in dir	rerent (BSAS?	N	165.0
	Name	County	5	State	Zip Code	e CBSA	FTE/Campus	
	0	1.00		2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each							0.0	0 166. 0
	1							
campus enter the name in column								1
0, county in column 1, state in								
0, county in column 1, state in column 2, zip code in column 3,								
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in								
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)							1.00	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI					nent Act			147.0
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use	r under §1886(n)? Ent	er "Y" for yes	or "N"	for no.		pr the	Y	
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OSPI L	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2018 To 12/31/2018		
					5/28/2019 12	
				Y/N	Date	_
			Fata	1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	I FOF ALL NU FE	sponses. Ente	r all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)			
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. (
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home c or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members c of directors through ownership, control, or family and othe	offices, drug ler or its of the board	Y			3.
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.
00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit rec					
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities	16		N		- ,
. 00	Column 1: Are costs claimed for nursing school? Column 2:	ir yes, is th	ie provider is	N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	structions		N		7.
. 00 . 00	Were nursing school and/or allied health programs approved		l during the	N		8.
00	cost reporting period? If yes, see instructions.	anu/or renewed	i dui ring the	IN		0.
00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	Ν		9.
00	program in the current cost report? If yes, see instruction					
0. 00	Was an approved Intern and Resident GME program initiated o		he current	N		10.
	cost reporting period? If yes, see instructions.					
1.00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11.
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
					1.00	
	Bad Debts				.,	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			st reporting	Y N	12.
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		*		Ν	14.
6.00	Did total beds available change from the prior cost reporti				<u>N</u>	15.
		Y/N	t A	Par Y/N		_
		1.00	Date 2.00	3.00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/03/2019	Y	04/03/2019	17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		Ν		18.
9. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

Health Financial Systems

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	1	Period: From 01/01/2018 To 12/31/2018		repared:
		Descri	ption	Y/N	Y/N	
		()	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	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost repo	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	f yes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit	Ν	27.00
	Interest Expense				<u> </u>	-
28.00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into dur	ing the cost	reporting	Ν	28.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		bt Service Re	serve Fund)	Ν	29.00
30.00	Has existing debt been replaced prior to its scheduled mati instructions.		debt? If yes,	see	Ν	30.00
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see	N	31.00
	instructions. Purchased Services					
	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instru	uctions.	0		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	plied pertainin	g to competiti	ve bidding? If	N	33.00
	Provi der-Based Physi ci ans					_
34.00	Are services furnished at the provider facility under an a	rrangement with	provi der-base	ed physi ci ans?	Y	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreemen	ts with the p	rovi der-based	N	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.			-	
				Y/N	Date	
				1.00	2.00	
0/ 00	Home Office Costs					
	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 p	repared by the	nome office?	Y		37.00
38.00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			Ν		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to othe			Ν		39. 00
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lfyes, see	Ν		40.00
	instructions.					_
		1.	00	2.	00	
	Cost Report Preparer Contact Information	1				_
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
42.00	respectively. Enter the employer/company name of the cost report	I NDI ANA UNI VER	SITY HEALTH			42.00
43.00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@I UHEALT	H. ORG	43.00
		1		- T		0

Heal th	Financial Systems	INDIANA UNIVERSITY	Y HEALTH BED	FORD		In Lieu	u of Form CM	8-2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT (QUESTI ONNAI RE	Provi der	CCN: 15-1328	Peri	od: 01/01/2018	Worksheet S Part II	-2
						12/31/2018		
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the ti	tle/position	DI RECTOR					41.00
	held by the cost report preparer in column	ns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cos	st report						42.00
	preparer.							
43.00	Enter the telephone number and email addre	ess of the cost						43.00
	report preparer in columns 1 and 2, respec	cti vel y.						

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	N: 15-1328	Period: From 01/01/2018	Worksheet S-3 Part I Date/Time Pre	
					To 12/31/2018	5/28/2019 12:	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	19	6, 93	69, 744. 00	0	1. (
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
~ ~	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)						2.
. 00	HMO I PF Subprovider						3.
. 00	HMO I RF Subprovider						4.
. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.
. 00	Hospital Adults & Peds. Swing Bed NF					0	
. 00	Total Adults and Peds. (exclude observation		19	6, 93	69, 744. 00	0	7.
00	beds) (see instructions)	01.00	,	0.44			
. 00	INTENSIVE CARE UNIT	31.00	6	2, 19	21, 600. 00	0	8.
00	CORONARY CARE UNIT						9.
). 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY		0.5	0.44			13.
4.00	Total (see instructions)		25	9, 12	91, 344. 00	0	14.
5.00	CAH visits					0	15.
5.00	SUBPROVIDER - IPF						16.
7.00 3.00	SUBPROVIDER - IRF						17.
9.00 9.00							19
	SKILLED NURSING FACILITY						
). 00 . 00	NURSING FACILITY OTHER LONG TERM CARE						20.
. 00	HOME HEALTH AGENCY						22
. 00							22
. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23
. 10		30, 00					24
. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24
. 00	RURAL HEALTH CLINIC						25
. 00	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
. 25 . 00	Total (sum of lines 14-26)	69.00	25			0	20
. 00 3. 00	Observation Bed Days		25			0	
. 00	Ambul ance Trips					0	29
). 00	Employee discount days (see instruction)						30.
. 00	Employee discount days (see fisting for the fi						31.
2.00			o		0		31.
	Labor & delivery days (see instructions)		0		U I		
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.
3. 00	LTCH non-covered days						33.
	LTCH site neutral days and discharges						33.

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	1	Period: From 01/01/2018 Fo 12/31/2018		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 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	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	1, 656 626 0 18 1, 674 460 2, 134	53 411 0 0 0 53 17 70	2, 90(18 2, 942 90(3, 842	3 3 2	214.00	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 13.00 14.00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0	0	{	3		15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0 0 0	0 26 0	(1,514 ((((((0.00		
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	0 0					33. 0 33. 0

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Prep 5/28/2019 12:	pared:
		Full Time Equivalents		Di s	scharges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 23.00 24.00 23.00 24.00 23.00 24.00 26.25 27.00 28.00 29.00 30.00 31.00 32.01	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00	0	1	84 23 60 129 0 0 84 23	1, 095	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 25.\ 00\\ 24.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 01\\ \end{array}$
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

HUSPI I		BEDFORD		In Lie	u of Form CMS-2	
	AL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 15-1328	Period: From 01/01	1/2018	Worksheet S-1	0
				/2018	Date/Time Pre 5/28/2019 12:	
	Uncompensated and indigent care cost computation				1.00	
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 colu	umn 8)		0. 231124	1 1.0
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				4, 637, 573	
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.0
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplemental particulation of the supplemental payments from M		cald?		0	4.0 5.0
5.00	Medicaid charges	eurcaru			34, 371, 993	6.0
7.00	Medicaid cost (line 1 times line 6)				7, 944, 193	
3.00	Difference between net revenue and costs for Medicaid program (line	7 minus sum of l	ines 2 and 5	; if	3, 306, 620	
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions for each	ch line)			1	
0.00	Net revenue from stand-al one CHIP				0	
0.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.0 11.0
1.00	Difference between net revenue and costs for stand-alone CHIP (line	11 minus line 0.	if < zero t	hon		
12.00	enter zero)	IT IIITIUS ITTIE 9,	11 < 2010 1	nen	0	12.0
	Other state or local government indigent care program (see instructi	ons for each lir	ne)		1	
3.00	Net revenue from state or local indigent care program (Not included				0	
4.00	Charges for patients covered under state or local indigent care pro-	gram (Not include	ed in lines 6	or	0	14.0
F 00						45.0
5.00 6.00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigen	t cara program (l	ino 15 minuo	Lino	0	15. C
0.00	13; if < zero then enter zero)	t care program (i	The to minus	inne	0	10.0
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and	d state/local inc	ligent care p	rogram	ns (see	
7.00	instructions for each line) Private grants, donations, or endowment income restricted to funding	a chari tu cara			0	17.0
18.00	Government grants, appropriations or transfers for support of hospi				0	17.0
9.00	Total unreimbursed cost for Medicaid , CHIP and state and local ind 8, 12 and 16)		ams (sum of l	i nes	3, 306, 620	
		Uni nsure	d Insur	od	Total (col. 1	
				eu		
		patients			+ col . 2)	
				nts		
	Uncompensated Care (see instructions for each line)	patients 1.00	s patier 2.00	nts)	+ col . 2) 3.00	
20. 00	Charity care charges and uninsured discounts for the entire facility	patients 1.00	s patier 2.00	nts	+ col . 2) 3.00	
	Charity care charges and uninsured discounts for the entire facilit (see instructions)	y 3, 362,	s patier 2.00 298 15	nts) 50, 385	+ col. 2) 3.00 3,512,683	20.0
	Charity care charges and uninsured discounts for the entire facility	y 3, 362,	s patier 2.00 298 15	nts)	+ col. 2) 3.00 3,512,683	20.0
1. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	y 3, 362, (see 777,	s patier 2.00 298 15	nts) 50, 385	+ col 2) 3.00 3,512,683 927,493	20. 0 21. 0
1. 00 2. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off a charity care	y 3, 362, (see 777, as 9,	s patier 2.00 298 1! 108 1! 090	<u>50, 385</u> 50, 385 50, 385 2, 186	+ col 2) 3.00 3,512,683 927,493 11,276	20. 0 21. 0 22. 0
21.00 2.00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	y 3, 362, (see 777, as 9,	s patier 2.00 298 1! 108 1! 090	nts D 50, 385 50, 385	+ col 2) 3.00 3,512,683 927,493 11,276	20. 0 21. 0 22. 0
21.00 22.00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off a charity care	y 3, 362, (see 777, as 9,	s patier 2.00 298 1! 108 1! 090	<u>50, 385</u> 50, 385 50, 385 2, 186	+ col 2) 3.00 3,512,683 927,493 11,276 916,217	20. 0 21. 0 22. 0
21.00 22.00 23.00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off a charity care	y 3, 362, (see 777, as 9, 768,	s patier 2.00 298 1! 108 1! 090 018 1/	nts 50, 385 50, 385 2, 186 48, 199	+ col 2) 3.00 3,512,683 927,493 11,276	20.0 21.0 22.0 23.0
21.00 22.00 23.00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog	y 3, 362, (see 777, as 9, 768, ys beyond a lengt	s patier 2.00 298 15 108 15 090 018 14	nts 50, 385 50, 385 2, 186 48, 199 mi t	+ col 2) 3.00 3,512,683 927,493 11,276 916,217 1.00	20.0 21.0 22.0 23.0
1.00 2.00 3.00 4.00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the imposed	y 3, 362, (see 777, as 9, 768, ys beyond a lengt	s patier 2.00 298 15 108 15 090 018 14	nts 50, 385 50, 385 2, 186 48, 199 mi t	+ col 2) 3.00 3,512,683 927,493 11,276 916,217 1.00	20. 0 21. 0 22. 0 23. 0 24. 0
21.00 22.00 23.00 24.00 25.00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in- stay limit	y 3,362, (see 777, as 9, 768, ys beyond a lengt ram? digent care progr	s patier 2.00 298 15 108 15 090 018 14	nts 50, 385 50, 385 2, 186 48, 199 mi t	+ col 2) 3.00 3,512,683 927,493 11,276 916,217 1.00 N 0	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0
 21.00 22.00 23.00 24.00 25.00 26.00 	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instruct	y 3, 362, (see 777, as 9, 768, ys beyond a Lengt ram? digent care progr ti ons)	s patier 2.00 298 15 108 15 090 018 14	nts 50, 385 50, 385 2, 186 48, 199 mi t	+ col 2) 3.00 3,512,683 927,493 11,276 916,217 1.00 N 0 4,765,853	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0
21.00 22.00 23.00 24.00 25.00 26.00 27.00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the indi- stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see	y 3, 362, (see 777, as 9, 768, ys beyond a lengt ram? digent care progr tions) e instructions)	s patier 2.00 298 15 108 15 090 018 14	nts 50, 385 50, 385 2, 186 48, 199 mi t	+ col. 2) 3.00 3,512,683 927,493 11,276 916,217 1.00 N 0 4,765,853 1,056,237	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0
21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in- stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct)	y 3, 362, (see 777, as 9, 768, ys beyond a lengt ram? digent care progr tions) e instructions)	s patier 2.00 298 15 108 15 090 018 14	nts 50, 385 50, 385 2, 186 48, 199 mi t	+ col. 2) 3.00 3,512,683 927,493 11,276 916,217 1.00 N 0 4,765,853 1,056,237 1,624,980	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 27. 0
21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 27. 01 28. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the indi- stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions)	y 3, 362, (see 777, as 9, 768, ys beyond a lengt ram? digent care progr tions) e instructions) nstructions)	s patier 298 2.00 298 1! 108 1! 090 018 14 :h of stay li :am's length	nts 50, 385 50, 385 2, 186 48, 199 mi t	+ col 2) 3.00 3,512,683 927,493 11,276 916,217 1.00 N 0 4,765,853 1,056,237 1,624,980 3,140,873	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 25. 0 26. 0 27. 0 27. 0 28. 0
24.00 25.00 26.00 27.00 27.01 28.00 29.00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in- stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct)	y 3, 362, (see 777, as 9, 768, ys beyond a lengt ram? digent care progr tions) e instructions) nstructions)	s patier 298 2.00 298 1! 108 1! 090 018 14 :h of stay li :am's length	nts 50, 385 50, 385 2, 186 48, 199 mi t	+ col. 2) 3.00 3,512,683 927,493 11,276 916,217 1.00 N 0 4,765,853 1,056,237 1,624,980	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 27. 00 28. 00 29. 00

Health Financial Systems INDI	ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CC		Period:	Worksheet A	
				From 01/01/2018 To 12/31/2018		nared
					5/28/2019 12:	16 pm
Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT		0		0 653, 090	653, 090	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0		0 917, 906		2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	23, 204	252, 707	275, 91	1 2, 435, 524	2, 711, 435	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	877, 579	12, 465, 266	13, 342, 84	5 -207,653	13, 135, 192	5.00
7.00 00700 OPERATION OF PLANT	413, 469	1, 946, 367	2, 359, 83			
8.00 00800 LAUNDRY & LINEN SERVICE	0	122, 476				8.00
9.00 00900 HOUSEKEEPING	367, 622	322, 346				9.00
10. 00 01000 DI ETARY	374, 789	298, 358	673, 14			1
11.00 01100 CAFETERIA	0	0		0 154,061		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 560, 086	2,059,465	3, 619, 55			
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	51, 094 430, 930	116, 966 10, 169, 502	168, 06 10, 600, 43			14.00 15.00
17. 00 01700 SOCI AL SERVI CE	430, 930	10, 109, 502		2 -9, 032, 943 0 48, 242		17.00
INPATIENT ROUTINE SERVICE COST CENTERS	UU	0		40, 242	40, 242	17.00
30. 00 03000 ADULTS & PEDIATRICS	2,010,315	1, 263, 445	3, 273, 76	0 -562, 390	2, 711, 370	30.00
31. 00 03100 I NTENSI VE CARE UNI T	931, 468	486, 023				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 045, 277	1, 857, 846	2, 903, 12	3 -1, 005, 974	1, 897, 149	50.00
51.00 05100 RECOVERY ROOM	274, 469	70, 581	345, 05	0 -45, 734	299, 316	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	959, 880	889, 259	1, 849, 13	9 -473, 813	1, 375, 326	54.00
56. 00 05600 RADI OI SOTOPE	72, 484	187, 148				56.00
57.00 05700 CT SCAN	307, 095	341, 075	648, 17			57.00
58. 00 05800 MRI	136, 671	191, 872	328, 54			
60. 00 06000 LABORATORY	281, 524	4, 518, 312	4, 799, 83			
65. 00 06500 RESPI RATORY THERAPY	645, 894	287, 476	933, 37			
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	609, 533	169, 467	779,00			66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	293, 781 67, 208	47, 011 19, 955	340, 79 87, 16			67.00
69. 00 06900 ELECTROCARDI OLOGY	296, 561	574, 418	870, 97			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	270, 301	0		0 185, 653		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	Ő	0		0 180, 416		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		9, 626, 437		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 62, 427		1
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	733, 052	324, 060	1, 057, 11	2 -184, 489	872, 623	90.00
90. 01 09001 CLINIC - DIABETES	440	86, 887	87, 32			90. 01
91.00 09100 EMERGENCY	1, 687, 787	1, 424, 426	3, 112, 21	3 - 493, 594	2, 618, 619	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART						92.00
SPECIAL PURPOSE COST CENTERS	44.450.040	40,400,744	54.044.00	/ 010.000	55 0/0 014	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	14, 452, 212	40, 492, 714	54, 944, 92	6 318, 288	55, 263, 214	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 592	9, 470	24, 06	2 -7, 445	16, 617	190 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES	14, 372	263, 426	263, 42			192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	23, 014	23, 01			
194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED	156, 409	61, 296				
194.0307953 HOME CARE	0	41	4			194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	14, 623, 213	40, 849, 961	55, 473, 17	4 0	55, 473, 174	200. 00

		I ANA UNI VERSI T				u of Form CMS	
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1328	Peri od:	Worksheet A	
					From 01/01/2018 To 12/31/2018	Date/Time P	renared
					10 12/31/2010	5/28/2019 1	
	Cost Center Description	Adjustments	Net Expenses		· ·		
			For Allocation				
		6.00	7.00				_
	GENERAL SERVICE COST CENTERS	1		1			
1.00	00100 CAP REL COSTS-BLDG & FIXT	115, 974	769, 064				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	76, 739					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	202, 702	2, 914, 137				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-2, 591, 084	10, 544, 108				5.00
7.00	00700 OPERATION OF PLANT	-59, 105	2, 003, 378				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-782	120, 428				8.00
9.00	00900 HOUSEKEEPI NG	-3, 233	538, 634				9.00
10.00	01000 DI ETARY	0	420, 766	,			10.00
11.00	01100 CAFETERI A	-109, 525	44, 536				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-542,690	2, 761, 758				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-4	1, 131, 759	1			14.00
15.00	01500 PHARMACY	80, 762		1			15.00
17.00	01700 SOCI AL SERVI CE	00,702	48, 242				17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	40, 242	1			
30.00	03000 ADULTS & PEDIATRICS	-381,826	2, 329, 544				30.00
31.00	03100 I NTENSI VE CARE UNI T	-95, 457	1, 017, 033	1			30.00
31.00	ANCI LLARY SERVICE COST CENTERS	-93,437	1,017,033	1			
F0 00		1 000 000	0/0.051				- 50.00
50.00	05000 OPERATING ROOM	-1, 028, 098	869, 051	•			50.00
51.00	05100 RECOVERY ROOM	0	299, 316	1			51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-37, 611	1, 337, 715	1			54.00
56.00	05600 RADI OI SOTOPE	0	151, 279				56.00
57.00	05700 CT SCAN	0	419, 734				57.00
58.00	05800 MRI	0	273, 533				58.00
60.00	06000 LABORATORY	-264, 270	4, 504, 110				60.00
65.00	06500 RESPI RATORY THERAPY	-57, 421	644, 855				65.00
66.00	06600 PHYSI CAL THERAPY	-1, 802	661, 971				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	322, 058				67.00
68.00	06800 SPEECH PATHOLOGY	0	70, 125				68.00
69.00	06900 ELECTROCARDI OLOGY	-2, 333	710, 808				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	185, 653				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS	0	180, 416				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9, 626, 437				73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	62, 427				76.97
70.77	OUTPATIENT SERVICE COST CENTERS	0	02, 427				- /0. //
90.00	09000 CLINIC	0	872, 623				90.00
90.00 90.01	09001 CLINIC - DIABETES	54, 214	141, 353	1			90.00
90.01	09100 EMERGENCY	-42, 758	2, 575, 861				90.01
		-42, /58	2, 5/5, 861				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			I			92.00
440.00	SPECIAL PURPOSE COST CENTERS	4 (07 (00	50 575 (0)				-
118.00		-4, 687, 608	50, 575, 606	1			118.00
	NONREI MBURSABLE COST CENTERS	1		1			-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16, 617	1			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	07950 OCCUPATI ONAL HEALTH	0	22, 577				194.00
194.02	2 07952 BLOOMNGTN AMBULANCE AND OCC MED	0	170, 766	,			194. 02
194.03	3 07953 HOME CARE	0	0				194.03
200.00		-4, 687, 608	50, 785, 566				200.00

Health Financial Systems RECLASSIFICATIONS

INDIANA UNIVERSITY HEALTH BEDFORD Provider CCN: 15-1328 Period: Ecom 01/C

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS:	STELCATIONS			Provider CCN: 15-	From 01/01/2018 To 12/31/2018 Date/Time	A-6 Prepared: 12:16 pm
	Cost Center	Increases Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ \end{array}$	A - BENEFITS EMPLOYEE BENEFITS DEPARTMENT	$\begin{array}{c} 4 & 00 \\ 0 & 0 \\ 0 & 0 \\$		2,408,686 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 20.00\\ 21.00\\ 22.00\\ 23.00\\ 24.00\\ \end{array}$
25.00	\square $_$ $_$ $_$ $_$ $_$ $_$ $_$	0.00	0	0		25.00
	0 B – DI ETARY/CAFETERI A		0	2, 408, 686		
1.00		<u>11.</u> 00	<u> </u>	7 <u>3, 637</u> 73, 637		1.00
1 00	C - CAPITAL LEASE	1.00		i.		1.00
1.00	CAP REL COSTS-BLDG & FIXT	<u>1.</u> 00	0	1 <u>6, 3</u> 99 16, 399		1.00
1.00	CARDIAC REHABILITATION		52,860	9,567		1.00
	E – DEPR EXPENSE		52, 860	9, 567		
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 28. \ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	$\begin{array}{cccccccccccccccccccccccccccccccccccc$		596, 095 908, 751 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ \end{array}$
1.00 2.00 3.00 4.00 5.00 6.00 7.00	F - BILLABLE DRUGS RADI OI SOTOPE DRUGS CHARGED TO PATI ENTS	56.00 73.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0 0 0	5, 024 9, 626, 437 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 6.00 7.00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

INDIANA UNIVERSITY HEALTH BEDFORD Provider CCN: 15-1328

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2018

					From 01/01/2018 To 12/31/2018	Date/Time Prepa 5/28/2019 12:16
_	Cost Center	Increases Line #	Salary	Other		
-	2.00	3.00	4.00	5.00		
		0.00	0	0		
		0.00	0	0		
0			0	9, 631, 461		
	G - IMPLANT SUPPLIES	72.00	0	180, 416		
	PATIENTS	72.00	0	100, 410		
		0.00	0	0		
0	0		0	180, 416		
	H - ACCRUED PTO	4.00	0	20 5/5		
	EMPLOYEE BENEFITS DEPARTMENT	4.00 9.00	0	28, 565 1, 436		
	NURSI NG ADMI NI STRATI ON	13.00	0	4, 365		
	OPERATING ROOM	50.00	0	2, 595		
	RECOVERY ROOM	51.00	0	4, 541		
	RADI OLOGY-DI AGNOSTI C	54.00	0	6, 315		
	OCCUPATIONAL THERAPY	67.00	0	5, 936		
	CLINIC EMERGENCY	90.00	0	1, 929		
	GIFT, FLOWER, COFFEE SHOP &	91.00 190.00	0	22, 300 892		1
	CANTEEN	190.00	0	072		1
	BLOOMNGTN AMBULANCE AND OCC	194.02	0	62		1
	MED					
2		0.00	0	0		1
		0.00	0	0		1
) ו	+	0.00	0			1
ľ	I - BILLABLE MEDICAL SUPPLIES		ų	70, 930		
Ē	MEDICAL SUPPLIES CHARGED TO	71.00	0	185, 653		
	PATI ENT					
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00 0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
(0		0	185, 653		
	J - PROPERTY INSURANCE	1 00		40.50/		
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00	0	40, 596 9, 155		
ĺ			0	49, 751		
- Ì	L - SOCIAL WORKER	I	-1	,		
•	SOCIAL SERVICE	17.00	48, 242	<u>0</u>		
(0		48, 242	0		
	N - NON-BILLABLE SUPPLIES	14.00		000 (11		
	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	988, 614 4, 216		
	CLINIC - DIABETES	90.01	0	4, 210		
ľ		0.00	0	0		
		0.00	О	0		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00 0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
	+	0.00	0	<u>992, 836</u>		1
ľ	0 - NON-BILLABLE DRUGS		U	, 12, 030		
	PHARMACY	15.00	0	16, 878		
ſ		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00 0.00	0	0		
1						

Heal th	Financial Systems	IN	INDIANA UNIVERSITY HEALTH BEDFORD				In Lieu of Form CMS-2552-10			
RECLASS	SI FI CATI ONS		F		CCN: 15-1328	Peri od:	Worksheet A-	6		
						From 01/01/2018 To 12/31/2018	Date/Time Pr 5/28/2019 12			
		Increases								
	Cost Center	Line #	Sal ary	Other						
	2.00	3.00	4.00	5.00						
9.00		0.00	0	0				9.00		
	0		0	16, 878						
500.00	Grand Total: Increases		181, 526	15, 149, 066				500.00		
	-									

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 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00

1.00

1.00

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 13.00 14.00 15.00 16.00

17.00

18.00

19.00

20.00

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3.00

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27.00

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n Financial Systems SSIFICATIONS	I NDI	ANA UNI VERSI TY			In Lieu Period:	u of Form CM Worksheet A	
					From 01/01/2018		
					To 12/31/2018	Date/Time P 5/28/2019 1	2:16 pm
	Decreases				1		
Cost Center	Line #	Salary		<u>Nkst. A-7 Ref.</u>	_		
6.00 A - BENEFITS	7.00	8.00	9.00	10.00			
ADMI NI STRATI VE & GENERAL	5.00	0	71, 358	()		1.00
OPERATION OF PLANT	7.00	0	85, 915	C			2.00
HOUSEKEEPI NG	9.00	0	116, 889	C			3.00
DI ETARY	10.00	0	80, 810	C			4.00
NURSING ADMINISTRATION	13.00	0	261, 363	C			5.00
CENTRAL SERVICES & SUPPLY	14.00	0	16, 485	0			6.00
PHARMACY ADULTS & PEDIATRICS	15.00	0	55, 575	((7.00
INTENSIVE CARE UNIT	30. 00 31. 00	0	374, 743 154, 073	(9.00
OPERATI NG ROOM	50.00	0	151, 530	(10.00
RECOVERY ROOM	51.00	0	50, 010	0			11.00
RADI OLOGY-DI AGNOSTI C	54.00	0	191, 047	C			12.00
RADI OI SOTOPE	56.00	0	14, 621	C			13.00
CT SCAN	57.00	0	24, 273	(14.00
MRI	58.00	0	5, 797	0			15.00
LABORATORY RESPI RATORY THERAPY	60.00 65.00	0	23, 110	((16.00 17.00
PHYSICAL THERAPY	66. 00	0	116, 536 96, 925	(17.00
OCCUPATI ONAL THERAPY	67.00	0	24, 670	(19.00
SPEECH PATHOLOGY	68.00	0	14, 393	0			20.00
ELECTROCARDI OLOGY	69.00	0	35, 704	C			21.00
CLINIC	90.00	0	118, 761	C			22.00
EMERGENCY	91.00	0	277, 608	C			23.00
GIFT, FLOWER, COFFEE SHOP &	190.00	0	8, 337	C	D		24.00
CANTEEN BLOOMNGTN AMBULANCE AND OCC	194.02	0	38, 153	C			25.00
MED	194.02	0	50, 155	C			23.00
0		0	2, 408, 686		_		
B - DIETARY/CAFETERIA					-1		
<u>DI ETARY</u>	<u>10.</u> 00	$ \frac{80, 424}{20, 424}$	$ \frac{73, 637}{72, 637}$	0	<u>)</u>		1.00
C – CAPITAL LEASE		80, 424	73, 637				_
PHYSICIANS' PRIVATE OFFICES	192.00	0	16, 399	11	1		1.00
		0	16, 399		_		
D - CARDI OLOGY		1			1		
ELECTROCARDI OLOGY	<u> 69.</u> 00	5 <u>2,8</u> 60	<u>9, 5</u> 67		<u>)</u>		1.00
		52, 860	9, 567				_
E - DEPR EXPENSE EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 727	ç			1.00
ADMI NI STRATI VE & GENERAL	5.00	0	80, 542	ç			2.00
OPERATION OF PLANT	7.00	0	209, 717	(3.00
LAUNDRY & LINEN SERVICE	8.00	0	1, 266	C			4.00
HOUSEKEEPI NG	9.00	0	1, 216	C			5.00
DI ETARY	10.00	0	15, 743	0			6.00
NURSING ADMINISTRATION	13.00	0	9,019	0			7.00
CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	4, 908 43, 208	(8.00 9.00
ADULTS & PEDIATRICS	30.00	0	32, 226	(10.00
INTENSIVE CARE UNIT	31.00	0	92, 044	(11.00
OPERATING ROOM	50.00	0	139, 204	C			12.00
RECOVERY ROOM	51.00	0	265	C			13.00
RADI OLOGY-DI AGNOSTI C	54.00	0	246, 503	C			14.00
RADI OI SOTOPE	56.00	0	86, 934	0			15.00
CT SCAN	57.00	0	116, 142	0			16.00
MRI LABORATORY	58.00 60.00	0	26, 567 8, 346	((17.00 18.00
RESPIRATORY THERAPY	65.00		8, 340 16, 585	(19.00
PHYSICAL THERAPY	66.00	0	7, 646	(20.00
ELECTROCARDI OLOGY	69.00	Ö	20, 172	C			21.00
CLINIC	90.00	О	2, 188	C			22.00
CLINIC - DIABETES	90.01	0	194	(23.00
	91.00	0	86, 347	0			24.00
PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH	192.00 194.00	0	247, 027 272	(25.00 26.00
BLOOMNGTN AMBULANCE AND OCC	194.00	0	8 797	(28.00

1, 504, 846

9, 569, 096

0

0

41

212 931

40, 478

0

0

0

0 0

0

8, 797

194.02

1<u>94.</u>03

15.00

50.00

54.00

57.00

MED HOME CARE

PHARMACY

CT SCAN

F - BILLABLE DRUGS

RADI OLOGY-DI AGNOSTI C

OPERATING ROOM

BLOOMNGTN AMBULANCE AND OCC

ECLASS	IFICATIONS			Provider (CCN: 15-1328	Period: From 01/01/2018	Worksheet A-6	
						To 12/31/2018	Date/Time Prepa 5/28/2019 12:16	
		Decreases				· · ·		
	Cost Center	Line # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00			
. 00	6. 00	58.00	8.00	20, 005		0		5.0
	RESPI RATORY THERAPY	65.00		20,000		0		6.0
. 00	ELECTROCARDI OLOGY	69.00		256		0		7.0
	EMERGENCY	91.00		220		0		8.0
.00		1 <u>94.</u> 00		165		0		9.0
C C	G - IMPLANT SUPPLIES		U	9, 631, 461				
	OPERATING ROOM	50.00		179, 846		0		1.0
.00	EMERGENCY	91.00		570		o		2.0
Ľ			0	180, 416				
-	H – ACCRUED PTO ADMI NI STRATI VE & GENERAL	5.00	0	5, 831		0		1.0
	OPERATION OF PLANT	7.00	0	1, 573				2.0
	DI ETARY	10.00	0	344		0		3. C
	CENTRAL SERVICES & SUPPLY	14.00	0	3, 027		0		4.0
	PHARMACY	15.00	0	6, 160		0		5.0
	ADULTS & PEDIATRICS	30.00	0	18, 794		0		6. (
	I NTENSI VE CARE UNI T RADI OI SOTOPE	31.00 56.00	0	14, 737 1, 855		0		7. (8. (
	CT SCAN	57.00	0	3, 358		0		9. (
	MRI	58.00	Ő	561		0		10. (
	RESPI RATORY THERAPY	65.00	0	10, 702		0		11. (
	PHYSI CAL THERAPY	66.00	0	1, 144		0		12. (
	SPEECH PATHOLOGY	68.00	0	2,645		0		13.0
-	ELECTROCARDIOLOGY	<u>69.</u> 00	0	<u>8, 205</u> 78, 936		0		14. (
	I - BILLABLE MEDICAL SUPPLIES		0	70, 750				
00	CENTRAL SERVICES & SUPPLY	14.00		317		0		1. (
	ADULTS & PEDIATRICS	30.00		4, 008		0		2. (
	INTENSIVE CARE UNIT	31.00		140		0		3. (
	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00		162, 006 5, 132		0		4. (5. (
	RADI OLOGI - DI AGNOSTI C	56.00		7, 219		0		6. (
	CT SCAN	57.00		1, 431		0		7. (
.00	CLINIC	90.00		3		0		8.0
00	EMERGENCY	<u>91.00</u>		<u>5, 397</u>		<u>0</u>		9. C
C	J – PROPERTY INSURANCE		0	185, 653				
	ADMI NI STRATI VE & GENERAL	5.00	0	49, 751		9		1. (
00		0.00	0	0		9		2.0
C	0		0	49, 751				
	L - SOCIAL WORKER NURSING ADMINISTRATION	13.00	48, 242	0				1. (
	0		48, 242	00		0		1.0
1	N - NON-BILLABLE SUPPLIES	I			1	1		
	ADMI NI STRATI VE & GENERAL	5.00		171		0		1. (
	OPERATION OF PLANT	7.00		148		0		2.
	HOUSEKEEPI NG DI ETARY	9.00		31, 432		0		3. 4.
	NURSING ADMINISTRATION	10. 00 13. 00		1, 423 844		0		4. 5.
	ADULTS & PEDIATRICS	30.00		128, 686		0		6.
00	INTENSIVE CARE UNIT	31.00		42, 388		0		7.
	OPERATING ROOM	50.00		375, 016		0		8.
	RADI OLOGY-DI AGNOSTI C	54.00		33, 568		0		9.
	RADI OI SOTOPE	56.00 57.00		2,748		0		10. 11
	CT SCAN MRI	57.00 58.00		42, 207 2, 080				11. 12.
	RESPIRATORY THERAPY	65.00		86, 829		0		12.
	PHYSICAL THERAPY	66.00		9, 512		0		14.
. 00	ELECTROCARDI OLOGY	69.00		31, 074		0		15.
	CLINIC	90.00		61, 842		0		16.
	EMERGENCY	91.00		142, 817		0		17.
	BLOOMNGTN AMBULANCE AND OCC	194.02		51		D		18. (
-	0	+	0	992, 836		1		
(0 - NON-BILLABLE DRUGS				1			
	CENTRAL SERVICES & SUPPLY	14.00	0	174		0		1.
	ADULTS & PEDIATRICS	30.00	0	3, 933		0		2.
	INTENSIVE CARE UNIT	31.00	0	1,619		0		3.
	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50.00 54.00	0	755 2, 947		0		4. 5.
	CT SCAN	57.00	0	2,947 547		0		э. 6.
	RESPIRATORY THERAPY	65.00	0	344		0		7.
00	RESFIRATORI IIIERAFI	05.00	01	344				

Heal th	Financial Systems	IN	I NDI ANA UNI VERSI TY HEALTH BEDFORD				In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS				Provider (CCN: 15-1328	Period:	Worksheet A-	6	
						From 01/01/2018 To 12/31/2018	Date/Time Pr	oparod	
						10 12/31/2018	5/28/2019 12	:16 pm	
		Decreases							
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref				
	6.00	7.00	8.00	9.00	10.00				
9.00	EMERGENCY	91.00	0	<u>2, 9</u> 35		0		9.00	
	0		0	16, 878					
500.00	Grand Total: Decreases		181, 526	15, 149, 066				500.00	

Heal th Financia	al Systems		
RECONCI LI ATI ON	OF CAPI TAL	COSTS	CENTERS

INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 Provider CCN: 15-1328 Period: From 01/01/2018 Worksheet A-7

					From 01/01/2018 To 12/31/2018		
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	931, 334	0		0 0	0	1.00
2.00	Land Improvements	1, 119, 735	0		0 0	0	2.00
3.00	Buildings and Fixtures	14, 929, 250	0		0 0	0	3.00
4.00	Building Improvements	5, 122, 999	91, 525		0 91, 525	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	19, 458, 202	1, 027, 554		0 1, 027, 554	5, 234, 882	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41, 561, 520	1, 119, 079		0 1, 119, 079	5, 234, 882	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	41, 561, 520	1, 119, 079		0 1, 119, 079	5, 234, 882	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		-				
1.00	Land	931, 334	0				1.00
2.00	Land Improvements	1, 119, 735	0				2.00
3.00	Buildings and Fixtures	14, 929, 250	0				3.00
4.00	Building Improvements	5, 214, 524	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	15, 250, 874	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	37, 445, 717	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	37, 445, 717	0				10.00

Heal th	Financial Systems IND	IANA UNIVERSITY	HEALTH BEDFOR	RD	In Lieu of Form CMS-2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1328	Period: From 01/01/2018 To 12/31/2018		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	V 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0)	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0)	0 0	0	3.00
		SUMMARY OF	F CAPI TAL				
	Cost Center Description	0ther	Total (1) (sum	-			
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMN	V 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0)			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2018 To 12/31/2018		pared	
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS							
. 00	CAP REL COSTS-BLDG & FIXT	22, 194, 843				0	1.0	
. 00	CAP REL COSTS-MVBLE EQUIP	15, 250, 875				0	2.0	
. 00	Total (sum of lines 1-2)	37, 445, 718	7, 445, 718 639, 150 ALLOCATION OF OTHER CAPI		8 1.000000 SUMMARY 0		3.	
		ALLUCA	ALLOCATION OF OTHER CAPITAL SUMMART OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
	•		Capi tal -Rel ate					
			d Costs	through 7)				
		6.00	7.00	8.00	9.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS		1	1				
. 00	CAP REL COSTS-BLDG & FIXT	0			0 1, 441, 945	0	1.	
. 00	CAP REL COSTS-MVBLE EQUIP	0	-		0 994, 645	0	2.	
. 00	Total (sum of lines 1-2)	0	Ŭ	JMMARY OF CAPI	0 2, 436, 590	0	3.	
			50	JWWARY OF CAPT	TAL			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
	•		instructions)	instructions)	Capi tal -Rel ate	of cols. 9		
					d Costs (see	through 14)		
					instructions)			
		11.00	12.00	13.00	14.00	15.00		
~~	PART III - RECONCILIATION OF CAPITAL COSTS					7/0.0//		
. 00	CAP REL COSTS-BLDG & FIXT	-672, 881			0 0	769, 064	1.	
2.00	CAP REL COSTS-MVBLE EQUIP	(72,001			0 0	994, 645	2. 3.	
3.00	Total (sum of lines 1-2)	-672, 881	0	1	u U	1, 763, 709	3.	

Health Financial Systems ADJUSTMENTS TO EXPENSES	I ND	I ANA UNI VERSI T	Y HEALTH BEDFORD Provider CCN: 15-1328	In Lie Period:	u of Form CMS-2 Worksheet A-8	2552-10
				From 01/01/2018 To 12/31/2018	Date/Time Prep	
			Expense Classification or To/From Which the Amount is		5/28/2019 12:1	ro pili
Cost Center Descrip		Amount	Cost Center		Wkst. A-7 Ref.	
1.00 Investment income - CAP	1.00 REL B	2.00 -689,280	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5. 00 11	1.00
2.00 COSTS-BLDG & FIXT (chapt Investment income - CAP	· ·	0	CAP REL COSTS-MVBLE EQUIP	2.00	o	2.00
COSTS-MVBLE EQUIP (chapt 3.00 Investment income - othe	er 2)	0		0.00	0	3. 00
(chapter 2) 4.00 Trade, quantity, and tim	e	0		0.00	0	4.00
di scounts (chapter 8) 5.00 Refunds and rebates of		0		0.00	0	5.00
6.00 expenses (chapter 8) 6.00 Rental of provider space	by	0		0.00	0	6. 00
7.00 suppliers (chapter 8) Telephone services (pay stations excluded) (chap	ter	0		0.00	0	7.00
21)8.00 Tel evi si on and radio ser	vice	0		0.00	0	8.00
(chapter 21) 9.00 Parking Lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment11.00 Sale of scrap, waste, et		-4, 128, 538		0.00	0	10.00 11.00
(chapter 23) 12.00 Related organization	A-8-1	5, 338, 718				12.00
transactions (chapter 10 13.00 Laundry and Linen servic		o		0.00	o	13.00
14.00 Cafeteria-employees and 15.00 Rental of quarters to em	guests	0		0.00	0	14.00
and others 16.00 Sale of medical and surg supplies to other than	i cal	0		0.00	О	16. 00
patients 17.00 Sale of drugs to other t	han	0		0.00	0	17.00
patients 18.00 Sale of medical records	and	0		0.00	0	18.00
abstracts 19.00 Nursing and allied healt education (tuition, fees books, etc.)		0		0.00	О	19. 00
20.00 Vending machines21.00 Income from imposition o interest, finance or pen		0 0		0.00 0.00	0 0	20. 00 21. 00
22.00 charges (chapter 21) 1 nterest expense on Medi overpayments and borrowi	ngs to	0		0.00	0	22. 00
23.00 Adjustment for respirato therapy costs in excess	ry A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
24.00 limitation (chapter 14) Adjustment for physical therapy costs in excess	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00 limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
(chapter 21) 26.00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27.00 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetis	t	0	*** Cost Center Deleted ***	19.00	_	28.00
 29.00 Physicians' assistant 30.00 Adjustment for occupation therapy costs in excess 		0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29. 00 30. 00
30.99 Hospice (non-distinct) (see	0	ADULTS & PEDIATRICS	30.00		30. 99
instructions) 31.00 Adjustment for speech pathology costs in exces	A-8-3 s of	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for	+ A	-125, 858	CAP REL COSTS-MVBLE EQUIP	2.00	9	32. 00
33.00 MI SCELLANEOUS INCOME	В	- 983	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.00

Health F	Financial Systems	IND	IANA UNIVERSIT	Y HEALTH BEDFORD	Inlie	In Lieu of Form CMS-2552-10		
	ENTS TO EXPENSES				Period:	Worksheet A-8		
					rom 01/01/2018			
					Го 12/31/2018		pared:	
						5/28/2019 12:	16 pm	
				Expense Classification or To/From Which the Amount is				
				I Allourt I's	to be Aujusteu			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.		
		1.00	2.00	3.00	4.00	5.00		
34.00 M	MI SCELLANEOUS I NCOME	В	-16, 391	ADMI NI STRATI VE & GENERAL	5.00	0	34.00	
35.00 N	MI SCELLANEOUS I NCOME	В	-5,063	OPERATION OF PLANT	7.00	0	35.00	
36.00 M	MI SCELLANEOUS I NCOME	В	-782	LAUNDRY & LINEN SERVICE	8.00	0	36.00	
37.00 N	MI SCELLANEOUS I NCOME	В	-3, 233	HOUSEKEEPI NG	9.00	0	37.00	
38.00 M	MISCELLANEOUS INCOME	В	-109, 525	CAFETERI A	11.00	0	38.00	
39.00 M	MI SCELLANEOUS I NCOME	В	-30, 910	NURSING ADMINISTRATION	13.00	0	39.00	
40.00 M	MI SCELLANEOUS I NCOME	В	-2,000	OPERATING ROOM	50.00	0	40.00	
41.00 M	MISCELLANEOUS INCOME	В	-37, 590	RADI OLOGY-DI AGNOSTI C	54.00	0	41.00	
42.00 M	MI SCELLANEOUS I NCOME	В	-57, 421	RESPI RATORY THERAPY	65.00	0	42.00	
	MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	69.00	0		
	PHONES	A		CAP REL COSTS-BLDG & FIXT	1.00		45.00	
	PHONES	A		CAP REL COSTS-MVBLE EQUIP	2.00		45.01	
	PHONES	A		EMPLOYEE BENEFITS DEPARTMEN				
	PHONES	A		ADMINISTRATIVE & GENERAL	5.00			
	PHONES	A		CENTRAL SERVICES & SUPPLY	14.00			
	HAF	A		ADMINISTRATIVE & GENERAL	5.00		101.00	
	CABLE	A		PHYSI CAL THERAPY	66.00			
	RECRUI TI NG	A		ADMI NI STRATI VE & GENERAL	5.00			
	BENEFITS	А		EMPLOYEE BENEFITS DEPARTMEN				
	ACCRUED PTO	A		EMPLOYEE BENEFITS DEPARTMEN				
	TELEPHONE EQUI PMENT	A		PHYSICAL THERAPY	66.00			
	MARKETING	A		ADMI NI STRATI VE & GENERAL	5.00			
	MARKETING	A		ELECTROCARDI OLOGY	69.00			
		A		RADI OLOGY-DI AGNOSTI C	54.00			
	INVESTMENT FEES	В		ADMI NI STRATI VE & GENERAL	5.00			
	JNWONTED SI TUATI ONS	A		ADMINISTRATIVE & GENERAL	5.00	0	101.10	
	TOTAL (sum of lines 1 thru 49)		-4, 687, 608				50.00	
	(Transfer to Worksheet A,							

(Transfer to Worksheet A, column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	I NDI ANA UNI VERSI	TY HEALTH BEDFORD	In Lie	eu of Form CMS-	2552-10
STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HOP	ME Provider CCN: 15-1328	Period: From 01/01/2018 To 12/31/2018		epared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
1.00			HOME OFFICE	805, 262	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	205, 532	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2, 770, 114	0	3.00
4.00			HOME OFFICE	7, 789, 312	7, 855, 637	4.00
4.01			HOME OFFICE	0	28, 481	4.01
4.02			RELATED PARTY	128, 063	226, 732	4.02
4.03			RELATED PARTY	1, 709, 486	1, 632, 496	
4.04	7.00	OPERATION OF PLANT	RELATED PARTY	0	54, 042	4.04
4.05			RELATED PARTY	1, 106, 156	1, 589, 455	4.05
4.06	15.00	PHARMACY	RELATED PARTY	572, 753	491, 991	4.06
4.07			RELATED PARTY	108, 360	54, 146	4.07
4.08	91.00	EMERGENCY	EMERGENCY ROOM	2, 725, 939	649, 279	4.08
4.09			SHARED EMPLOYEES	247, 469	247, 469	4.09
4.10			SHARED EMPLOYEES	127	127	4.10
4.11			SHARED EMPLOYEES	490, 498	490, 498	4.11
4.12			SHARED EMPLOYEES	122, 625	122, 625	4.12
4.13			SHARED EMPLOYEES	4, 317, 858	4, 317, 858	
4.14			SHARED EMPLOYEES	422, 214	422, 214	4.14
4.15			SHARED EMPLOYEES	53, 067	53, 067	4.15
4.16			SHARED EMPLOYEES	32, 079	32, 079	
4.17			SHARED EMPLOYEES	12,000	12,000	-
4.18		OCCUPATIONAL HEALTH	SHARED EMPLOYEES	8, 893	8, 893	4.18
5.00	TOTALS (sum of lines 1-4).			23, 627, 807	18, 289, 089	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATIONSHIP	FED 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	0.00 U HEALTH, INC. 50.00	6.00
7.00	F	0.00 UH BLOOMINGTO 50.00	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		100.00
	non-financial) specify:		

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	I	NDI ANA UN	NIVERSITY F	IEALTH BEDF	ORD		In Lie	u of Form (CMS-2552-10
STATEME OFFICE	INT OF COSTS OF	SERVICES FROM	RELATED ORGAN	II ZATI ONS	AND HOME	Provi der	CCN: 1	5-1328	Period: From 01/01/2018	Worksheet	A-8-1
UFFICE									To 12/31/2018	Date/Time 5/28/2019	
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6.00	7.00									
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED	AS A RES	SULT OF TRA	ANSACTI ONS	WITH	RELATED C	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:									
1.00	805, 262	9									1.00
2.00	205, 532	9									2.00
3.00	2, 770, 114	0									3.00

4.00	-66, 325	0	4.00
4.01	-28, 481	0	4.01
4.02	-98, 669	0	4. 02
4.03	76, 990	0	4.03
4.04	-54, 042	0	4.04
4.05	-483, 299	0	4.05
4.06	80, 762	0	4.06
4.07	54, 214	0	4.07
4.08	2, 076, 660	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	0	0	4.14
4.15	0	0	4.15
4.16	0	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
5.00	5, 338, 718		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

nus no	been posted to norksheet A,		
	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

rerinbur	Sement under title Aviii.	
6.00	HOME OFFICE	6.00
7.00	HEALTHCARE	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

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

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

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

Heal th	Fi nanci a	I Systems	
	ED DAGED		

INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Peri od:	Worksheet A-8	3-2
						From 01/01/2018 To 12/31/2018	8∣ B∣Date/Time Pre	narod
						10 12/31/2010	5/28/2019 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMINISTRATIVE & GENERAL	241, 469		C		0	1.00
2.00		ADULTS & PEDIATRICS	490, 498				0	2.00
3.00		INTENSIVE CARE UNIT	122, 625		27, 168		0	3.00
4.00		OPERATING ROOM	1, 026, 098		(-	0	4.00
5.00		LABORATORY	281, 524				0	5.00
6.00		EMERGENCY	2, 523, 350	2, 119, 418	403, 932	0	0	6.00
7.00	0.00		0	0	(0	0	7.00
8.00	0.00		0	0	(0	0	8.00
9.00	0.00		0	0	(0	0	9.00
10.00	0.00			0		0	0	10.00
200.00			4, 685, 564		557,026		0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
					Education	12	Thisurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	0.00	0	12.00		0	1.00
2.00		ADULTS & PEDIATRICS	0	0		-	0	2.00
3.00		INTENSI VE CARE UNI T	0	0	(0	3.00
4.00		OPERATING ROOM	0	0	(0	4.00
5.00		LABORATORY	0	0	(0	0	5.00
6.00		EMERGENCY	0	0	0	o o	0	6.00
7.00	0, 00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	C	0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	0	0	0			1.00
2.00		ADULTS & PEDIATRICS	0	0	(381, 826		2.00
3.00		INTENSIVE CARE UNIT	0	0	(95, 457		3.00
4.00		OPERATING ROOM	0	0		1, 026, 098		4.00
5.00		LABORATORY	0	0		264, 270		5.00
6.00		EMERGENCY	0	0		2, 119, 418		6.00
7.00	0.00		0	0		0		7.00
8.00	0.00		0	0		0		8.00
9.00	0.00					0		9.00
10. 00 200. 00	0.00		0 0	-				10.00 200.00
200.00	I		0	0	l l	4, 128, 538		200.00

INDIANA UNIVERSITY HEALTH BEDFORD Provider CCN: 15-1328 Period:

In Lieu of Form CMS-2552-10 Worksheet B

CUST A	LLUCATION - GENERAL SERVICE COSTS		Provider C		From 01/01/2018 To 12/31/2018		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL REI BLDG & FI XT	LATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	769, 064	769, 064				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	994, 645		994, 64	5		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 914, 137	2, 406				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	10, 544, 108	116, 761	203, 81	1 175, 561	11, 040, 241	5.00
7.00	00700 OPERATION OF PLANT	2,003,378	86, 558	151, 089	82, 715	2, 323, 740	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	120, 428	3, 249	5, 670	0 0	129, 347	8.00
9.00	00900 HOUSEKEEPI NG	538, 634	8, 432	14, 718	3 73, 543	635, 327	9.00
10.00	01000 DI ETARY	420, 766	17, 152	29, 938	3 58, 888	526, 744	10.00
11.00	01100 CAFETERI A	44, 536	11, 229	19, 600	16, 089	91, 454	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 761, 758	23, 606	41, 20	5 302, 446	3, 129, 015	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 131, 759	19, 920	34, 770	10, 221	1, 196, 670	14.00
15.00	01500 PHARMACY	1,028,249	5, 753	10, 042	86, 208	1, 130, 252	15.00
17.00	01700 SOCIAL SERVICE	48, 242	518				
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·					1
30.00	03000 ADULTS & PEDI ATRI CS	2, 329, 544	41, 620	72, 64	7 402, 160	2, 845, 971	30.00
31.00	03100 I NTENSI VE CARE UNI T	1,017,033	10, 706				•
	ANCI LLARY SERVICE COST CENTERS					.,,	
50.00	05000 OPERATI NG ROOM	869, 051	52, 123	90, 98	2 209, 109	1, 221, 265	50.00
51.00	05100 RECOVERY ROOM	299, 316	02, 120				
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 337, 715	21, 281				
56.00	05600 RADI OI SOTOPE	151, 279	0				
57.00	05700 CT SCAN	419, 734	4, 623				
58.00	05800 MRI	273, 533	4, 906				
60.00	06000 LABORATORY	4, 504, 110	22, 034				
65.00	06500 RESPI RATORY THERAPY	644, 855	6, 196				
66.00	06600 PHYSI CAL THERAPY	661, 971	12, 952				
67.00	06700 OCCUPATI ONAL THERAPY						67.00
68.00	06800 SPEECH PATHOLOGY	322, 058	4, 567			393, 367 88, 029	
		70, 125	1, 624				
69.00	06900 ELECTROCARDI OLOGY	710, 808	16, 436				•
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	185, 653	0		0		•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	180, 416	0				•
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 626, 437	0		0 0		•
76.97	07697 CARDI AC REHABI LI TATI ON	62, 427	8, 663	15, 12	10, 575	96, 786	76.97
~~ ~~	OUTPATIENT SERVICE COST CENTERS	070 (00)	07.000	10.07	1	1 00/ 1/0	
90.00	09000 CLINIC	872, 623	27, 999				
90.01	09001 CLINIC - DIABETES	141, 353	2, 444				
91.00	09100 EMERGENCY	2, 575, 861	21, 751	37, 96	337, 643		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	SPECIAL PURPOSE COST CENTERS	,		1	1	[-
118.00		50, 575, 606	555, 509	969, 640	2, 886, 533	50, 302, 843	118.00
	NONREI MBURSABLE COST CENTERS				1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 617	4, 388		2, 919		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	173, 098		-	173, 098	
	07950 OCCUPATIONAL HEALTH	22, 577	9, 934	17, 340	0 0	49, 851	194.00
	07952 BLOOMNGTN AMBULANCE AND OCC MED	170, 766	26, 135	(31, 290		
194.03	07953 HOME CARE	0	0	(0 0	0	194. 03
200.00	Cross Foot Adjustments					0	200. 00
201.00	Negative Cost Centers		0	(0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	50, 785, 566	769, 064	994, 64	5 2, 920, 742	50, 785, 566	202.00
		. '					-

	I Financial Systems INE	DI ANA UNI VERSI TY	Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre 5/28/2019 12:	epared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	11, 040, 241					5.00
7.00	00700 OPERATION OF PLANT	645, 477	2, 969, 217				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	35, 929	17, 123	182, 39	19		8.00
9.00	00900 HOUSEKEEPI NG	176, 478	44, 444		0 856, 249		9.00
10.00	01000 DI ETARY	146, 316	90, 402		0 41, 671	805, 133	10.00
11.00	01100 CAFETERI A	25, 404	59, 184		0 27, 281	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	869, 162	124, 424		0 57, 354	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	332, 405	104, 993		0 48, 397	0	
15.00	01500 PHARMACY	313, 956	30, 324		0 13, 978		
17.00	01700 SOCIAL SERVICE	16, 476	2, 730		0 1, 258	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	790, 540	219, 367				
31.00	03100 I NTENSI VE CARE UNI T	342, 432	56, 430	27, 55	69 26, 012	190, 391	31.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	339, 237	274, 729			0	
51.00	05100 RECOVERY ROOM	98, 395	0		0 0	-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	441, 153	112, 165		0 51, 703		
56.00	05600 RADI OI SOTOPE	46,049	0		0 0	0	
57.00	05700 CT SCAN 05800 MRI	137, 183	24, 369		0 11, 233 0 11, 919	0	
58.00 60.00	06000 LABORATORY	87, 317	25, 857		-		
65.00	06500 RESPIRATORY THERAPY	1, 283, 577	116, 135 32, 657		0 53, 533 0 15, 053		
66.00	06600 PHYSI CAL THERAPY	219, 742 227, 628	68, 267		0 31, 468		
67.00	06700 OCCUPATIONAL THERAPY	109, 268	24, 071		0 11,096	0	
68.00	06800 SPEECH PATHOLOGY	24, 452	8, 561		0 3, 946	0	
69.00	06900 ELECTROCARDI OLOGY	223, 522	86, 630		0 39, 933	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	51, 570	00, 030		0 0		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	50, 115	0		0 0		
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 673, 965	0		0 0	-	
76.97		26, 885	45, 660		0 21,047	0	
/0///	OUTPATIENT SERVICE COST CENTERS	20,000	10/000		21/01/		
90.00	09000 CLI NI C	304, 481	147, 576		0 68, 026	0	90.00
90.01	09001 CLINIC - DIABETES	41, 152	12, 879		0 5,937	0	90.01
91.00	09100 EMERGENCY	825, 887	114, 646			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 906, 153	1, 843, 623	182, 39	9 821, 452	805, 133	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 773	23, 128		0 10, 661		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	48, 082	912, 357		0 0		192.00
	07950 OCCUPATI ONAL HEALTH	13, 847	52, 360		0 24, 136		194.00
	207952 BLOOMNGTN AMBULANCE AND OCC MED	63, 386	137, 749		0 0		194.02
	3 07953 HOME CARE	0	0		0 0	0	
200.00							200.00
201.00		0	0		0 0		201.00
202.00) TOTAL (sum lines 118 through 201)	11,040,241	2, 969, 217	182, 39	9 856, 249	805, 133	

MCRIF32 - 15.5.166.1

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1328	Period: From 01/01/2018 To 12/31/2018		
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY		SOCIAL SERVICE	
		11.00	13.00	14.00	15.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.00	00500 ADMI NI STRATI VE & GENERAL						5.0
. 00	00700 OPERATION OF PLANT						7.0
3.00	00800 LAUNDRY & LINEN SERVICE						8.0
9.00	00900 HOUSEKEEPI NG						9.0
10.00	01000 DI ETARY						10.0
11.00	01100 CAFETERI A	203, 323					11.0
13.00	01300 NURSING ADMINISTRATION	18, 865	4, 198, 820				13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	2,096	0	1, 684, 50	61		14.0
15.00	01500 PHARMACY	6, 288	1 1	46, 80			15.0
17.00	01700 SOCIAL SERVICE	1, 048			0 0		17.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		J		-1		
30.00	03000 ADULTS & PEDIATRICS	34, 586	1, 602, 181	147, 8	70 629	61, 714	30.0
31.00	03100 I NTENSI VE CARE UNI T	11, 529		48, 7			
	ANCILLARY SERVICE COST CENTERS	,•	1 ,1	,			1
50.00	05000 OPERATI NG ROOM	11, 529	220, 991	456, 80	69 121	0	50.0
51.00	05100 RECOVERY ROOM	3, 144		100, 00	0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 625		38, 7	-	0	
56.00	05600 RADI OLSOTOPE	1, 048		3, 22			
57.00	05700 CT SCAN	5, 240	1 1	48, 52		-	
58.00	05800 MRI	2,096		2, 6			
50.00	06000 LABORATORY	20, 961	1	175, 14			
55.00	06500 RESPIRATORY THERAPY	9, 433	1	97, 69			
56. 00	06600 PHYSI CAL THERAPY	9, 433		11, 0			
50.00 57.00	06700 OCCUPATI ONAL THERAPY	3, 144		11, 0			
57.00 58.00	06800 SPEECH PATHOLOGY	1, 048	1		0 0		
			1	25.2			
59.00	06900 ELECTROCARDI OLOGY	3, 144		35, 34			
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	-	207, 0			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	201, 21			
73.00	07300 DRUGS CHARGED TO PATIENTS	0	-		0 1, 538, 989		
6. 97	07697 CARDI AC REHABI LI TATI ON	1, 048	0		0 0	0	76. 9
	OUTPATIENT SERVICE COST CENTERS	10 577					
0.00	09000 CLI NI C	12, 577	441, 981		0 582	0	
0. 01	09001 CLINIC - DIABETES	0	0		0 0	0	
91.00	09100 EMERGENCY	25, 153	1, 049, 705	163, 4	78 469	0	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.0
	SPECIAL PURPOSE COST CENTERS		<u>т т</u>				
18.00		197, 035	4, 198, 820	1, 684, 49	99 1, 541, 663	80, 827	118.0
	NONREI MBURSABLE COST CENTERS		,		- 1	r	
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 048			0 0		190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	-		0 0		192.0
	07950 OCCUPATI ONAL HEALTH	0	-		0 0		194.0
	07952 BLOOMNGTN AMBULANCE AND OCC MED	5, 240	0	(62 0		194. C
94.03	07953 HOME CARE	0	0		0 0	0	194. C
200.00	Cross Foot Adjustments						200.0
201.00		0	0		0 0	0	201.0
	TOTAL (sum lines 118 through 201)		4, 198, 820		61 1, 541, 663		202.0

OST ALLO	nancial Systems INDI CATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1328	Perio	od: 01/01/2018	Worksheet Part I	В
					То	12/31/2018		Prepare
	Cost Center Description	Subtotal	Intern &	Total			0, 20, 201,	
		R	esidents Cost					
			& Post Stepdown					
			Adjustments					
		24.00	25.00	26.00				
GEN	IERAL SERVI CE COST CENTERS							
00 001	00 CAP REL COSTS-BLDG & FIXT							1.
00 002	200 CAP REL COSTS-MVBLE EQUIP							2.
	OO EMPLOYEE BENEFITS DEPARTMENT							4.
	500 ADMINISTRATIVE & GENERAL							5.
	OO OPERATION OF PLANT							7.
	300 LAUNDRY & LINEN SERVICE							8.
	200 HOUSEKEEPI NG							9.
	DOO DI ETARY							10.
	00 CAFETERI A							11.
1	800 NURSI NG ADMI NI STRATI ON							13.
	OO CENTRAL SERVICES & SUPPLY							14.
								15.
	00 SOCIAL SERVICE							17.
	ATLENT ROUTINE SERVICE COST CENTERS	(400 015	0	4 400 6	15			- 20
1	000 ADULTS & PEDIATRICS	6, 480, 815	0	6, 480, 8				30.
	OO INTENSIVE CARE UNIT	2, 507, 748	0	2, 507, 7	48			31.
	OOO OPERATING ROOM	2, 688, 842	0	2, 688, 8	24.2			50.
	00 RECOVERY ROOM	621, 506	0	621, 5				50.
	00 RADI OLOGY-DI AGNOSTI C	2, 246, 058	0	2, 246, 0				54.
	00 RADI OLOGI - DI AGNOSTI C	216,097	0	2, 240, 0				56.
	VOO CT SCAN	720, 504	0	720, 5				57.
	800 MRI	444, 186	0	444, 1				58.
	DOO LABORATORY	6, 270, 269	0	6, 270, 2				60.
	500 RESPIRATORY THERAPY	1, 165, 708	0	1, 165, 7				65.
	00 PHYSI CAL THERAPY	1, 222, 524	0	1, 222, 5				66.
	OO OCCUPATI ONAL THERAPY	540, 946	0	540, 9				67.
	BOO SPEECH PATHOLOGY	126,036	0	126, 0				68.
	200 ELECTROCARDI OLOGY	1, 303, 758	0	1, 303, 7				69.
00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	444, 279	0	444, 2	279			71.
00 072	200 IMPL. DEV. CHARGED TO PATIENTS	431, 746	0	431, 7	46			72.
00 073	BOO DRUGS CHARGED TO PATIENTS	13, 839, 391	0	13, 839, 3	391			73.
	97 CARDI AC REHABI LI TATI ON	191, 426	0	191, 4	26			76.
	PATIENT SERVICE COST CENTERS							
	DOO CLINIC	2, 071, 366	0	2,071,3				90.
	001 CLINIC - DIABETES	208, 118	0	208, 1				90.
	00 EMERGENCY	5, 260, 691	0	5, 260, 6	91			91.
	200 OBSERVATION BEDS (NON-DISTINCT PART		0					92.
	CLAL PURPOSE COST CENTERS	40,000,014		40.000.0				
B. 00	SUBTOTALS (SUM OF LINES 1 through 117)	49, 002, 014	0	49,002,0	14			118.
	IREI MBURSABLE COST CENTERS	75 100	0	75 4	02			190.
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	75, 193	-	75, 1 1 122 F				
	200 PHYSI CLANS' PRI VATE OFFI CES	1, 133, 537	0	1, 133, 5				192.
	250 OCCUPATIONAL HEALTH	140, 194	0	140, 1				194.
	252 BLOOMNGTN AMBULANCE AND OCC MED 253 HOME CARE	434, 628	0	434, 6	20			194. 194.
4. 03 079 D. 00	Cross Foot Adjustments	0	0		0			200.
1.00	Negative Cost Centers	0	0		0			200. 201.
		U	0					1201.

INDIANA UNIVERSITY HEALTH BEDFORD

In Lieu of Form CMS-2552-10

		JIANA UNIVERSITY				U OT FORM CMS	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		eriod: com 01/01/2018 o 12/31/2018	Worksheet B Part II Date/Time Pre 5/28/2019 12:	pared:
			CAPI TAL REL	ATED COSTS		0/20/2017 12.	
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	DLDG & TIXI	WVDLL LQUIF	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 406	4, 199	6, 605	6, 605	1
5.00	00500 ADMI NI STRATI VE & GENERAL	0	116, 761	203, 811	320, 572	397	
7.00	00700 OPERATION OF PLANT	0	86, 558		237, 647	187	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	3, 249	5, 670	8, 919	0	8.00
9.00	00900 HOUSEKEEPI NG	0	8, 432	14, 718	23, 150	166	9.00
10.00	01000 DI ETARY	0	17, 152	29, 938	47, 090	133	10.00
11.00	01100 CAFETERI A	0	11, 229	19, 600	30, 829	36	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	23, 606		64, 811	683	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	19, 920		54, 690	23	
15.00	01500 PHARMACY	0	5, 753		15, 795	195	
17.00	01700 SOCIAL SERVICE	0	518	904	1, 422	22	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	41, 620	72, 647	114, 267	914	30.00
30.00	03100 I NTENSI VE CARE UNI T	0	10, 706	18, 688	29, 394	421	31.00
31.00	ANCI LLARY SERVICE COST CENTERS	0	10, 700	10,000	29, 394	421	31.00
50.00	05000 OPERATI NG ROOM	0	52, 123	90, 982	143, 105	472	50.00
51.00	05100 RECOVERY ROOM	0	02,120	0	0	124	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	21, 281	37, 146	58, 427	434	1
56.00	05600 RADI OI SOTOPE	0	0	0	0	33	1
57.00	05700 CT SCAN	0	4, 623	8, 070	12, 693	139	57.00
58.00	05800 MRI	0	4, 906	8, 563	13, 469	62	58.00
60.00	06000 LABORATORY	0	22, 034	38, 460	60, 494	127	60.00
65.00	06500 RESPI RATORY THERAPY	0	6, 196	10, 815	17, 011	292	65.00
66.00	06600 PHYSI CAL THERAPY	0	12, 952	22, 608	35, 560	276	1
67.00	06700 OCCUPATIONAL THERAPY	0	4, 567	7, 971	12, 538	133	
68.00	06800 SPEECH PATHOLOGY	0	1, 624	2, 835	4, 459	30	
69.00	06900 ELECTROCARDI OLOGY	0	16, 436		45, 125	110	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00 76.97	07300 DRUGS CHARGED TO PATIENTS	0	0 (()	15 101	22 704	0	73.00
/0.9/	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	8, 663	15, 121	23, 784	24	/0.9/
90.00	09000 CLINIC	0	27, 999	48, 873	76, 872	331	90.00
90.01	09001 CLINIC - DIABETES	0	2,444		6, 709		1
91.00	09100 EMERGENCY	0	21, 751	37, 967	59, 718	763	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	_	,		0		92.00
	SPECIAL PURPOSE COST CENTERS	-					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	555, 509	969, 646	1, 525, 155	6, 527	118.00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 388		12, 047		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	173, 098		173, 098		192.00
	07950 OCCUPATIONAL HEALTH	0	9, 934	17, 340	27, 274		194.00
	07952 BLOOMNGTN AMBULANCE AND OCC MED	0	26, 135	0	26, 135		194.02
	07953 HOME CARE	0	0	0	0	0	194.03
200.00			_		0	~	200.00
201.00 202.00			0 769, 064	0 994, 645	1 762 700		201.00 202.00
202.00	1 101AL (SUM TIMES TTO LINUUYIT 201)	0	1 709,004	994,045	1, 763, 709	0, 005	1202.00

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	TLON			TAI	DEL	ATED	

INDIANA UNIVERSITY HEALTH BEDFORD

		TANA UNI VERSI I					2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part II Date/Time Pre 5/28/2019 12:	pared:
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT 7.00	LINEN SERVICE	9.00	10.00	
		5.00	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS	1	[[1 1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	320, 969					5.00
7.00	00700 OPERATION OF PLANT	18, 767	256, 601				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1,045					8.00
9.00	00900 HOUSEKEEPI NG	5, 131					9.00
10.00	01000 DI ETARY	4, 254	7, 813				10.00
11.00	01100 CAFETERI A	739					
13.00	01300 NURSI NG ADMI NI STRATI ON	25, 270					
14.00	01400 CENTRAL SERVICES & SUPPLY	9, 664	9, 074			0	
15.00	01500 PHARMACY	9, 128				0	
17.00	01700 SOCIAL SERVICE	479	236	0	47	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	22, 984	18, 958	3, 896	3, 813	46, 469	30.00
31.00	03100 I NTENSI VE CARE UNI T	9, 956	4, 877	1, 729	981	14, 392	31.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 863	23, 742	2, 350	4, 774	0	50.00
51.00	05100 RECOVERY ROOM	2, 861	0	0 0	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 826	9, 693	0	1, 950	0	54.00
56.00	05600 RADI OI SOTOPE	1, 339	0	0 0	0	0	56.00
57.00	05700 CT SCAN	3, 988	2, 106	0	424	0	57.00
58.00	05800 MRI	2, 539	2, 235	0	449	0	58.00
60.00	06000 LABORATORY	37, 319	10, 036	0	2,019	0	60.00
65.00	06500 RESPI RATORY THERAPY	6, 389			568	0	65.00
66.00	06600 PHYSI CAL THERAPY	6, 618	5, 900	0 0	1, 187	l o	66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 177	2,080	0 0	418	l o	67.00
68.00	06800 SPEECH PATHOLOGY	711	740				1
69.00	06900 ELECTROCARDI OLOGY	6, 499					1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 499				0	1
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS	1, 457	0	-	-	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	77, 726		0	-	0	
76.97	07697 CARDI AC REHABI LI TATI ON	782	3, 946		-	0	
	OUTPATIENT SERVICE COST CENTERS		-,	-		-	
90.00	09000 CLINIC	8, 852	12, 754	0	2, 565	0	90.00
90.01	09001 CLINIC - DIABETES	1, 196				0	1
91.00	09100 EMERGENCY	24,012		-			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	21,012	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0, 10,	1, 770		92.00
72.00	SPECIAL PURPOSE COST CENTERS			1			/2.00
118.00		317,070	159, 330	11, 444	30, 976	60.861	118.00
110.00	NONREI MBURSABLE COST CENTERS	317,070	137, 330	/ 11, 444	30, 770	00,001	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	255	1, 999	0	402		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 398					192.00
	07950 OCCUPATIONAL HEALTH	403				-	192.00
	07950 OCCOPATIONAL HEALTH	1, 843					194.00
	07952 BLOOMINGTH AMBULANCE AND OCC MED	1, 643	11, 904 0		0		194.02
200.00		0		, U	0		200.00
200.00	5	0	_	0	_	_	200.00
201.00		320, 969	256, 601	-	-		201.00
202.00	I I I I I I I I I I I I I I I I I I I	320,909	250,001	444	32, 200	00,001	1202.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	N: 15-1328	Period: From 01/01/2018 To 12/31/2018		epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &		5/28/2019 12: SOCI AL SERVI CE	16 pm
		11.00	13.00	SUPPLY	15.00	17.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1 1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
3.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	37, 748	1				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 502					13.00
	01400 CENTRAL SERVICES & SUPPLY	389		75, 66			14.00
15.00	01500 PHARMACY	1, 167		2, 10	05 31, 538		15.00
17.00	01700 SOCIAL SERVICE	195	0		0 0	2, 401	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·			-	
	03000 ADULTS & PEDIATRICS	6, 419	40, 898	6, 64		1, 833	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 140	14, 103	2, 19	91 5	568	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 140	5, 641	20, 51	19 2	0	50.00
51.00	05100 RECOVERY ROOM	584	4, 231		0 0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 530	0	1, 74	12 10	0	54.00
56.00	05600 RADI OI SOTOPE	195	0	14		0	56.00
57.00	05700 CT SCAN	973	0	2, 18	30 2	0	57.00
58.00	05800 MRI	389	0	. 11		0	58.00
50.00	06000 LABORATORY	3, 892	1	7, 86	57 0	0	60,00
65.00	06500 RESPI RATORY THERAPY	1, 751	1	4, 38		0	65.00
56.00	06600 PHYSI CAL THERAPY	1, 751	1	49		0	
57.00	06700 OCCUPATI ONAL THERAPY	584			0 0	0	
58.00	06800 SPEECH PATHOLOGY	195			0 0	0	
59.00	06900 ELECTROCARDI OLOGY	584	-	1, 58	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		9, 30		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		9, 03		0	
	07200 TMPL. DEV. CHARGED TO PATTENTS	0		9, 03		0	
		195	-		0 31, 483 0 0	0	
/0.9/	07697 CARDIAC REHABILITATION	195	U U		0 0	0	/0.9/
00 00		2 225	11 202		0 10	0	00.00
		2, 335			0 12	0	
	09001 CLINIC - DIABETES	0	Ű		0 0	0	
	09100 EMERGENCY	4, 670	26, 796	7, 34	13 10	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS		T T				
118.00		36, 580	107, 182	75, 66	52 31, 538	2, 401	118.00
	NONREIMBURSABLE COST CENTERS		,				-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	195			0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1		0 0		192.00
	07950 OCCUPATI ONAL HEALTH	0	-		0 0	0	194.00
	07952 BLOOMNGTN AMBULANCE AND OCC MED	973	0		3 0		194. 02
94.03	07953 HOME CARE	0	0		0 0	0	194.03
200.00							200.00
101 00		0	0		0 0	<u>م</u>	201.00
201.00					0 0	0	

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INDIANA UNIVERSITY HEALTH BEDFORD

Health Financial Systems	NDIANA UNIVERSIT	Y HEALTH BEDFOR	RD .	IN LIEU OF FORM CMS	5-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: Worksheet B	
				rom 01/01/2018 Part II o 12/31/2018 Date/Time Pu	ronarod
			'	5/28/2019 12	
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15.00
17.00 01700 SOCIAL SERVICE					17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	267, 106	0	267, 106		30.00
31. 00 03100 I NTENSI VE CARE UNI T	80, 757	0	80, 757	,	31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	212, 608	0	212, 608	3	50.00
51.00 05100 RECOVERY ROOM	7,800	0	7,800		51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	87, 612	0	87, 612		54.00
56. 00 05600 RADI OI SOTOPE	1, 712	0			56.00
57.00 05700 CT SCAN	22, 505	0			57.00
58. 00 05800 MRI	19, 262	0			58.00
60. 00 06000 LABORATORY	121, 754	0			60.00
65. 00 06500 RESPI RATORY THERAPY	33, 222	0			65.00
66. 00 06600 PHYSI CAL THERAPY	53, 197	l o			66.00
67.00 06700 OCCUPATI ONAL THERAPY	18, 930	0			67.00
68.00 06800 SPEECH PATHOLOGY	6, 284	0			68.00
69. 00 06900 ELECTROCARDI OLOGY	65, 720	0			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 799	l o			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 495	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	109, 209	0			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	29, 525	0			76.97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	115, 003	0	115, 003	8	90.00
90. 01 09001 CLINIC - DIABETES	9, 242	0			90.01
91.00 09100 EMERGENCY	138, 682	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
SPECIAL PURPOSE COST CENTERS		-	1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117	') 1, 421, 424	0	1, 421, 424		118.00
NONREI MBURSABLE COST CENTERS	///////////////////////////////////////		.,,		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 905	0	14, 905	j	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	253, 339				192.00
194. 00 07950 OCCUPATI ONAL HEALTH	33, 112	n	33, 112		194.00
194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED	40, 929	n	40, 929		194.02
194. 03 07953 HOME CARE	0, 727	0			194.02
200.00 Cross Foot Adjustments	0	0			200.00
201.00 Negative Cost Centers		0			200.00
202.00 TOTAL (sum Lines 118 through 201)	1, 763, 709				201.00
	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. 0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	1-02.00

	ON - STATI STI CAL BASI S		Provider CC		eriod:	Worksheet B-1	
(Trovider con.		From 01/01/2018			
(o 12/31/2018	Date/Time Pre 5/28/2019 12:	pared: 16 pm
(CAPI TAL REL	ATED COSTS	I		372072017 12.	
,	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci I i ati on	ADMI NI STRATI VE	
	sost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Reconciliation	& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	L SERVICE COST CENTERS	1 (0, 0, 40					1 00
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	163, 349	121, 032				1.00 2.00
	EMPLOYEE BENEFITS DEPARTMENT	511	511	14, 600, 009			4.00
	ADMINISTRATIVE & GENERAL	24, 800		877, 579		39, 745, 325	
	DPERATION OF PLANT LAUNDRY & LINEN SERVICE	18, 385 690		413, 469 0		2, 323, 740 129, 347	
	HOUSEKEEPING	1, 791	1, 791	367, 622	-	635, 327	
10.00 01000 [DI ETARY	3, 643	3, 643	294, 365		526, 744	
		2, 385		80, 424		91, 454	
	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY	5, 014 4, 231	5, 014 4, 231	1, 511, 844 51, 094		3, 129, 015 1, 196, 670	
	PHARMACY	1, 222	1, 222	430, 930		1, 130, 252	
	SOCIAL SERVICE	110		48, 242	0	59, 315	
	ENT ROUTI NE SERVI CE COST CENTERS	8, 840	8, 840	2, 010, 315	0	2, 845, 971	30.00
	NTENSIVE CARE UNIT	8, 840 2, 274	8, 840 2, 274	931, 468			
	ARY SERVICE COST CENTERS	_,	_/	,	-	.,,	
	DPERATING ROOM	11, 071	11, 071	1, 045, 277			
	RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	0 4, 520	0 4, 520	274, 469 959, 880		354, 224 1, 588, 167	
	RADI OL SOTOPE	4, 520	4, 520	72, 484		165, 779	
	CT SCAN	982	982	307, 095		493, 862	
58.00 05800 M		1,042	1,042	136, 671		314, 343	
	_ABORATORY RESPI RATORY THERAPY	4, 680 1, 316		281, 524 645, 894		4, 620, 923 791, 078	
	PHYSI CAL THERAPY	2, 751	2, 751	609, 533		819, 469	
67.00 06700 0	OCCUPATIONAL THERAPY	970		293, 781		393, 367	
	SPEECH PATHOLOGY	345		67, 208		88, 029	
	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	3, 491 0	3, 491 0	243, 701 0		804, 686 185, 653	
	MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	180, 416	
	DRUGS CHARGED TO PATIENTS	0	0	0	0	9, 626, 437	
76.97 07697 0	CARDI AC REHABI LI TATI ON	1, 840	1, 840	52, 860	0 0	96, 786	76.97
90.00 09000 0	I ENT SERVICE COST CENTERS	5, 947	5, 947	733, 052	0	1, 096, 143	90.00
	CLINIC - DIABETES	519		440		148, 150	
	EMERGENCY	4, 620	4, 620	1, 687, 787	0	2, 973, 222	1
	DBSERVATION BEDS (NON-DISTINCT PART L PURPOSE COST CENTERS						92.00
	SUBTOTALS (SUM OF LINES 1 through 117)	117, 990	117, 990	14, 429, 008	-11, 040, 241	39, 262, 602	118.00
NONREL	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	932					190.00
	PHYSICIANS' PRIVATE OFFICES DCCUPATIONAL HEALTH	36, 766 2, 110		0	-	173, 098 49, 851	
	BLOOMNGTN AMBULANCE AND OCC MED	5, 551	2,110	156, 409	0	228, 191	
194.0307953 H		0	0	0	0	0	194.03
	Cross Foot Adjustments						200.00
	Negative Cost Centers Cost to be allocated (per Wkst. B,	769, 064	994, 645	2, 920, 742		11, 040, 241	201.00
	Part I)	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_, .20, .12		, 0.10, 211	
1 1	Jnit cost multiplier (Wkst. B, Part I)	4. 708104	8. 218033	0. 200051		0. 277775	
	Cost to be allocated (per Wkst. B, Part II)			6, 605		320, 969	204.00
205.00 l	Jnit cost multiplier (Wkst. B, Part			0.000452		0. 008076	205.00
	II) VAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
	VAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

SI AL	LLOCATION - STATISTICAL BASIS			Provider C		Peri od:	Worksheet B-1	1
						From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 12:	
	Cost Center Description		PERATION OF PLANT QUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (FTE)	
		-	7.00	LAUNDR) 8.00	9.00	10.00	11.00	-
C	GENERAL SERVICE COST CENTERS	I						
00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0 00 0	00100 CAP REL COSTS-BLDG & FIX 00200 CAP REL COSTS-MVBLE EQUI 00400 EMPLOYEE BENEFITS DEPARTI 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPL' 01500 PHARMACY 01700 SOCIAL SERVICE	> /ENT /	119, 653 690 1, 791 3, 643 2, 385 5, 014 4, 231 1, 222 110	233, 392 0 0 0 0 0 0 0 0 0 0	74, 85 3, 64 2, 38 5, 01 4, 23 1, 22 11	3 49,765 5 0 4 0 1 0 2 0	194 18 2 6 1	8 13 2 14 5 15
	INPATIENT ROUTINE SERVICE COST 03000 ADULTS & PEDIATRICS	CENTERS	8, 840	79, 457	8, 840	37,997	33	3 30
	03100 I NTENSI VE CARE UNI T		2,274	35, 264			11	
ŀ	ANCILLARY SERVICE COST CENTERS	I	· 1					
00 00 00 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05600 RADIOISOTOPE 05700 CT SCAN		11, 071 0 4, 520 0 982	47, 932 0 0 0 0	(0 0 0 0	11 3 13 1 5	3 5 ² 3 54
	05800 MRI		1,042	0			2	
	06000 LABORATORY		4,680	0			20	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		1, 316 2, 751	0	1, 316 2, 751		9	
	06700 OCCUPATI ONAL THERAPY		970	0	970		3	3 6
	06800 SPEECH PATHOLOGY		345	0	345		1	68
	06900 ELECTROCARDI OLOGY		3, 491	0	3, 49		3	
	07100 MEDICAL SUPPLIES CHARGED 07200 IMPL. DEV. CHARGED TO PA		0	0			0	
	07300 DRUGS CHARGED TO PATIENTS		0	0			0	
	07697 CARDIAC REHABILITATION		1, 840	0	1, 840	0 0	1	17
-	OUTPATIENT SERVICE COST CENTER 09000 CLINIC	S	5, 947	0	5, 94	7 0	12	2 9
	09001 CLINIC - DIABETES		519	0	519		0	
00 0	09100 EMERGENCY		4, 620	70, 739	4, 620	0 0	24	1 9
	09200 OBSERVATI ON BEDS (NON-DI	STINCT PART						9
3. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES	through 117)	74, 294	233, 392	71, 813	3 49, 765	188	111
	NONREI MBURSABLE COST CENTERS		71,271	200,072	, , , , , , , , , , , , , , , , , , , ,	, ,,,,,,,,	100	1
0. 00	19000 GIFT, FLOWER, COFFEE SHO		932	0	932	2 0		19
	19200 PHYSI CLANS' PRI VATE OFFI 07950 OCCUPATI ONAL HEALTH	JES	36, 766 2, 110	0	2, 110) 19:
	07952 BLOOMNGTN AMBULANCE AND	DCC MED	5, 551	0	2,110			5 19
	07953 HOME CARE		0	0		0 0	0) 19
0.00								200
. 00 2. 00		⁻ Wkst. B,	2, 969, 217	182, 399	856, 249	805, 133	203, 323	20 3 20
3.00 1.00	Unit cost multiplier (Wks Cost to be allocated (pe		24. 815232 256, 601	0. 781514 11, 444			1, 048. 056701 37, 748	
5. 00	Part II) Unit cost multiplier (Wk	st. B, Part	2. 144543	0. 049033	0. 43134	1. 222968	194. 577320	20
5.00	3	be allocated						20
7.00	(per Wkst. B-2) NAHE unit cost multiplie Parts III and IV)	⁻ (Wkst. D,						20

ST ALLOCA	TI ON – STATI STI CAL BASI S		Provider CC	F	Period: From 01/01/2018 Fo 12/31/2018	Worksheet B-1 Date/Time Prepar 5/28/2019 12:16
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HR)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)	SOCI AL SERVICE (TOTAL PATI ENT DAYS)	
		13.00	14.00	15.00	17.00	
GENER	AL SERVICE COST CENTERS	•				
00 00200 00 00400 00 00500 00 00700 00 00800 00 00900	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINI STRATI VE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY					1 2 4 5 7 8 9 9
. 00 01100 . 00 01300 . 00 01400 . 00 01500 . 00 01700	CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY SOCIAL SERVICE	76 0 0 0	1, 510, 434 42, 021 0	9, 643, 160		11 13 14 15 17
	I ENT ROUTINE SERVICE COST CENTERS	29	132, 585	3, 932	2 2, 906	30
	INTENSIVE CARE UNIT	10	43, 737			31
	LARY SERVICE COST CENTERS					
	OPERATING ROOM	4	409, 644			50
	RECOVERY ROOM	3	0		-	51
	RADI OLOGY-DI AGNOSTI C	0	34, 766			54
	RADIOISOTOPE	0	2,888		-	56
.00 05700 .00 05800	CT SCAN	0	43, 513 2, 380			57
	LABORATORY	0	157, 036		-	60
	RESPI RATORY THERAPY	0	87, 592	344	-	65
	PHYSI CAL THERAPY	1	9, 873	(66
	OCCUPATIONAL THERAPY	0	0	C	0 0	67
. 00 06800	SPEECH PATHOLOGY	0	0	c	0 0	68
	ELECTROCARDI OLOGY	2	31, 694		0 0	69
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	185, 653		0 0	71
	IMPL. DEV. CHARGED TO PATIENTS	0	180, 416		0 0	72
	DRUGS CHARGED TO PATIENTS	0	0			73
	CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	0	0	(0 0	76
		8	0	3, 643	3 0	90
	CLINIC - DIABETES	0	0		o o	90
	EMERGENCY	19	146, 580	2, 935		91
. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92
	AL PURPOSE COST CENTERS	,				
	SUBTOTALS (SUM OF LINES 1 through 117)	76	1, 510, 378	9, 643, 160	3, 806	118
	I MBURSABLE COST CENTERS		0	· · · · · ·		100
	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0			190 192
	OCCUPATIONAL HEALTH	0	0			192
	BLOOMNGTN AMBULANCE AND OCC MED	0	56		-	194
	HOME CARE	0	0		o o	194
0. 00	Cross Foot Adjustments					200
1.00	Negative Cost Centers					201
2.00 3.00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	4, 198, 820 55, 247. 631579	1, 684, 561 1. 115283			202
4.00	Cost to be allocated (per Wkst. B, Part II)	107, 182	75, 665	31, 538	3 2, 401	204
5.00	Unit cost multiplier (Wkst. B, Part	1, 410. 289474	0. 050095	0. 003271	0. 630846	205
6.00 7.00	NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					206

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 12:	
		Title	XVIII	Hospi tal	Cost	
				Costs		L
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	.,	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	1			4
0. 00 03000 ADULTS & PEDIATRICS	6, 480, 815		6, 480, 8			
1.00 03100 INTENSIVE CARE UNIT	2, 507, 748		2, 507, 7	48 0	0	31.00
ANCILLARY SERVICE COST CENTERS	1					
0. 00 05000 OPERATI NG ROOM	2, 688, 842		2, 688, 8			
1.00 05100 RECOVERY ROOM	621, 506		621, 5		-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 246, 058		2, 246, 0		0	
6. 00 05600 RADI 0I SOTOPE	216, 097		216, 0		0	00.0
7.00 05700 CT SCAN	720, 504		720, 5		0	
8. 00 05800 MRI	444, 186		444, 1		0	
0. 00 06000 LABORATORY	6, 270, 269		6, 270, 2		0	
5. 00 06500 RESPI RATORY THERAPY	1, 165, 708		1, 165, 7		0	1 00.0
6. 00 06600 PHYSI CAL THERAPY	1, 222, 524		1, 222, 5		0	1 00.0
7. 00 06700 OCCUPATI ONAL THERAPY	540, 946		540, 9		0	
8.00 06800 SPEECH PATHOLOGY	126, 036		126, 0	36 0	0	
9. 00 06900 ELECTROCARDI OLOGY	1, 303, 758		1, 303, 7	58 0	0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	444, 279		444, 2	79 0	0	1
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	431, 746		431, 7	46 0	0	1 / 2 / 9
3. 00 07300 DRUGS CHARGED TO PATIENTS	13, 839, 391		13, 839, 3	91 0	0	73.0
6. 97 07697 CARDI AC REHABI LI TATI ON	191, 426		191, 4	26 0	0	76.9
OUTPATIENT SERVICE COST CENTERS		-				
0. 00 09000 CLINIC	2, 071, 366		2, 071, 3	66 0	0	90.0
0. 01 09001 CLINIC - DIABETES	208, 118		208, 1		0	1
1.00 09100 EMERGENCY	5, 260, 691		5, 260, 6	91 0	0	1 / 4
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 210, 107		2, 210, 1	07	0	92.0
00.00 Subtotal (see instructions)	51, 212, 121	0	51, 212, 1	21 0	0	200.
01.00 Less Observation Beds	2, 210, 107		2, 210, 1	07	0	201.0
02.00 Total (see instructions)	49,002,014	0	49,002,0	14 0	0	202.

	Financial Systems IND ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre	manadi
					10 12/31/2018	5/28/2019 12:	
			Title	XVIII	Hospi tal	Cost	
		Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	5 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					4
30.00	03000 ADULTS & PEDIATRICS	5, 236, 639		5, 236, 63			30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 993, 812		5, 993, 81	2		31.00
	ANCI LLARY SERVI CE COST CENTERS	L					4
	05000 OPERATI NG ROOM	2, 343, 843	21, 738, 752			0.00000	
51.00	05100 RECOVERY ROOM	286, 404	3, 102, 184			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	609, 334	12, 363, 752			0.00000	
56.00	05600 RADI OI SOTOPE	222, 802	2, 186, 704			0.000000	
57.00	05700 CT SCAN	552, 797	6, 615, 776			0.000000	
58.00	05800 MRI	184, 252	2, 418, 227	2, 602, 47		0.000000	
60.00	06000 LABORATORY	2, 815, 029	16, 566, 967	19, 381, 99		0.000000	
65.00	06500 RESPI RATORY THERAPY	1, 083, 207	2, 974, 033			0.000000	
66.00	06600 PHYSI CAL THERAPY	295, 293	2, 641, 406			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	151, 936	883, 686			0.000000	
68.00	06800 SPEECH PATHOLOGY	40, 850	327, 221	368, 07		0.000000	
69.00	06900 ELECTROCARDI OLOGY	769, 218	9, 840, 591	10, 609, 80		0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	473, 450	1, 621, 026			0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	124, 035	1, 657, 646			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	5, 107, 499	45, 575, 965			0.000000	
76.97	07697 CARDI AC REHABI LI TATI ON	539	1, 156, 107	1, 156, 64	6 0. 165501	0. 000000	76.97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	56	10, 682, 890			0.000000	
90. 01	09001 CLINIC - DIABETES	0	75, 648			0.000000	
	09100 EMERGENCY	1, 092, 434	30, 980, 120			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	63, 102	11, 161, 030			0.000000	
200.00		27, 446, 531	184, 569, 731	212, 016, 26	2		200.00
201.00							201.00
202.00	Total (see instructions)	27, 446, 531	184, 569, 731	212, 016, 26	2		202.00

Heal th	Fi nar	ici al	Syst	ems			
COMPLIE					COCTC	TO	0

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1328 Period: From 01/01/2018 To 12/31/2018 Worksheet C Date/Time Prepared: 52/82/2019 12: 16 pm Impart ENT ROUTINE_SERVICE COST CENTERS Title XVIII Hospital Cost 0.00 03000 ADULTS & PEDIATRICS 30.00 30.00 10.00 11.00 11.00 31.00 ANCI LLARY SERVICE COST CENTERS 31.00 0.00 03000 (PERATINK ROM 0.000000 51.00 (StoO) (PERATINK ROM 0.000000 51.00 (StoO) (PERATINK ROM 0.000000 53.00 (CT SCAN 0.000000 56.00 (StoO) (RAD LOKY ROM 0.000000 56.00 (StoO) RAD LOKY ROM 0.000000 56.00 (StoO) RESPIRATIORY THERAPY 0.000000 56.00 (StoO) RESPIRATORY THERAPY 0.000000 66.00 (StoO) RESPIRATORY THERAPY 0.000000 67.00 (StoO) RESPIRATORY THERAPY 0.000000 67.00 (StoO) RESPIRATORY THERAPY 0.000000 67.00 (StoO) RESPIRATORY THERAPY 0.000000 68.00 (StoO) RESPIRATOR THERAPY 0.000000 71.00 (T COM) LAUL THERAPY 0.000000 72.00 (Health Financial Systems	NDIANA UNIVERSITY	HEALTH BEDFORD	In Lieu of Form CMS-2552-10		
Cost Center Description PPS Inpatient Ratio Inpatient (Ratio) Inpatient (Ratio) INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0.00 03000 ADULTS & PEDIATRICS 31.00 ANCILLARY SERVICE COST CENTERS 31.00 50.00 05000 (PERATING ROM 0.000000 51.00 05000 (PERATING ROM 0.000000 51.00 05000 RECVER YROM 0.000000 51.00 05000 RADULTS (CV-DIAKNOSTIC 0.000000 56.00 05600 RADULTSOTOPE 0.000000 57.00 05700 (TSCAN 0.000000 57.00 05700 (TSCAN 0.000000 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 06600 PHYSICAL THERAPY 0.000000 66.00 06600 SPEECH PATHOLOGY 0.000000 67.00 06700 CCUPATIONAL THERAPY 0.000000 68.00 06900 OCOUPATIONAL THERAPY 0.000000 68.00 06600 SPEECH PATHOLOGY 0.000000 69.00 06700 CCUPATIONAL THERAPY 0.000000 71.00 0.000000 68.00	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2018 To 12/31/2018	Part I Date/Time Prepa 5/28/2019 12:16	
Raitio Raitio 11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 11.00 03000 ADULTS & PEDIATRICS 30.00 11.00 0001 INTENSIVE CARE UNIT 31.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 05000 (PERATING ROOM 0.000000 51.00 51.00 05100 RECOVERY ROM 0.000000 51.00 54.00 05400 RADI 0LOGY-DI AGNOSTIC 0.000000 54.00 56.00 05700 CT SCAN 0.000000 57.00 57.00 05700 CT SCAN 0.000000 58.00 66.00 06500 RADI 0LOGY-THERAPY 0.000000 66.00 66.00 06500 RADI 0LOGY THERAPY 0.000000 66.00 66.00 06500 RADI 0LOGY THERAPY 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 ELCETRCARDI OLOGY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 71.00 71.00 07			Title XVIII	Hospi tal	Cost	
30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 ANDULLARY SERVICE COST CENTERS 31.00 50.00 05000 OPERATING ROOM 0.000000 51.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 56.00 05600 OFERATING ROOM 0.000000 57.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 56.00 05600 RADIOLOGY-DIAGNOSTIC 0.000000 57.00 05700 CT SCAN 0.000000 58.00 05800 MRI 0.000000 60.00 06600 RESPIRATORY THERAPY 0.000000 65.00 06500 RESPIRATORY THERAPY 0.000000 66.00 06600 OPECHATINOLAL THERAPY 0.000000 67.00 06700 OCCUPATIONAL THERAPY 0.000000 68.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 06900 ELECTROCARDIOLOGY 0.000000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 72.00 072.00 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS <td>Cost Center Description</td> <td>Ratio</td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description	Ratio				
31.00 03100 INTENSIVE CARE UNIT 31.00 ANCILLARY SERVICE COST CENTERS 50.00 5000 5100 5000 5100 5000 5100 5000 5100 5000 58.00 58.00 58.00 58.00 56.00 56.00 50.00 56.00 50.00 56.00 50.00 50.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.	INPATIENT ROUTINE SERVICE COST CENTERS					
ANCI LLARY SERVICE COST CENTERS 50.00 05000 DPERATING ROOM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 57.00 05700 CT SCAN 0.000000 55.00 58.00 05800 MRI 0.000000 58.00 65.00 065000 LABORATORY 0.000000 58.00 65.00 06500 RESPI RATORY THERAPY 0.000000 60.00 66.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06400 PHYSI CAL THERAPY 0.000000 65.00 66.00 06400 DCCUPATI IONAL THERAPY 0.000000 66.00 66.00 06400 DELECTROCARDI OLOGY 0.000000 67.00 67.00 067000 CCUPATI IONAL THERAPY 0.000000 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 69.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000	30. 00 03000 ADULTS & PEDIATRICS				3	30.00
50.00 05000 0PERATING ROOM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 54.00 05400 RADI LOGY-DI AGNOSTI C 0.000000 56.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 57.00 05700 CT SCAN 0.000000 58.00 60.00 06000 LABORATORY 0.000000 58.00 60.00 06500 RESPI RATORY THERAPY 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06700 0CCUPATI ONAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 68.00 69.00 04800 SPEECH PATHOLOGY 0.000000 71.00 71.00 DTIONE CAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUS CHARGED TO PATIENTS 0	31. 00 03100 I NTENSI VE CARE UNI T				3	31.00
51.00 05100 RECOVERY ROOM 0.000000 51.00 54.00 05400 RADI OLCGY-DI AGNOSTI C 0.000000 54.00 56.00 0500 RADI OLCGY-DI AGNOSTI C 0.000000 56.00 57.00 0570 CT SCAN 0.000000 56.00 58.00 05800 MRI 0.000000 60.00 60.00 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 65.00 06400 PHYSI CAL THERAPY 0.000000 65.00 66.00 06400 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 69.00 69.00 OFECH PATHOLOGY 0.000000 69.00 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.0000000 73.00 74.07<	ANCILLARY SERVICE COST CENTERS					
54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.000000 54.00 56.00 05600 RADI 0I SOTOPE 0.000000 56.00 57.00 CT SCAN 0.000000 57.00 58.00 05800 MRI 0.000000 58.00 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 66.00 65.00 06500 RESPI RATORY THERAPY 0.000000 66.00 66.00 06400 DCUPATI ONAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 68.00 69.00 OC6000 SEECH PATHOLOGY 0.000000 69.00 69.00 OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.00 07407 CARDI AC REHABI LI TATI ON	50. 00 05000 OPERATI NG ROOM	0. 000000			5	50.00
56.00 05600 RADIOLSTOPE 0.00000 56.00 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MRI 0.000000 68.00 60.00 LABORATORY 0.000000 60.00 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 0C700 OCCUPATIONAL THERAPY 0.000000 66.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 73.00 OT300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.97 OADIGAC CARDIAC REHABILITATION 0.000000 73.00 73.00 75.97 07697 CARDIAC REHABILITATION <td>51.00 05100 RECOVERY ROOM</td> <td>0. 000000</td> <td></td> <td></td> <td>5</td> <td>51.00</td>	51.00 05100 RECOVERY ROOM	0. 000000			5	51.00
57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MRI 0.000000 58.00 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.97 CARDI AC REHABI LI TATI ON 0.000000 73.00 73.00 70.00 09000 CLI NI C 0.000000 90.01 90.01 90.00 09000 CLI NI C 0.000000 90.01 91.00 90.00 <td< td=""><td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td><td>0. 000000</td><td></td><td></td><td>5</td><td>54.00</td></td<>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			5	54.00
58.00 05800 MRI 0.00000 58.00 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 07400 DATI ENT SERVICE COST CENTERS 0.000000 73.00 90.00 09000 CLI NI C 0.000000 90.01 90.01 09000 CLI NI C 0.000000 90.01 91.00 90200 DERGENCY 0.000000 90.01 91.00 Subtotal (see instructions)	56. 00 05600 RADI OI SOTOPE	0. 000000			5	56.00
60.00 06000 LABORATORY 0.00000 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.97 OZ697 CARDI AC REHABI LI TATI ON 0.000000 73.00 70.00 09000 CLI NI C 0.400000 90.01 90.00 09000 CLI NI C 0.000000 90.01 91.00 90001 CLI NI C 0.000000 90.01 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 91.00 92.00 OBSERVATI ON BEDS	57.00 05700 CT SCAN	0. 000000			5	57.00
65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 D7300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.97 O7697 CARDI AC REHABI LI TATI ON 0.000000 73.00 70.00 09000 CLI NI C DI ABETES 0.000000 90.01 90.01 09001 CLI NI C DI ABETES 0.000000 90.01 91.00 O9200 OBERVATI ON BEDS (NON-DI STI NCT PART 0.000000 91.00 92.00 09200 OBERVATI ON BEDS (NON-DI STI NCT PART 0.000000 91.00 92.00 O92000 Subtotal (see in structi ons)	58. 00 05800 MRI	0. 000000			5	58.00
66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.97 CARDI AC REHABILITATI ON 0.000000 73.00 76.97 07697 CARDI AC REHABILITATI ON 0.000000 00 09000 CLI NI C 0.000000 90.01 90.00 09000 CLI NI C 0.000000 90.01 91.00 09020 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92.00 200.00 Less Observati on Beds 200.000 201.00 201.00	60. 00 06000 LABORATORY	0. 000000			6	60.00
66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.97 CARDI AC REHABILITATI ON 0.000000 73.00 76.97 07697 CARDI AC REHABILITATI ON 0.000000 00 09000 CLI NI C 0.000000 90.01 90.00 09000 CLI NI C 0.000000 90.01 91.00 09020 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92.00 200.00 Less Observati on Beds 200.000 201.00 201.00	65. 00 06500 RESPI RATORY THERAPY	0. 000000			6	5.00
68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07697 CARDIAC REHABILITATION 0.000000 76.97 00170.01 09000 CLINIC 0.000000 76.97 00170.01 09000 CLINIC 0.000000 90.00 90.00 09000 CLINIC - DIABETES 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 90.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 92.00 09200 Subtotal (see instructions) 200.00 201.00 200.00		0. 000000			6	6. 00
69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.97 07697 CARDIAC REHABILITATION 0.000000 76.97 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 90.00 91.00 OPG200 DBRERGENCY 0.000000 90.00 92.00 09200 DBRERGENCY 0.000000 91.00 92.00 09200 DBRERGENCY 0.000000 92.00 92.00 09200 DBRERVITION BEDS (NON-DISTINCT PART 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	67.00 06700 OCCUPATIONAL THERAPY	0. 000000			6	57.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.97 07697 CARDIAC REHABILITATION 0.000000 76.97 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 90.00 91.00 09001 CLINIC - DI ABETES 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	68.00 06800 SPEECH PATHOLOGY	0. 000000			6	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.97 07697 CARDIAC REHABILITATION 0.000000 76.97 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09001 CLINIC 0.000000 90.00 90.10 09001 CLINIC - DIABETES 0.000000 90.01 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 91.00 92.00 09200 DBERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 200.00 Less Observation Beds 200.00 201.00 201.00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000			6	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.97 07697 CARDI AC REHABILITATION 0.000000 76.97 0UTPATIENT SERVICE COST CENTERS 0.000000 90.	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			7	71.00
76.97 07697 CARDI AC REHABILITATION 0.00000 76.97 OUTPATIENT SERVICE COST CENTERS 00000 00000 CLINIC 90.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			7	2.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.00 90.01 90.00 91.00 92.00 <t< td=""><td>73.00 07300 DRUGS CHARGED TO PATIENTS</td><td>0. 000000</td><td></td><td></td><td>7</td><td>73.00</td></t<>	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			7	73.00
90.00 09000 CLINIC 0.00000 90.00 90.01 09001 CLINIC - DIABETES 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			7	76.97
90.01 09001 CLINIC - DIABETES 0.00000 90.01 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00						
91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00 201.00						
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 200.00 200.00 201.00 Less Observation Beds 201.00 201.00 201.00						
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
201.00 Less Observation Beds 201.00		0. 000000				
202.00 Total (see instructions) 202.00						
	202.00 Total (see instructions)				20	02.00

MPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018	5/28/2019 12:	pared 16 pm
	-	Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	6, 480, 815		6, 480, 8		6, 480, 815	
. 00 03100 I NTENSI VE CARE UNI T	2, 507, 748		2, 507, 7	48 0	2, 507, 748	31.0
ANCI LLARY SERVI CE COST CENTERS		1		10		
0. 00 05000 OPERATING ROOM	2, 688, 842		2, 688, 8		2, 688, 842	
. 00 05100 RECOVERY ROOM	621, 506		621, 5		621, 506	
00 05400 RADI OLOGY-DI AGNOSTI C	2, 246, 058		2, 246, 0		2, 246, 058	
0. 00 05600 RADI OI SOTOPE	216, 097		216, 0		216, 097	
7. 00 05700 CT_SCAN 3. 00 05800 MRI	720, 504		720, 5		720, 504	
	444, 186		444, 1		444, 186	
0. 00 06000 LABORATORY 5. 00 06500 RESPI RATORY THERAPY	6, 270, 269		6, 270, 2 1, 165, 7		6, 270, 269 1, 165, 708	
0.00 06600 PHYSICAL THERAPY	1, 165, 708		1, 165, 7		1, 165, 708	
2. 00 06600 PHYSICAL THERAPY 2. 00 06700 OCCUPATI ONAL THERAPY	540, 946		540, 9		540, 946	
3. 00 106700 OCCUPATIONAL THERAPY			126, 0			
2. 00 1068001 SPEECH PATHOLOGY 2. 00 1069001 ELECTROCARDI OLOGY	126, 036 1, 303, 758		1, 303, 7		126, 036 1, 303, 758	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	444, 279		444, 2		444, 279	
2. 00 07100 Medical Supplies charged to patient	444, 279		444, 2		444, 279	
8. 00 07200 TMPL. DEV. CHARGED TO PATTENTS	13, 839, 391		13, 839, 3		13, 839, 391	
0. 97 07697 CARDIAC REHABILITATION	13, 839, 391		13, 839, 3		13, 839, 391	
OUTPATIENT SERVICE COST CENTERS	191, 420		191, 4	20 0	191, 420	/0.
0. 00 09000 CLINIC	2,071,366		2,071,3	66 0	2, 071, 366	90.
). 01 09001 CLINIC - DIABETES	2,071,300		2, 071, 3		2, 071, 366 208, 118	
. 00 09100 EMERGENCY	5, 260, 691		5, 260, 6		5, 260, 691	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 210, 107		2, 210, 1		2, 210, 107	
00.00 Subtotal (see instructions)	51, 212, 121				51, 212, 121	
11.00 Less Observation Beds	2, 210, 107		2, 210, 1		2, 210, 107	
12.00 Total (see instructions)	49,002,014		Z, ∠10, I	07		201.

MCRIF32 - 15.5.166.1

		DIANA UNIVERSITY	HEALTH BEDFOR			u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018		
		-		e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	-11					
30.00	03000 ADULTS & PEDIATRICS	5, 236, 639		5, 236, 63			30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 993, 812		5, 993, 81	2		31.00
	ANCI LLARY SERVI CE COST CENTERS	+ +			-		
50.00	05000 OPERATI NG ROOM	2, 343, 843	21, 738, 752			0. 000000	
51.00	05100 RECOVERY ROOM	286, 404	3, 102, 184			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	609, 334	12, 363, 752				
56.00	05600 RADI OI SOTOPE	222, 802	2, 186, 704	2, 409, 50			
57.00	05700 CT SCAN	552, 797	6, 615, 776	7, 168, 57	3 0. 100509	0.00000	
58.00	05800 MRI	184, 252	2, 418, 227	2, 602, 47	9 0. 170678	0.00000	58.00
60.00	06000 LABORATORY	2, 815, 029	16, 566, 967	19, 381, 99		0.00000	
65.00	06500 RESPI RATORY THERAPY	1, 083, 207	2, 974, 033	4, 057, 24	0 0. 287316	0.00000	65.00
66.00	06600 PHYSI CAL THERAPY	295, 293	2, 641, 406				
67.00	06700 OCCUPATI ONAL THERAPY	151, 936	883, 686				
68.00	06800 SPEECH PATHOLOGY	40, 850	327, 221				
69.00	06900 ELECTROCARDI OLOGY	769, 218	9, 840, 591	10, 609, 80	9 0. 122882	0.00000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	473, 450	1, 621, 026	2, 094, 47	6 0. 212119		
	07200 I MPL. DEV. CHARGED TO PATIENTS	124, 035	1, 657, 646	1, 781, 68	1 0. 242325	0.00000	
	07300 DRUGS CHARGED TO PATIENTS	5, 107, 499	45, 575, 965	50, 683, 46		0.00000	
76.97	07697 CARDI AC REHABI LI TATI ON	539	1, 156, 107	1, 156, 64	6 0. 165501	0.00000	76.97
	OUTPATIENT SERVICE COST CENTERS			1			
	09000 CLI NI C	56	10, 682, 890				
90.01	09001 CLINIC - DIABETES	0	75, 648			0. 000000	
	09100 EMERGENCY	1, 092, 434	30, 980, 120				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	63, 102	11, 161, 030			0. 000000	
200.00		27, 446, 531	184, 569, 731	212, 016, 26	2		200.00
201.00							201.00
202.00	Total (see instructions)	27, 446, 531	184, 569, 731	212, 016, 26	2		202.00

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIE			DATIO		COCTC	ΤO	0

Health Financial Systems INC	I ANA UNI VERSI TY	HEALTH BEDFORD	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/28/2019 12:	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	r				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56. 00 05600 RADI 0I SOTOPE	0. 000000				56.00
57.00 05700 CT SCAN	0. 000000				57.00
58. 00 05800 MRI	0. 000000				58.00
60. 00 06000 LABORATORY	0.000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0.000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 CLINIC - DIABETES	0. 000000				90.01
91. 00 09100 EMERGENCY	0, 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 000000				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	1				

Health Financial Systems	DI ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018		pared: 16 pm	
			XVIII	Hospi tal	Cost		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs		
	Related Cost			Program	(column 3 x		
	(from Wkst. B,	Part I, col.		. Charges	column 4)		
	Part II, col.	8)	2)				
	26)						
	1.00	2.00	3.00	4.00	5.00		
ANCI LLARY SERVI CE COST CENTERS				1			
50. 00 05000 OPERATI NG ROOM	212, 608	24, 082, 595					
51.00 05100 RECOVERY ROOM	7,800	3, 388, 588				51.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	87, 612	12, 973, 086				54.00	
56. 00 05600 RADI OI SOTOPE	1, 712	2, 409, 506	0. 00071	1 111, 144	79	56.00	
57.00 05700 CT SCAN	22, 505	7, 168, 573					
58. 00 05800 MRI	19, 262	2, 602, 479	0.00740	1 90, 386			
60. 00 06000 LABORATORY	121, 754	19, 381, 996	0. 00628	2 1, 380, 840	8, 674	60.00	
65. 00 06500 RESPI RATORY THERAPY	33, 222	4,057,240	0.00818	8 650, 644	5, 327	65.00	
66. 00 06600 PHYSI CAL THERAPY	53, 197	2, 936, 699	0. 01811	5 196, 181	3, 554	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	18, 930	1, 035, 622	0. 01827	9 98, 335	1, 797	67.00	
68.00 06800 SPEECH PATHOLOGY	6, 284	368, 071	0. 01707	3 31, 231	533	68.00	
69. 00 06900 ELECTROCARDI OLOGY	65, 720	10, 609, 809	0.00619	4 447, 863	2, 774	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 799	2,094,476	0.00515	6 236, 017	1, 217	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 495	1, 781, 681	0. 00589	1 28, 500	168	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	109, 209	50, 683, 464	0.00215	5 2, 544, 618	5, 484	73.00	
76. 97 07697 CARDIAC REHABILITATION	29, 525	1, 156, 646	0. 02552	6 153	4	76.97	
OUTPATIENT SERVICE COST CENTERS	OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	115, 003	10, 682, 946	0. 01076	5 0	0	90.00	
90. 01 09001 CLINIC - DIABETES	9, 242	75, 648	0. 12217	1 0	0	90.01	
91.00 09100 EMERGENCY	138, 682	32, 072, 554	0. 00432	4 62, 297	269	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	91, 090	11, 224, 132	0. 00811	6 3, 570	29	92.00	
200.00 Total (lines 50 through 199)	1, 164, 651	200, 785, 811		7, 402, 493	41, 687	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1328 Period: From 01/01/2018 To 12/31/2018 Worksheet D Part IV THROUGH COSTS Title XVIII Hospital Cost Cost Center Description Non Physician Anesthetist Cost Nursing School Adjustments Nursing School Adjustments Allied Health Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments	Health Financial Systems	INDIANA UNIVERSITY	HEALTH BEDFOR	RD	In Lie	eu of Form CMS-:	2552-10
To 12/31/2018 Date/Time Prepared: 5/28/2019 Cost Center Description Non Physician Anesthetist Nursing School Post-Stepdown Cost Nursing School Adjustments Allied Health Post-Stepdown Adjustments Allied Health Alson 1.00 2A 2.00 3A 3.00		SERVICE OTHER PASS	Provider C				
Title XVIII Hospital 5/28/2019 12:16 pm Cost Center Description Non Physician Nursing School Allied Health Allied Health Non Physician Norsing School Nursing School Allied Health Allied Health Cost Adjustments Adjustments Adjustments 1.00 2A 2.00 3A 3.00	THROUGH COSTS						norod.
Title XVIII Hospital Cost Cost Center Description Non Physician Nursing School Nursing School Allied Health Anesthetist Post-Stepdown Adjustments Adjustments Adjustments 1.00 2A 2.00 3A 3.00					10 12/31/2018		
Cost Center DescriptionNon Physician Anesthetist CostNursing School Post-Stepdown AdjustmentsAllied Health Post-Stepdown Adjustments1.002A2.003A3.00			Title	2 XVIII	Hospi tal		
Anesthetist CostPost-Stepdown AdjustmentsPost-Stepdown Adjustments1.002A2.003A3.00	Cost Center Description	Non Physician N				Allied Health	
1.00 2A 2.00 3A 3.00							
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVICE COST CENTERS						
		0	0		0 0	0	
51.00 05100 RECOVERY ROOM 0 0 51.00	51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
		0	0		0 0	0	
		0	0		0 0	0	56.00
		0	0		0 0	0	
		0	0		0 0	0	00.00
		0	0		0 0	0	
		0	0		0 0	0	65.00
		0	0		0 0	0	66.00
		0	0		0 0	0	07.00
		0	0		0 0	0	
		0	0		0 0	0	
		0	0		0 0	0	
		0	0		0 0	0	
		0	0		0 0	0	
		0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				-	1		
		0	C		0 0	0	
		0	C		0 0	0	
		0	C		0 0	-	
		0			0	-	
200.00 Total (lines 50 through 199) 0 0 0 0 0 0 0200.00	200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00

Health Financial Systems IND	ANA UNIVERSITY	HEALTH BEDFOR	RD	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS		F	Period: From 01/01/2018 Fo 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	11		1	1	I	-
50. 00 05000 OPERATI NG ROOM	0	0	(24, 082, 595		
51.00 05100 RECOVERY ROOM	0	0	(3, 388, 588		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(12, 973, 086		•
56. 00 05600 RADI OI SOTOPE	0	0	(2, 409, 506		
57.00 05700 CT SCAN	0	0	(7, 168, 573		
58. 00 05800 MRI	0	0	(2, 602, 479		
60. 00 06000 LABORATORY	0	0	(19, 381, 996		•
65. 00 06500 RESPI RATORY THERAPY	0	0	(4, 057, 240		•
66. 00 06600 PHYSI CAL THERAPY	0	0	(2, 936, 699		
67.00 06700 OCCUPATI ONAL THERAPY	0	0	(1, 035, 622		
68.00 06800 SPEECH PATHOLOGY	0	0	(368, 071	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(10, 609, 809	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(2, 094, 476	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(1, 781, 681	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(50, 683, 464	0.000000	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	(1, 156, 646	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	(10, 682, 946	0.000000	90.00
90. 01 09001 CLINIC - DIABETES	0	0	(75, 648	0.000000	90.01
91.00 09100 EMERGENCY	0	0	(32, 072, 554	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(11, 224, 132	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	(200, 785, 811		200. 00

Health Financial Systems IND	DI ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Pre 5/28/2019 12:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	940, 307		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	113, 186		0 0	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	298, 989		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	111, 144		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	168, 232		0 0	0	57.00
58. 00 05800 MRI	0. 000000	90, 386		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	1, 380, 840		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	650, 644		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	196, 181		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	98, 335		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	31, 231		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	447, 863		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	236, 017		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	28, 500		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 544, 618		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	153		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · ·					
90. 00 09000 CLI NI C	0.000000	0		0 0	0	90.00
90. 01 09001 CLINIC - DIABETES	0. 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0.000000	62, 297		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3, 570		0 0	0	92.00
200.00 Total (lines 50 through 199)		7, 402, 493		0 0	0	200. 00
• • •	•					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1328 Period: Worksheet D From 01/01/2018 Part V	
To 12/31/2018 Date/Time Prepa	red:
5/28/2019 12:10	pm
Title XVIII Hospital Cost	
Charges Costs	
Cost Center Description Cost to Charge PPS Reimbursed Cost Cost PPS Services	
Ratio From Services (see Reimbursed Reimbursed (see inst.)	
Worksheet C, inst.) Services Services Not	
Part I, col. 9 Subject To Subject To	
Ded. & Coins. Ded. & Coins.	
(see inst.) (see inst.) 1.00 2.00 3.00 4.00 5.00	
ANCI LLARY SERVICE COST CENTERS	
	50.00
	50.00
	51.00
	54.00 56.00
	58.00 57.00
	57.00
	60.00 65.00
	55.00 56.00
	56.00 67.00
	57.00 68.00
	58.00 59.00
	59.00 71.00
	72.00 73.00
	73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 0. 165501 0 534, 873 0 0 0 OUTPATI ENT SERVI CE COST CENTERS 0	/0.9/
	90.00
	90.00 90.01
	90.01 91.00
	91.00 92.00
	92.00 00.00
	DU. 00 D1. 00
Only Charges	51.00
	02.00

Health Financial Systems INE	DIANA UNIVERSIT	/ HEALTH BEDFOR	RD	In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1328	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pro 5/28/2019 12	epared: :16 pm
		Title	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces Subj ect To	Services Not Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	692, 484	0				50.00
51.00 05100 RECOVERY ROOM	154, 880	0				51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	572, 561	0				54.00
56. 00 05600 RADI 0I SOTOPE	88, 575	0				56.00
57.00 05700 CT SCAN	267, 135	0				57.00
58. 00 05800 MRI	144, 992	0				58.00
60. 00 06000 LABORATORY	1, 810, 193	0				60.00
65. 00 06500 RESPI RATORY THERAPY	330, 044	0				65.00
66. 00 06600 PHYSI CAL THERAPY	384, 239	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	147, 526	0				67.00
68.00 06800 SPEECH PATHOLOGY	13, 242	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	388, 918	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	82, 980	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	87,632	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 573, 785		1			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	88, 522	0				76.97
OUTPATIENT SERVICE COST CENTERS	1	-	1			4
90. 00 09000 CLINIC	924, 889					90.00
90. 01 09001 CLINIC - DIABETES	37, 724	0	•			90.01
91. 00 09100 EMERGENCY	1, 615, 534	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 120, 683					92.00
200.00 Subtotal (see instructions)	14, 526, 538	2, 749				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	14, 526, 538	2, 749				202.00

Health Financial Systems	ANA UNIVERSITY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2018	Worksheet D Part V	
		Component (To 12/31/2018	Date/Time Pre	
					5/28/2019 12:	16 pm
		litle		<u>Swing Beds - SNF</u>		
Cast Castan Decariation	Cost to Charge	DDC Deimburged	Charges Cost	Cost	Costs PPS Services	
Cost Center Description		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(See Thist.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			•			
50.00 05000 OPERATI NG ROOM	0. 111651	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 183411	0		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 173132	0		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 089685	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 100509	0		0 0	0	57.00
58. 00 05800 MRI	0. 170678	0		0 0	0	
60. 00 06000 LABORATORY	0. 323510	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 287316	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 416292	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 522339	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0. 342423	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 122882	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 212119	0		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 242325	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 273055	0		0 0	0	10100
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 165501	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	0.400005		1	0		
90. 00 09000 CLINIC	0. 193895	0		0 0	-	
90. 01 09001 CLINIC - DIABETES	2.751137	0		0 0	0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 164025 0. 196907	0		0 0	0	
200.00 Subtotal (see instructions)	0. 196907	0			, s	200.00
201.00 Less PBP Clinic Lab. Services-Program		0			0	200.00
Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00
····· ····· ····· ···· ···· ···· ···· ····	· ·	0	1			

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CON: 15-1328 Period: Tom 01/01/2018 Period: Deriver Statistics Period: Tom 01/01/2018 Worksheet D Period: Deriver Statistics Cost Center Description Cost Reinbursed Services Subject To Ded. & Coins. Cost Cost Reinbursed Services Subject To Ded. & Coins. Swing Beds - SNF Cost ANCILLARY SERVICE COST CENTERS 0 0 0 Solog Rations Solog Rations ANCILLARY SERVICE COST CENTERS 0 0 0 Solog Rations Solog Rations Solog Rations ANCILLARY SERVICE COST CENTERS 0 0 0 Solog Rations Solog Rati	Health Financial Systems IND	DI ANA UNI VERSI TY	HEALTH BEDFORD)	In Lieu	u of Form CMS-2552-10
Cost Center Description Cost Cost S Cost Cost Reimbursed Services Subject To Ded. & Coins. Subject To Ded. & Coins. (see inst.) Cost Center Description Cost Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS Ded. & Coins. (see inst.) 50.00		VACCINE COST			From 01/01/2018	Part V
Cost Center Description Cost Reimbursed Services Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 0 50.00 05000 OPERATING ROOM 0 0 50.00 05000 RECOVERY ROOM 0 0 50.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 51.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 52.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 53.00 05500 RESPIRATORY 0 0 0 56.00 05500 CT SCAN 0 0 0 0 50.00 06500 RESPIRATORY THERAPY 0 0 0 0 66.00 06500 RESPIRATORY THERAPY 0 0 0 0 67.00 06000 LABGRATORY 0 0 0 0 0 68.00 066000 SECECH PATHOLOGY 0 0 0 0 0 70.00 0700 MPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>5/28/2019 12:16 pm</td>						5/28/2019 12:16 pm
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OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 90.01 90.01 09000 CLINIC 90.00 90.01 90.01 09000 CLINIC 90.00 90.01 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 200.00 Subtotal (see instructions) 0 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	o			73.00
90.00 09000 CLINIC 0 0 90.00 90.01 09001 CLINIC DIABETES 0 0 90.01 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 200.00 Subtotal (see instructions) 0 0 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0	o			76.97
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200.00 201.00Subtotal (see instructions)00200.00201.00Less PBP Clinic Lab. Services-Program00201.000nl y Charges0000		0	0			91.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 0		0	0			
Only Charges		0	0			
		0				201.00
202.00 Net Charges (line 200 - line 201) 0 0 202.00						
	202.00 Net Charges (line 200 - line 201)	0	0			202.00

Health Financial Systems INC	IANA UNIVERSITY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1328	Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018	Part V Date/Time Pre	nared
				10 12/01/2010	5/28/2019 12:	
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 111651	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 183411	0		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 173132	0		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 089685	0		0 0	0	56.00
57. 00 05700 CT SCAN	0. 100509	0		0 0	0	57.00
58. 00 05800 MRI	0. 170678	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 323510	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 287316	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 416292	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 522339	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 342423	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 122882	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 212119	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 242325	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 273055	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 165501	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 193895	0		0 0	0	
90. 01 09001 CLINIC - DIABETES	2. 751137	0		0 0	0	
91. 00 09100 EMERGENCY	0. 164025	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 196907	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		0			0	202.00
202.00 Net Charges (line 200 - line 201)		0	I	0 0	0	202.00

Health Financial Systems IND	I ANA UNIVERSITY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-2552	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepare 5/28/2019 12:16 p	ed: pm
		Ti tl	e XIX	Hospi tal	Cost	
	Cost	S				
Cost Center Description	Subject To Ded. & Coins. [Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 56.00 05600 RADI OL SOTOPE 57.00 05700 CT SCAN 58.00 05600 MRI 60.00 06000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 IMPL. DEV.			•		51. 54. 56. 57. 58. 60. 65. 66. 67. 68. 69. 71. 72.	0.00 .00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				8.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			76.	o. 97
						00
90.00 09000 CLINIC 90.01 09001 CLINIC - DIABETES 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program 0nly Charges 0nly Charges	0 0 0 0	0 0 0 0 0			90. 91.	
202.00 Net Charges (line 200 - line 201)	0	0			202.	. 00

I NDI ANA	UNI VERSI TY	HEALTH	BEDFORD

neur tri	Financial Systems INDIANA UNIVERSITY	HEALTH BEDFORD	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Peri od:	Worksheet D-1	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared
			10 12/31/2010	5/28/2019 12:	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
	PART I – ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		4, 456	1.00
2.00	Inpatient days (including private room days, excluding swing			4, 420	2.00
3.00	Private room days (excluding swing-bed and observation bed d		rivate room days,	0	3.00
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation l			2, 906	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	18	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private re	oom days) after December	21 of the cost	0	6.00
5.00	reporting period (if calendar year, enter 0 on this line)	com days) arter becember	ST OF THE COST	0	0.00
7.00	Total swing-bed NF type inpatient days (including private ro	om days) through December	- 31 of the cost	18	7.00
	reporting period			-	
8.00	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	1, 656	9.00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	oply (including private r	soom davis)	18	10.00
10.00	through December 31 of the cost reporting period (see instru		udys)	10	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room davs) after	0	11.00
	December 31 of the cost reporting period (if calendar year, o			-	
12.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including privat	te room days)	0	12.00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.00
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Prog	year, enter 0 on this lir	ne) davc)	0	14.00
14.00	Total nursery days (title V or XIX only)	Tall (excluding swing-bed	uays)	0	14.00
16.00	Nursery days (title V or XIX only)			0	16.00
10.00	SWING BED ADJUSTMENT				10.00
17.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 d	of the cost		17.00
	reporting period	-			
18.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18.00
10.00	reporting period		S + h +	100 14	10.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	129. 14	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	129.14	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			6, 480, 815	21.00
22.00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost report	ting period (line	0	22.00
~~ ~~	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	2, 325	24.00
24.00	7 x line 19)	er si or the cost reporti	ng period (inne	2, 525	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
	x line 20)				
26.00	Total swing-bed cost (see instructions)			28, 601	
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 452, 214	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ad and abar muchting had ab		0	
	General inpatient routine service charges (excluding swing-b	ed and observation bed cr	harges)	0	28.00 29.00
	Privato room charges (excluding swing bod charges)			0	
29. 00	Private room charges (excluding swing-bed charges)				
29.00 30.00	Semi -private room charges (excluding swing-bed charges)	÷line 28)			
29.00 30.00 31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	31.00
29.00 30.00 31.00 32.00	Semi -private room charges (excluding swing-bed charges)	÷line 28)			31.00 32.00
29.00 30.00 31.00 32.00 33.00 34.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	inus line 33)(see instruc	ctions)	0. 000000 0. 00 0. 00 0. 00 0. 00	31.00 32.00 33.00 34.00
29.00 30.00 31.00 32.00 33.00 34.00 35.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li	inus line 33)(see instruc ine 31)	ctions)	0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00	31.00 32.00 33.00 34.00 35.00
29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	inus line 33)(see instruc ine 31)		0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0	31.00 32.00 33.00 34.00 35.00 36.00
29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	inus line 33)(see instruc ine 31)		0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00	31.00 32.00 33.00 34.00 35.00 36.00
29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	inus line 33)(see instruc ine 31)		0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0	31.00 32.00 33.00 34.00 35.00 36.00
29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 m Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	inus line 33)(see instruc ine 31) and private room cost di		0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0	31.00 32.00 33.00 34.00 35.00 36.00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	inus line 33)(see instruc ine 31) and private room cost di JUSTMENTS		0. 000000 0. 00 0. 00 0. 00 0 6, 452, 214	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see	inus line 33)(see instruc ine 31) and private room cost di JUSTMENTS e instructions)		0. 000000 0. 00 0. 00 0. 00 6, 452, 214 1, 459. 78	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	inus line 33)(see instruc ine 31) and private room cost di JUSTMENTS e instructions) e 38)		0. 000000 0. 00 0. 00 0. 00 0 6, 452, 214	32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00

	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2018		
					To 12/31/2018	5/28/2019 12:	
	Cost Center Description	Total		e XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
	Intensive Care Type Inpatient Hospital Units	II					
. 00	INTENSIVE CARE UNIT	2, 507, 748	900	2, 786. 3	460	1, 281, 739	
. 00 . 00	CORONARY CARE UNIT						44
. 00	SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description			•			
00	Program inpatient ancillary service cost (Wks	at D 2 col 2	line 200)			1.00 1,814,969	48
00	Total Program inpatient costs (sum of lines			ons)		5, 514, 104	
	PASS THROUGH COST ADJUSTMENTS			shey		6, 61 1, 161	
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50
. 00) Pass through costs applicable to Program inpa	ationt ancillar	v convione (fr	com Wkat D a	um of Dorte II	0	51
. 00	and IV)		y services (II	UNI WKSL. D, S	uni ul Parts II		1 51
. 00	Total Program excludable cost (sum of lines !					0	1
. 00	Total Program inpatient operating cost exclud		lated, non-phy	ysician anesth	etist, and	0	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	o2)					-
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	55
00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operation	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	endina 1996 u	updated and co	mpounded by the		
	market basket	oor tring porrou	ondring 1770, c		inpoundou by the		
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61
	amount (line 56), otherwise enter zero (see i		5 (ITTIES 54 X	00), 01 1% 01	the target		
. 00	Relief payment (see instructions)	· · · · · · · · · · · · · · · · · · ·				0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost reporti	na period (See	26, 276	64
	instructions) (title XVIII only)	to through bood		,	ng por ou (ooo	20,2,0	
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no costs (lino	64 plus lino 6	5) (+i +l o XV/L)	Lonly) For	26, 276	66
. 00	CAH (see instructions)	le costs (ITTIE	04 prus rine t	55)(title xiii	i oniy). Toi	20, 270	
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost re	porting period	0	67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs arter D	ecember 31 or	the cost repo	rting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient i	routine costs (line 67 + line	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU					1	
. 00	Skilled nursing facility/other nursing facili	2					70
. 00 . 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71
. 00	Medically necessary private room cost applica	,	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from V	Vorksheet B, P	art II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 75 - In						77
00	Inpatient routine service cost (line 74 minus	s line 77)					78
00	Aggregate charges to beneficiaries for excess			· · · · · · · · · · · · · · · · · · ·			79
00 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		UST IIMITATION	ı (iine /8 min	us ine 79)		80
00	Inpatient routine service cost per drem finm)				82
00	Reasonable inpatient routine service costs (s		· .				83
00	Program inpatient ancillary services (see in						84
00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		i Jugii 63)			1	86
. 00	Total observation bed days (see instructions)					1, 514	87
. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			1, 459. 78	
00	Observation bed cost (line 87 x line 88) (see					2, 210, 107	

Health Financial Systems INC	ANA UNIVERSITY	(HEALTH BEDFOR	D	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2018 Fo 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	267, 106	6, 480, 815	0.04121	5 2, 210, 107	91, 090	90.00
91.00 Nursing School cost	0	6, 480, 815	0.00000	2, 210, 107	0	91.00
92.00 Allied health cost	0	6, 480, 815	0.00000	2, 210, 107	0	92.00
93.00 All other Medical Education	0	6, 480, 815	0.00000	2, 210, 107	0	93.00

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eal th	Financial Systems INDIANA UNIVERSITY H	EALTH BEDFORD	In Lie	u of Form CMS-2	2552-
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Peri od:	Worksheet D-1	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared
			10 12/01/2010	5/28/2019 12:	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s oxcluding nowborn)		4, 456	1.
. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			4, 430	
	Private room days (excluding swing-bed and observation bed da		rivate room davs	4, 420	3.
	do not complete this line.		, varo i com aajo,		0.
. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		2, 906	4.
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	18	5.
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)	m davc) through December	21 of the cost	10	7
. 00	Total swing-bed NF type inpatient days (including private roo reporting period	in days) through becember	31 OF THE COST	18	7.
. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December '	R1 of the cost	0	8.
. 00	reporting period (if calendar year, enter 0 on this line)	in days) arter becomber t		0	0.
. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	53	9.
	newborn days)	0			
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.
	through December 31 of the cost reporting period (see instruc				
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.
2.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room dave)	0	12.
2.00	through December 31 of the cost reporting period	x only (merualing priva	le room uays)	0	12.
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	te room davs)	0	13.
	after December 31 of the cost reporting period (if calendar y	ear, enter O on this lin	ne)		
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16.
	SWING BED ADJUSTMENT		<u> </u>		1
7.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 d	of the cost		17.
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	os after December 21 of	the cost		18.
0.00	reporting period	es al tel becember 51 01			10.
9.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	129.14	19
	reporting period	3			
0. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	129.14	20.
	reporting period				
	Total general inpatient routine service cost (see instruction			6, 480, 815	
2.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	er 31 of the cost report	ting period (line	0	22
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na neriod (line 6	0	23.
5.00	x line 18)	Si di the cost reporti	ig period (The o	0	25.
4.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	2, 325	24.
	7 x line 19)			_,	
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)			28, 601	26.
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 452, 214	27
8.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and obconvetion had a	argos)	0	28
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	a and observation bed ci	lai yes)	0	20
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
1	Average private room per diem charge (line 29 ÷ line 3)	20)		0.00	1
1	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li			0.00	35
	Private room cost differential adjustment (line 3 x line 35)			0	36
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 452, 214	37
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	USTMENTS			-
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 450 70	1 20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 459. 78 77, 368	
	Medically necessary private room cost applicable to the Program			11, 368	
0.00					

					From 01/01/2018		
					To 12/31/2018		
			Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	npatient Days	sDiem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Units			-			
00	INTENSIVE CARE UNIT	2, 507, 748	900	0 2, 786. 3	39 17	47, 369	
00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
00	SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description			•	·		
						1.00	
00 00	Program inpatient ancillary service cost (Wk			onc)		79, 528	
00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 46)(S		uns)		204, 265	49
00	Pass through costs applicable to Program inp	atient routine s	ervices (fro	m Wkst. D, sur	n of Parts I and	0	50
. 00	Pass through costs applicable to Program inp	atient ancillary	services (f	rom Wkst. D, s	sum of Parts II	C	51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclu		ated, non-ph	vsician anestł	netist, and		
	medical education costs (line 49 minus line			, 	·		
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
	Program di scharges						
. 00 . 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and tar	aet amount (line 56 minus	line 53)		
. 00	Bonus payment (see instructions)	5	5			C	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996, u	updated and co	ompounded by the	0.00) 59
00	market basket Lesser of lines 53/54 or 55 from prior year	cost conort und	atad by the	markat backat		0.00	60
. 00 . 00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)			0		
. 00	Relief payment (see instructions)		+: `			0	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see instruc	trons)			C) 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost reporti	ng period (See	0	64
	instructions)(title XVIII only)	Ū			0 1 1		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the o	cost reportino	g period (See	C) 65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino 6	1 plus lipo	65) (+i +l o - V/L I	Lonly) For	0) 66
. 00	CAH (see instructions)				i oniy). Toi		
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eporting period	C	67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost repo	orting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + lin	e 68)			69
	PART III - SKILLED NURSING FACILITY, OTHER N						
. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service (cost (line 37)	1		70
. 00	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 1/ v li	ine 35)			72
. 00	Total Program general inpatient routine serv						74
. 00	Capital -related cost allocated to inpatient	•			Part II, column		75
	26, line 45)						
. 00	Per diem capital-related costs (line 75 ÷ li						76
00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77
00	Aggregate charges to beneficiaries for exces		ovider record	ds)			79
00	Total Program routine service costs for comp	• •		· ·	nus line 79)		80
00	Inpatient routine service cost per diem limi						81
00	Inpatient routine service cost limitation (I						82
00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in)				83
. 00	Utilization review - physician compensation		s)				84
. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				1	
	Total observation bed days (see instructions	.)				1, 514	1 87
. 00 . 00	Adjusted general inpatient routine cost per					1, 459. 78	

Health Financial Systems INE	ANA UNIVERSITY	Y HEALTH BEDFOR	D	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	267, 106	6, 480, 815	0. 04121	5 2, 210, 107	91, 090	90.00
91.00 Nursing School cost	0	6, 480, 815	0.00000	2, 210, 107	0	91.00
92.00 Allied health cost	0	6, 480, 815	0.00000	2, 210, 107	0	92.00
93.00 All other Medical Education	0	6, 480, 815	0.00000	2, 210, 107	0	93.00

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFOR	RD	In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Pre 5/28/2019 12:	pared:
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	2 072 220		20.00
30. 00 03000 ADULTS & PEDI ATRICS 31. 00 03100 I NTENSI VE CARE UNI T			2, 972, 228 2, 758, 629		30.00 31.00
ANCI LLARY SERVICE COST CENTERS			2, 756, 029		31.00
50. 00 05000 OPERATI NG ROOM		0. 11165	940, 307	104, 986	50.00
51. 00 05100 RECOVERY ROOM		0. 18341			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17313			
56. 00 05600 RADI OI SOTOPE		0. 08968	111, 144	9, 968	56.00
57.00 05700 CT SCAN		0. 10050	168, 232	16, 909	57.00
58. 00 05800 MRI		0. 17067			
60. 00 06000 LABORATORY		0. 32351			
65. 00 06500 RESPI RATORY THERAPY		0. 28731			
66. 00 06600 PHYSI CAL THERAPY		0. 41629		81, 669	1
67.00 06700 OCCUPATI ONAL THERAPY		0. 52233			
68.00 06800 SPEECH PATHOLOGY		0. 34242		10, 694	
69. 00 06900 ELECTROCARDI OLOGY	_	0. 12288		55, 034	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 21211		50, 064 6, 906	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 24232 0. 27305			
73. 00 07300 DRUGS CHARGED TO PATTENTS 76. 97 07697 CARDIAC REHABILITATION		0. 27305			
OUTPATIENT SERVICE COST CENTERS		0. 10550	100	25	/0.9/
90. 00 09000 CLINIC		0. 19389	05	0	90.00
90. 01 09001 CLINIC - DIABETES		2. 75113		0	90.01
91. 00 09100 EMERGENCY		0. 16402		10, 218	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-	0. 19690			
200.00 Total (sum of lines 50 through 94 a			7, 402, 493		200.00
201.00 Less PBP Clinic Laboratory Services	s-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 20			7, 402, 493		202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2018	Worksheet D-3	
	Component	CCN: 15-Z328	To 12/31/2018	Date/Time Pre 5/28/2019 12:	pared 16 pm
	Title	XVIII :	Swing Beds - SNF		
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			0		30.0
1.00 03100 INTENSIVE CARE UNIT			0		31.0
ANCI LLARY SERVI CE COST CENTERS		1			
0.00 05000 OPERATING ROOM		0. 11165	-	0	
1.00 05100 RECOVERY ROOM		0. 18341	-	0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17313	-	0	
6. 00 05600 RADI OI SOTOPE		0. 08968		0	1 00.
7.00 05700 CT SCAN		0. 10050		0	1 07.1
8. 00 05800 MRI		0. 17067		0	00.
0. 00 06000 LABORATORY		0. 32351		1, 976	
5. 00 06500 RESPI RATORY THERAPY		0. 28731		0	
6.00 06600 PHYSI CAL THERAPY		0. 41629		2, 224	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 52233		1, 436	
8. 00 06800 SPEECH PATHOLOGY		0. 34242		0	
9.00 06900 ELECTROCARDI OLOGY		0. 12288		0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21211		0	1
2.00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 24232		0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 27305		3, 225	
6. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 16550	1 0	0	76. (
0.00 09000 CLINIC		0. 19389	5 0	0	90.
0. 01 09001 CLINIC - DIABETES		2. 75113		0	
1. 00 09100 EMERGENCY		0. 16402		0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 10402	-	0	
00.00 Total (sum of lines 50 through 94 and 96 through 98)		0.19090	26, 012	8, 861	
01.00 Less PBP Clinic Laboratory Services-Program only cha	raes (line 61)		20, 012		200. 0
02.00 Net charges (line 200 minus line 201)	iges (inte of)		26, 012		201.0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CON: 15-1328 Period: To 12/31/2018 Period: To 00/01/2012 Worksheet D-3 (build of Cost program Carbon 01/01/2018) Cost Center Description Title XIX Hospital Cost Cost Inpatient Program Carbon Charges Inpatient Program Carbon Cost Inpatient Program Carbon Cos	Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFOR	RD	In Lie	u of Form CMS-:	2552-10
Cost Center Description Title XIX Hospital Cost Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Program Charges Program Charges Cost 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03100 (INTENSIVE CARE UNIT 91.923 30.00 ANCILLARY SERVICE COST CENTERS 91.923 31.00 50.00 05000 (PEATI NG ROOM 0.111651 0 51.00 51.00 05100 (RECOVERY ROOM 0.183411 0 51.00 54.00 05600 (RADI 0107Y-DI AGNOSTI C 0.113132 12.707 2.200 54.00 56.00 05700 CT SCAN 0.100509 30.135 3.029 57.00 66.00 06600 LABORATORY 0.287316 23.944 1.922 66.00 60.00 06600 PHYSI CAL THERAPY 0.323510 53.342 17.257 60.00 61.00 06500 PHYSI CAL THERAPY 0.287316 22.968 9.478 65.00 62.00 06600 PHYSI CAL THERAPY 0.242423<	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		From 01/01/2018	Date/Time Pre	pared:
Cost Center Description Ratio of Cost To Charges Inpatient Program (Charges) Inpatient Program (Charges) Inpatient Program (Charges) 1.00 2.00 3.00 0.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSI VE CABE UNIT 91, 923 ANCILLARY SERVICE COST CENTERS 91, 923 0.00 05000 (PERATING ROOM 0.111651 0.00 05000 (PERATING ROOM 0.111651 0.00 05000 (PERATING ROOM 0.113132 0.100 (STOOR VED AGNOSTI C 0.173132 0.000 05800 (MRI 0.100509 30, 135 0.00 05800 (MRI 0.170678 0 0.00 06600 0 05000 (DEPERTINGTW THERAPY 0.282310 53, 342 0.00 06600 0 00 000 CUPATIONAL THERAPY 0.282310 53, 342 0.00 06600 0 PERATINGTW THERAPY 0.282339 2, 599 0.00 06600 0 SPECH PATHORY THERAPY 0.282339 2, 599 0.00 06600 0 SPECH PATHOLOGY 0.342423 638 218 0.00 0000 0000 OUPATIONAL THERAPY 0.223355 0 72.00 0.00 000000000000000000		Titl	e XIX	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS (col. 1 x col. 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 91,923 30.00 31.00 03100 INTENSIVE CARE UNIT 95,675 31.00 ANCILLARY SERVICE COST CENTERS 95,675 31.00 50.00 05000 OPERATING ROOM 0.111651 0 0 50.00 51.00 05000 OPERATING ROOM 0.133411 0 0 51.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 53.342 17.257 60.00 66.00 66.00 66.00<	Cost Center Description		Ratio of Cos		Inpatient	
Impart ENT ROUTI NE SERVICE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDLATRI CS 91, 923 30.00 31.00 03100 INTENS VE CARE UNIT 95, 675 31.00 50.00 05000 OPERATI NG ROOM 0.111651 0 0 50.00 51.00 05100 RECOVERY ROOM 0.183411 0 0 51.00 51.00 05100 RECOVERY ROOM 0.173132 12, 707 2, 200 54.00 50.00 05700 CT SCAN 0.100509 30, 135 3, 029 57.00 50.00 05700 CT SCAN 0.100509 30, 135 3, 029 57.00 50.00 05800 MRI 0.170678 0 0 58.00 60.00 06000 LABORATORY 0.8323510 53.342 17, 257 60.00 61.00 06000 CLESTROCARDI ULGY 0.323510 53.344 1, 392 66.00 65.00 06500 RESPI RATORY THERAPY 0.282310 53.342 17, 257 60.00 66.00 06600 PHYSI CAL THERAPY 0			To Charges	Program	Program Costs	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 91,923 30.00 31.00 03100 INTENSIVE CARE UNIT 95,675 31.00 ANCILLARY SERVICE COST CENTERS 95,675 31.00 50.00 05000 PERATING ROOM 0.111651 0 0 50.00 51.00 05100 RECOVERY ROOM 0.133411 0 051.00 51.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.1335 3,229 57.00 56.00 56.00 05000 RESPIRATORY 0.100509 30.135 3,229 57.00 58.00 05800 MRI 0.170678 0 58.00 56.00 60.00 06000 PHYSICAL THERAPY 0.323510 53.342 17.257 60.00 61.00 06500 OPHYSICAL THERAPY 0.342423 638 218 68.00 69.00 06000 PHYSICAL THERAPY 0.322310 53.342 17.257 60.00 69.00 06200 PHYSICAL THERAPY 0.24232 638 218 68.00 69.00				Charges	(col. 1 x col.	
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50.00 05000 OPERATING ROOM 0.111651 0 0 50.00 51.00 05100 RECOVERY ROOM 0.183411 0 0 51.00 54.00 05400 RADIOLOGY-DIAGNOSTI C 0.173132 12.707 2.200 54.00 56.00 05600 RADIOLOGY-DIAGNOSTI C 0.170578 0 0.889685 3,422 307 56.00 57.00 05700 CT SCAN 0.100509 30.135 3.029 57.00 58.00 0 58.00 0.170678 0 0 58.00 0 58.00 0.6600 PHYSI CAL THERAPY 0.287316 32.988 9.478 65.00 0 66.00 0.6600 PHYSI CAL THERAPY 0.416292 3,344 1,392 66.00 66.00 0.6600 PHYSI CAL THERAPY 0.22339 2,599 1,358 67.00 68.00 0.66000 SPEECH PATHOLOGY 0.3242423 638 218 68.00 69.00 0.6900 ELECTROCARDI OLOGY 0.342423 638 218 68.00 69.00 0.212119 3.237 687 71.00 0.212119 3.237 687 71.00 0				95, 675		31.00
51.00 05100 RECOVERY ROOM 0.183411 0 0 51.00 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.173132 12,707 2,200 54.00 56.00 RADI 0LOGY-DI AGNOSTI C 0.089685 3,422 307 56.00 57.00 05700 CT SCAN 0.100509 30,135 3.029 57.00 58.00 05800 MRI 0.170678 0 58.00 60.00 06000 LABORATORY 0.323510 53,342 17,257 60.00 65.00 06500 RESPI RATORY THERAPY 0.287316 32,988 9,478 65.00 66.00 06600 PHYSI CAL THERAPY 0.416292 3,344 1,392 66.00 67.00 06700 CCUPATI ONAL THERAPY 0.522339 2,599 1,358 67.00 68.00 SPEECH PATHOLOGY 0.342423 638 218 68.00 69.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.212282 6,262 769 99.00 71.00 07300 DRUGS CHARGED TO PATI ENTS 0.273055 110,531			r	-		
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56.00 05600 RADI 0I SOTOPE 0.089685 3,422 307 56.00 57.00 05700 CT SCAN 0.100509 30,135 3,029 57.00 58.00 05800 MRI 0.170678 0 0 58.00 60.00 06000 LABORATORY 0.323510 53.342 17,257 60.00 65.00 06500 RESPI RATORY THERAPY 0.287316 32,988 9,478 65.00 66.00 06600 PHYSI CAL THERAPY 0.342423 638 218 68.00 67.00 06700 0CCUPATI ONAL THERAPY 0.324243 638 218 68.00 68.00 06800 SPEECH PATHOLOGY 0.122882 6,262 769 69.00 71.00 MDI OL CAL SUPPLI ES CHARGED TO PATI ENT 0.212119 3,237 687 71.00 72.00 IMPL DEV. CHARGED TO PATI ENTS 0.242325 0 0 72.00 73.00 D7000 CENT CE COST CENTERS 0.165501 0						
57.00 05700 CT SCAN 0.100509 30,135 3,029 57.00 58.00 05800 MRI 0.170678 0 0 58.00 60.00 06000 LABORATORY 0.323510 53,342 17,257 60.00 65.00 06500 RESPI RATORY THERAPY 0.287316 32,988 9,478 65.00 66.00 06600 PHYSI CAL THERAPY 0.416292 3,344 1,392 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.522339 2,599 1,358 67.00 68.00 06800 SPEECH PATHOLOGY 0.342423 638 218 68.00 69.00 ELECTROCARDI OLOGY 0.122882 6,262 769 97.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.212119 3,2371 687 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.273055 110,531 30,181 73.00 76.97 O7697 CARDI AC REHABI LI TATI ON 0.16500 0 90.00 90.01 90.01 90.01 9						
58.00 05800 MRI 0.170678 0 58.00 60.00 06000 LABORATORY 0.323510 53.342 17.257 60.00 65.00 06500 RESPI RATORY THERAPY 0.287316 32.988 9,478 65.00 66.00 06600 PHYSI CAL THERAPY 0.416292 3,344 1,392 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.522339 2,599 1,358 67.00 68.00 06800 SPEECH PATHOLOGY 0.342423 638 218 68.00 69.00 06900 ELECTROCARDI OLOGY 0.122882 6,262 769 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.242119 3,237 68.7 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.273055 110,531 30,181 73.00 76.97 ORTOT ENVICE COST CENTERS 0.193895 0 0 90.00 90.01 90.00 OPG00 CLI NI C DI ABETES 0.196907 3,570 703 92.00 92.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
60.00 06000 LABORATORY 0.323510 53,342 17,257 60.00 65.00 06500 RESPI RATORY THERAPY 0.287316 32,988 9,478 65.00 66.00 06600 PHYSI CAL THERAPY 0.416292 3,344 1,392 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.522339 2,599 1,388 67.00 68.00 06800 SPECH PATHOLOGY 0.342423 638 218 68.00 69.00 06900 ELECTROCARDI OLOGY 0.323510 0.3237 687 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.212182 6,262 769 69.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.242325 0 0 72.00 76.97 ORDI AC REHABI LI TATI ON 0.165501 0 0 76.97 0011 09001 CLI NI C DI ABETES 2.751137 0 0 90.01 90.00 09000 CLI NI C DI ABETES 2.751137 0 0 90.01 91.00					3, 029	
65.00 06500 RESPIRATORY THERAPY 0.287316 32,988 9,478 65.00 66.00 06600 PHYSI CAL THERAPY 0.416292 3,344 1,392 66.00 67.00 0C700 0CUPATI ONAL THERAPY 0.522339 2,599 1,358 67.00 68.00 06800 SPEECH PATHOLOGY 0.342423 638 218 68.00 69.00 06900 ELECTROCARDI OLOGY 0.122882 6,262 769 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.212119 3,237 687 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.242325 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.273055 110,531 30,181 73.00 76.97 ORDIA C REHABILITATION 0.165501 0 0 70.97 70.00 09000 CLINIC 0.193895 0 0 90.00 90.00 09000 CLINIC 0 1.949 91.00 90.01 91.00 09100			0. 17067	8 0	0	
66.00 06600 PHYSI CAL THERAPY 0.416292 3,344 1,392 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.522339 2,599 1,358 67.00 68.00 06800 SPEECH PATHOLOGY 0.342423 638 218 68.00 69.00 06900 ELECTROCARDI OLOGY 0.122882 6,262 769 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.212119 3,237 687 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.242325 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.165501 0 0 76.97 0.010 09000 CLINIC 0.165501 0 0 76.97 0.00 09000 CLINIC 0.16395 0 0 90.00 90.00 09000 CLINIC 0 90.01 90.01 90.01 90.01 90.01 90.01 90.01 09000 CLINIC DI ABETES 0 0 90.01 90.01 90.01			0. 32351	0 53, 342	17, 257	
67.00 06700 0CCUPATI ONAL THERAPY 0.522339 2,599 1,358 67.00 68.00 06800 SPEECH PATHOLOGY 0.342423 638 218 68.00 69.00 06900 ELECTROCARDI OLOGY 0.122882 6,262 769 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.212119 3,237 687 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.242325 0 0 72.00 73.00 07697 CARDI AC REHABILI TATI ON 0.165501 0 0 76.97 0010 DUTPATI ENT SERVICE COST CENTERS 0.193895 0 0 90.00 90.00 09000 CLI NI C DI ABETES 0.165001 0 0 90.01 09010 EMERGENCY 0.164025 72,850 11,949 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.196907 3,570 703 92.00 92.000 D92000 EMERGENCY 0.196907 3,570 79,528 200.00 201.00	65. 00 06500 RESPI RATORY THERAPY		0. 28731	6 32, 988	9, 478	65.00
68.00 06800 SPEECH PATHOLOGY 0.342423 638 218 68.00 69.00 06900 ELECTROCARDIOLOGY 0.122882 6,262 769 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.212119 3,237 687 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.242325 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.273055 110,531 30,181 73.00 76.97 0.01PATIENT SERVICE COST CENTERS 0.145501 0 0 76.97 0.000 CLINIC DIABETES 0.193895 0 0 90.00 90.00 09000 CLINIC DIABETES 2.751137 0 0 90.01 90.01 09010 EMERGENCY 0.164025 72,850 11,949 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.196907 3,570 703 92.00 92.000 D92000 EMERGENCY 0.196907 335,625 79,528 200.00 201.00 201.00	66. 00 06600 PHYSI CAL THERAPY		0. 41629	2 3, 344	1, 392	66.00
69.00 06900 ELECTROCARDI OLOGY 0.122882 6,262 769 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.212119 3,237 687 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.242325 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.273055 110,531 30,181 73.00 76.97 07697 CARDI AC REHABILITATION 0.165501 0 0 76.97 00100 FUNTATIENT SERVICE COST CENTERS 0.193895 0 0 90.00 90.00 09000 CLINIC - DI ABETES 2.751137 0 0 90.00 90.01 09100 EMERGENCY 0.164025 72,850 11,949 91.00 92.00 092000 OBSERVATION BEDS (NON-DI STINCT PART 0.196907 3,570 703 92.00 200.00 Total (sum of Lines 50 through 94 and 96 through 98) 335,625 79,528 200.00 201.00	67.00 06700 OCCUPATI ONAL THERAPY		0. 52233	9 2, 599	1, 358	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.212119 3,237 687 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.242325 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.273055 110,531 30,181 73.00 76.97 07697 CARDI AC REHABILITATION 0.165501 0 0 76.97 00100 CLINIC DI ABETES 0.193895 0 0 90.00 90.00 09000 CLINIC - DI ABETES 0.164025 72,850 11,949 91.00 91.00 090200 OBSERVATION BEDS (NON-DI STINCT PART 0.196907 3,570 703 92.00 200.00 092000 DESERVATION BEDS (NON-DI STINCT PART 0.196907 3,570 703 92.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00	68.00 06800 SPEECH PATHOLOGY		0. 34242	3 638	218	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.242325 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.273055 110,531 30,181 73.00 76.97 07697 CARDIAC REHABILITATION 0.165501 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0.193895 0 0 90.00 90.00 90.00 09000 CLINIC - DIABETES 0.164025 72,850 11,949 90.00 90.00 09100 EMERGENCY 0.164025 72,850 11,949 90.00 92.00 092000 OBSERVATION BEDS (NON-DISTINCT PART 0.196907 3,570 703 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 335,625 79,528 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00	69. 00 06900 ELECTROCARDI OLOGY		0. 12288	2 6, 262	769	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.273055 110,531 30,181 73.00 76.97 07697 CARDI AC REHABILITATION 0.165501 0 0 76.97 0UTPATIENT SERVICE COST CENTERS 0.193895 0 0 90.00 90.01 90.00 09001 CLINIC DIABETES 0.193895 0 0 90.01 91.00 09100 EMERGENCY 0.164025 72,850 11,949 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.196907 3,570 703 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 0.196907 335,625 79,528 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21211	9 3, 237	687	71.00
76.97 O7697 CARDI AC REHABILITATION 0.165501 0 0 76.97 OUTPATI ENT SERVICE COST CENTERS 0 0.193895 0 0 90.00 90.00 90.00 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 <td< td=""><td>72.00 07200 IMPL. DEV. CHARGED TO PATIENTS</td><td></td><td>0. 24232</td><td>5 0</td><td>0</td><td>72.00</td></td<>	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24232	5 0	0	72.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.193895 0 0 90.00 90.01 09000 CLINIC DIABETES 2.751137 0 0 90.01 91.00 09100 EMERGENCY 0.164025 72,850 11,949 91.00 92.00 095ERVATI ON BEDS (NON-DI STINCT PART 0.196907 3,570 703 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 0 335,625 79,528 200.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27305	5 110, 531	30, 181	73.00
90. 00 09000 CLINIC 0.193895 0 0 90. 00 90. 01 09001 CLINIC - DIABETES 2.751137 0 0 90. 01 91. 00 09100 EMERGENCY 0.164025 72, 850 11, 949 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.196907 3, 570 703 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 335, 625 79, 528 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00	76. 97 07697 CARDI AC REHABI LI TATI ON		0. 16550	1 0	0	76.97
90. 01 09001 CLINIC - DIABETES 2.751137 0 90. 01 91. 00 09100 EMERGENCY 0.164025 72, 850 11, 949 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.196907 3, 570 703 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 335, 625 79, 528 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00	OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY 0.164025 72,850 11,949 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.196907 3,570 703 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 335,625 79,528 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	90. 00 09000 CLINIC		0. 19389	5 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.196907 3,570 703 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 335,625 79,528 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	90. 01 09001 CLINIC - DIABETES		2. 75113	7 0	0	90.01
200.00 Total (sum of lines 50 through 94 and 96 through 98) 335,625 79,528 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	91.00 09100 EMERGENCY		0. 16402	5 72, 850	11, 949	91.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 19690	7 3, 570	703	92.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	200.00 Total (sum of lines 50 through 94 a	nd 96 through 98)		335, 625	79, 528	200.00
202.00 Net charges (line 200 minus line 201) 335,625 202.00	201.00 Less PBP Clinic Laboratory Services	-Program only charges (line 61)				201.00
	202.00 Net charges (line 200 minus line 20	1)		335, 625		202.00

	i i ovi dei c		Period: From 01/01/2018	Worksheet D-3	
	Component	CCN: 15-Z328	To 12/31/2018		pared
	Titl	e XIX	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			4
0.00 03000 ADULTS & PEDIATRICS			0		30.
11.00 03100 I NTENSI VE CARE UNI T			0		31.
ANCI LLARY SERVI CE COST CENTERS		1			4
0. 00 05000 OPERATI NG ROOM		0. 11165		0	
1.00 05100 RECOVERY ROOM		0. 18341		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17313		0	
6. 00 05600 RADI 0I SOTOPE		0. 08968		0	00.
7. 00 05700 CT SCAN		0. 10050		0	
8. 00 05800 MRI		0. 17067		0	
0. 00 06000 LABORATORY		0. 32351		0	
5. 00 06500 RESPI RATORY THERAPY		0. 28731		0	00.
6. 00 06600 PHYSI CAL THERAPY		0. 41629		0	00.
7. 00 06700 OCCUPATI ONAL THERAPY		0. 52233		0	
8.00 06800 SPEECH PATHOLOGY		0. 34242		0	
9.00 06900 ELECTROCARDI OLOGY		0. 12288		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21211		0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24232		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 27305		0	
6. 97 07697 CARDI AC REHABI LI TATI ON		0. 16550	01 0	0	76.
OUTPATIENT SERVICE COST CENTERS		0.10000	-		
		0. 19389		0	
0. 01 09001 CLINIC - DIABETES		2.75113		0	
11.00 09100 EMERGENCY		0. 16402		0	1
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 19690	0	0	1
Total (sum of lines 50 through 94 and 96 through 98)	- (1) (1)		0	0	200.
01.00 Less PBP Clinic Laboratory Services-Program only charge	s (II ne 61)	1	0		201.

	Financial Systems INDIANA UNIVERSITY HE ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Peri od:	u of Form CMS-2 Worksheet E	2002-11
			From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Title XVIII	Hospi tal	5/28/2019 12: Cost	16 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	i onc)		14, 529, 287 0	1.00 2.00
3.00	OPPS payments	1013)		0	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruc	tions)		0 0. 000	
6.00	Line 2 times line 5			0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. I	V col 13 line 200		0	8.00 9.00
10.00	Organ acqui si ti ons	V, COL. 13, THIC 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			14, 529, 287	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for p	ayment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e Ratio of line 15 to line 16 (not to exceed 1.000000)	2)		0.000000	17 00
18.00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete onl	vifling 11 exceeds li	ng 18) (see	0	20.00
20.00	instructions)	y IT THE IT EXCEEDS IT	lie 10) (See	0	20.00
21.00	Lesser of cost or charges (see instructions)			14, 674, 580	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	ructions)		0	22.00 23.00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		0	24.00
05 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u>``</u>		00.470	05.00
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line		ructions)	88, 173 12, 433, 159	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			2, 153, 248	
20.00	instructions)	50)		0	
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	
30.00	Subtotal (sum of lines 27 through 29)			2, 153, 248	
31.00	Primary payer payments			319	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	(FS)		2, 152, 929	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	20)		0	33.00
34.00	Allowable bad debts (see instructions)			1, 554, 980	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		1, 010, 737 1, 128, 244	
37.00	Subtotal (see instructions)			3, 163, 666	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	:)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration	·)		0	
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	tions)	0	39.98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 3, 163, 666	39.99 40.00
40.00	Sequestration adjustment (see instructions)			63, 273	
40. 02	Demonstration payment adjustment amount after sequestration			0	
41.00	Interim payments Tentative settlement (for contractors use only)			3, 502, 429 0	
42.00 43.00	Balance due provider/program (see instructions)			-402, 036	
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	636, 642	
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money				92.00
92.00 93.00	Time Value of Money (see instructions)			0	93.00

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	•
		I npati en	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		4, 800, 43	1	3, 502, 429	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2.00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3.00
	payment. If none, write "NONE" or enter a zero. (1)					
0.01	Program to Provider	1				0.01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER			0	0	3. 01 3. 02
3.02				0	0	3.02
3.03				0	0	3.04
3.05				0	0	3. 05
	Provider to Program	, I				
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50 3.51
3.51 3.52				0	0	3.5
3.52				0	0	3. 52
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4, 800, 43	1	3, 502, 429	4.00
	TO BE COMPLETED BY CONTRACTOR	1 1		1		
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 PROVIDER			0	0	5.0
5.02				0	0	5.02
5.03				0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50				0	0	5.5
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.99
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		145, 09	6	0	6.0
6. 02	SETTLEMENT TO PROGRAM			0	402, 036	6. 02
7.00	Total Medicare program liability (see instructions)		4, 945, 52		3, 100, 393	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C	1	1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1328 CCN: 15-Z328	Period: From 01/01/201 To 12/31/201		
		Component	0011. 10 2020		5/28/2019 12:	
			XVIII	Swing Beds - SN		
		Inpatien	it Part A	Pa	nrt 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		37, 2		0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					0.00
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3. 02				0	0	3. 02
3.03				0	0	
3.04				0	0	
3. 05				0	0	3.05
	Provider to Program		1		1	1
3.50	ADJUSTMENTS TO PROGRAM			0	0	
3.51 3.52				0	0	
3.52				0	0	
3.54				0	0	
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		37, 2	20	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1			5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		•			1
5. 01	TENTATI VE TO PROVI DER			0	0	
5. 02				0	0	
5.03				0	0	5.03
	Provider to Program			0	0	
5.50 5.51	TENTATI VE TO PROGRAM			0	0	
5.52				0	0	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
	5. 50-5. 98)			Ŭ.		
5.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
5.01	SETTLEMENT TO PROVIDER		4	18	0	•
5.02	SETTLEMENT TO PROGRAM			0	0	
7.00	Total Medicare program liability (see instructions)		37,6		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(0	1.00	2.00	
8.00	Name of Contractor		-	1.00	2.00	8.00

Heal th	Financial Systems INDIANA UNIVERSITY H	EALTH BEDFORD	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1328	Period: From 01/01/2018	Worksheet E-1 Part II	
				Date/Time Pre 5/28/2019 12:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1 4 44
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 [ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of co line 168	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	, , ,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)		32.00
			- 1		

LCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1328	Period: From 01/01/2018	Worksheet E-2	
		Component CCN: 15-Z328	To 12/31/2018	Date/Time Prep 5/28/2019 12:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
00	Inpatient routine services - swing bed-SNF (see instructions)		26, 539	0	1 1.
00	Inpatient routine services - swing bed SM (see instructions)		20, 337	0	2.
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A. and sum of Wkst. D.	8, 950	0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4
	instructions)				_
00	Program days		18	0	
00 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional met		0	0	6
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	indu oni y	35, 489	0	
00	Primary payer payments (see instructions)		33, 407	0	
00	Subtotal (line 8 minus line 9)		35, 489	0	
00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	
	professional services)	1 5			
00	Subtotal (line 10 minus line 11)		35, 489	0	12
00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0	0	13
00	for physician professional services)				
00	80% of Part B costs (line 12 x 80%) Subtotal (enter the lesser of line 12 minus line 13, or line 1		35, 489	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	4)	30, 409	0	
50	Pioneer ACO demonstration payment adjustment (see instructions	.)	0	0	16
55	Rural community hospital demonstration project (§410A Demonstr		0		16
	adjustment (see instructions)				
99	Demonstration payment adjustment amount before sequestration		0	0	16
00	Allowable bad debts (see instructions)		4, 487	0	17
01	Adjusted reimbursable bad debts (see instructions)		2, 917	0	
00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	
00	Total (see instructions)		38, 406	0	
01 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration)		768	0	
02	Interim payments		37, 220	0	
00	Tentative settlement (for contractor use only)		0	0	
00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	418	0	
00	Protested amounts (nonallowable cost report items) in accordan	-	1, 544	0	
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				
0. 00	Is this the first year of the current 5-year demonstration per	iod under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from W	/kst D-1 Pt II line			201
1.00	66 (title XVIII hospital))				201
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF))				
3.00	Total (sum of lines 201 and 202)				203
. 00	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	ration	
00	period) Medicare swing-bed SNF target amount				205
	Medicare swing bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				1
. 00	Program reimbursement under the §410A Demonstration (see instr				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2		1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209
). 00	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 2				

LUUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	ovider CCN: 15-1328	Peri od:	Worksheet E-2	
	Cor	mponent CCN: 15-Z328	From 01/01/2018 To 12/31/2018		
		Title XIX	Swing Beds - SNF		<u></u> p.
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		0		1 1.
00	Inpatient routine services - swing bed-NF (see instructions)		0		2.
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,	and sum of Wkst. D,	0		3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru	ictions)			
00	Per diem cost for interns and residents not in approved teaching	program (see	0.00		4.
	instructions)				
00	Program days		0		5.
00	Interns and residents not in approved teaching program (see instr		0		6.
00	Utilization review - physician compensation - SNF optional method	onl y	0		7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8
00	Primary payer payments (see instructions)		0		9
. 00	Subtotal (line 8 minus line 9)		0		10
00	Deductibles billed to program patients (exclude amounts applicabl	e to physician	0		11
	professional services)				
. 00	Subtotal (line 10 minus line 11)		0		12
. 00	Coinsurance billed to program patients (from provider records) (e	exclude coinsurance	0		13
	for physician professional services)				
. 00	80% of Part B costs (line 12 x 80%)		0		14
. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0		15
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16
. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16
. 55	Rural community hospital demonstration project (§410A Demonstrati	on) payment			16
	adjustment (see instructions)				
. 99	Demonstration payment adjustment amount before sequestration		0		16
. 00	Allowable bad debts (see instructions)		0		17
. 01	Adjusted reimbursable bad debts (see instructions)		0		17
. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	ions)	0		18
00	Total (see instructions)		0		19
. 01	Sequestration adjustment (see instructions)		0		19
. 02	Demonstration payment adjustment amount after sequestration)		0		19
00	Interim payments		0		20
00	Tentative settlement (for contractor use only)		0		21
00	Balance due provider/program (line 19 minus lines 19.01, 20, and	-	0		22
00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0		23
	chapter 1, §115.2				1
	Rural Community Hospital Demonstration Project (§410A Demonstrati			1	4
J. 00	Is this the first year of the current 5-year demonstration period	under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.				-
1 00	Cost Reimbursement Madi apra avian bad SNE innationt routing apruida apata (from What				1201
1.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst	. D-I, Pt. II, IIne			201
2 00	66 (title XVIII hospital))	ct D 2 col 2 lin			202
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wk 200 (title XVIII swing-bed SNF))	St. D-3, COL 3, TH	le		202
2 00	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				203
1.00	Computation of Demonstration Target Amount Limitation (N/A in fir	st year of the curre	nt 5 year domons		1204
	period)	st year of the curre	int 5-year demons	liation	
5 00	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				200
	Program reimbursement under the §410A Demonstration (see instruct				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, c		1		207
	and 3)		·		200
9 00	Adjustment to Medicare swing-bed SNF PPS payments (see instructio	ins)			209
	Reserved for future use				210
2. 50	Comparision of PPS versus Cost Reimbursement		1		12.10
		plus line 210) (see			215

	Financial Systems INDIANA UNIVERSIT		In Lie	u of Form CMS-	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Peri od:	Worksheet E-3	
			From 01/01/2018 To 12/31/2018		narod
			10 12/31/2010	5/28/2019 12:	
		Title XVIII	Hospi tal	Cost	
			DELUBURAEUENT	1.00	
4 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COST	REIMBURSEMENT	5 544 404	1 1 00
1.00 2.00	Inpatient services	ati ana)		5, 514, 104	•
2.00	Nursing and Allied Health Managed Care payment (see instruct Organ acquisition	ctrons)		0	
4.00	Subtotal (sum of lines 1 through 3)			5, 514, 104	
5.00	Primary payer payments			0, 514, 104	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions))		5, 569, 245	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES)		0,007,210	0.00
	Reasonable charges				1
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for			0	•
12.00	Amounts that would have been realized from patients liable		n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13	3(e)			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
14.00	Total customary charges (see instructions)			0	
15.00	Excess of customary charges over reasonable cost (complete instructions)	only if line 14 exceeds 11	ne 6) (see	0	15.00
16.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	e 14) (see	0	16.00
10.00	instructions)	only if the b exceeds iff	(300	0	10.00
17.00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
18.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			5, 569, 245	19.00
20.00	Deductibles (exclude professional component)			560, 024	•
21.00	Excess reasonable cost (from line 16)			0	•
22.00	Subtotal (line 19 minus line 20 and 21)			5, 009, 221	
23.00	Coinsurance			5, 348	
24.00	Subtotal (line 22 minus line 23)			5, 003, 873	•
25.00	Allowable bad debts (exclude bad debts for professional ser	rvices) (see instructions)		65, 513	•
26.00	Adjusted reimbursable bad debts (see instructions)			42, 583	
27.00 28.00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (sum of lines 24 and 25, or line 26)	nstructions)		47,002	
28.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			5, 046, 456 0	•
29.00	Pioneer ACO demonstration payment adjustment (see instructi	i onc)		0	
29.30	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			5, 046, 456	
30.00	Sequestration adjustment (see instructions)			100, 929	
	Demonstration payment adjustment amount after sequestration	n		00, 100, 12	•
31.00	Interim payments			4, 800, 431	
32.00	Tentative settlement (for contractor use only)			0	
	Balance due provider/program (line 30 minus lines 30.01, 30	0.02, 31, and 32)		145, 096	
34.00	Protested amounts (nonallowable cost report items) in account		chapter 1,	242, 254	

34.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,
§115.2242,25434.00

ALAN	Financial Systems INDIANA UNIVERSITY E SHEET (If you are nonproprietary and do not maintain type accounting records, complete the General Fund column	Provi der C	CN: 15-1328	Period: From 01/01/2018	u of Form CMS- Worksheet G	
nly)	spe accounting records, comprete the general rund cordinin			To 12/31/2018	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	5/28/2019 12: Plant Fund	
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	38, 934, 774		0 0	0	1.
00	Temporary investments	0		0 0	0	
00	Notes receivable	0		0 0	0	
. 00	Accounts receivable	9, 356, 527		0 0	0	
00	Other receivable	-2, 315, 436		0 0	0	
00 00	Allowances for uncollectible notes and accounts receivable	1, 101, 380			0 0	
00	Inventory Prepaid expenses	221, 074			0	
00	Other current assets	72, 103			0	
). 00	Due from other funds	0		0 0	0	
. 00	Total current assets (sum of lines 1-10)	47, 370, 422		0 0	0	
	FI XED ASSETS			I		1
2.00	Land	931, 334	(0 C	0	12
3.00	Land improvements	1, 119, 735	(0 0	0	13
1.00	Accumulated depreciation	-1, 049, 586		0 0	0	14
5.00	Bui I di ngs	20, 143, 774		0 0	0	
6.00	Accumulated depreciation	-13, 039, 737		0 0	0	
7.00	Leasehold improvements	0		0 0	0	
8.00	Accumulated depreciation	0		0 0	0	
	Fixed equipment	0		0 0	0	
0.00	Accumulated depreciation	200.0(1			0	
1.00 2.00	Automobiles and trucks Accumulated depreciation	200, 961 -189, 321			0	
3.00	Major movable equipment	15, 049, 914			0	
4.00	Accumulated depreciation	-11, 681, 031			0	
5.00	Minor equipment depreciable	11,001,031			0	
5.00	Accumulated depreciation	Ö		0 0	0	
7.00	HIT designated Assets	0		0 0	0	
8.00	Accumulated depreciation	0	(o o	0	28
9.00	Mi nor equipment-nondepreciable	1, 532, 587	(0 0	0	29
0. 00	Total fixed assets (sum of lines 12-29)	13, 018, 630	(0 0	0	30
	OTHER ASSETS					
1. 00	Investments	0		0 0	0	
2.00	Deposits on Leases	0		0 0	0	
3.00	Due from owners/officers	0		0 0	0	
4.00	Other assets	3, 851, 842		0 0	0	
5.00	Total other assets (sum of lines 31-34)	3, 851, 842		0 0	0	
6. 00	Total assets (sum of lines 11, 30, and 35)	64, 240, 894	(0 0	0	36
7 00	CURRENT LI ABI LI TI ES	2, 141, 685		0 0	0	37
B. 00	Accounts payable Salaries, wages, and fees payable	530, 409			0	
7.00 7.00	Payroll taxes payable	922, 891			0	
0. 00	Notes and Loans payable (short term)	74, 336			0	
1.00	Deferred income	0		0 0	0	
2.00	Accel erated payments	0				42
3.00	Due to other funds	0	(o o	0	43
4.00	Other current liabilities	3, 930, 294	(o c	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	7, 599, 615	(0 0	0	45
	LONG TERM LIABILITIES	1				
6. 00	Mortgage payable	0		0 0	0	
7.00	Notes payable	0		0 0	0	
B. 00	Unsecured Loans	0		0	0	
9.00	Other long term liabilities	142, 101		0 0	0	
0. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	142, 101			0	
1.00	CAPITAL ACCOUNTS	7, 741, 716		<u> </u>	0	51
2.00	General fund balance	56, 499, 178				52
3.00	Specific purpose fund	55, 477, 176				53
4.00	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
6.00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant				0	
8.00	Plant fund balance - reserve for plant improvement,				0	
'	replacement, and expansion				-	
~ ~~	Total fund balances (sum of lines 52 thru 58)	56, 499, 178		o o	0	59
9.00						

STATEM	Financial Systems INC IENT OF CHANGES IN FUND BALANCES	I ANA UNI VERSI TY	Provi der CC		Per	ri od:	u of Form CMS- Worksheet G-1	
	LINE OF CHANGES THE FOND DALANCES				Fro To	om 01/01/2018 12/31/2018	Date/Time Pre 5/28/2019 12:	pared: 16 pm
		General	Fund	Speci al	Pur	oose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
1.00	Fund balances at beginning of period	1.00	50, 418, 408	3.00		4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11, 393, 937			0		2.00
3.00	Total (sum of line 1 and line 2)		61, 812, 345			0		3.00
4.00	RESTRICTED FUND BALANCE	77,000			0		0	4.00
5.00		0			0		0	5.00
6.00		0			0		0	6.00
7.00		0			0		0	7.00
8.00		0			0		0	
9.00		0			0		0	
10.00	Total additions (sum of line 4-9)		77, 000			0		10.00
11.00	Subtotal (line 3 plus line 10)		61, 889, 345			0		11.00
12.00	INTERCOMPANY CAPITAL TRANSFER	5, 390, 165			0		0	
13.00	ROUNDING	2			0		0	
14.00		0			0		0	
15.00		0			0 0		0	
16.00 17.00		0			0		0	
18.00	Total deductions (sum of lines 12-17)	0	5, 390, 167		U	0	0	18.00
19.00	Fund balance at end of period per balance		56, 499, 178			0		19.00
17.00	sheet (line 11 minus line 18)		00, 177, 170			0		
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8,00	_			
1.00	Fund balances at beginning of period	0			0			1.00
0 00								1 2 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	о			0			3.00
3.00 4.00		0	0		0			3. 00 4. 00
3.00 4.00 5.00	Total (sum of line 1 and line 2)	O	0		0			3. 00 4. 00 5. 00
3.00 4.00 5.00 6.00	Total (sum of line 1 and line 2)	O	0		0			3. 00 4. 00 5. 00 6. 00
3.00 4.00 5.00 6.00 7.00	Total (sum of line 1 and line 2)	0	0 0 0		0			3. 00 4. 00 5. 00 6. 00 7. 00
3.00 4.00 5.00 6.00 7.00 8.00	Total (sum of line 1 and line 2)	0	0 0 0 0		0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE		0 0 0					3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9)	0	0 0 0 0		0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0 0					3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9)		0 0 0 0 0		0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
7.00 8.00 9.00 10.00 11.00 12.00 13.00	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY CAPITAL TRANSFER				0			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
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY CAPITAL TRANSFER		0 0 0 0 0 0 0		0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 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	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY CAPITAL TRANSFER				0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
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	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY CAPITAL TRANSFER				0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 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	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY CAPITAL TRANSFER				0			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
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	Total (sum of line 1 and line 2) RESTRICTED FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY CAPITAL TRANSFER ROUNDING	000			0 0			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

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	ALTH BEDFOR Provider CC	CN: 15-1328	Period: From 01/01/2018 To 12/31/2018		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		5, 207, 4	06	5, 207, 406	
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF		29, 2	32	29, 232	
6.00	Swing bed - NF			0	0	
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)		5, 236, 6	38	5, 236, 638	10.00
	Intensive Care Type Inpatient Hospital Services			1	1	
11.00	INTENSIVE CARE UNIT		5, 993, 8	13	5, 993, 813	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)			10	5 000 010	15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	5, 993, 8	13	5, 993, 813	16.00
47 00	11-15)		44 000 4	F 4	44 000 454	17.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		11, 230, 4		11, 230, 451	
18.00	Ancillary services		16, 152, 9			
19.00	Outpatient services		63, 1			
20.00	RURAL HEALTH CLINIC			0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0	0 0	21.00
22.00 23.00						22.00
23.00	AMBULANCE SERVICES					23.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					24.00
26.00	HOSPICE					25.00
27.00	PHYSI CI AN REVENUE			0 1, 717, 91	7 1, 717, 917	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	27, 446, 5			
20.00	G-3, line 1)	to wkst.	27, 440, 3	51 100, 207, 04	213,734,177	20.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			55, 473, 17	4	29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)				b	36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)				b	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		55, 473, 17	4	43.00
	to Wkst. G-3, line 4)					

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10					
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1328 Period:		Worksheet G-3			
			From 01/01/2018 To 12/31/2018	Date/Time Pre	narod
10 12/31/2010			5/28/2019 12:16 pm		
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			213, 734, 179	1.00
2.00	Less contractual allowances and discounts on patients' accounts			148, 483, 461	2.00
3.00	Net patient revenues (line 1 minus line 2)			65, 250, 718	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			55, 473, 174	4.00
5.00	Net income from service to patients (line 3 minus line 4)			9, 777, 544	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00				0	8.00
9.00				0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00				0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00				0	16.00
17.00	······································			0	17.00
18.00				0	18.00
	00 Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	5			0	20.00
21.00				0	21.00
22.00				0	
23.00	Governmental appropriations			0	
	MI SCELLANEOUS I NCOME			1, 616, 393	
	Total other income (sum of lines 6-24)			1, 616, 393	
				11, 393, 937	26.00
27.00				0	27.00
28.00 Total other expenses (sum of line 27 and subscripts)			0	28.00	
29.00	Net income (or loss) for the period (line 26 minus line 28)		l	11, 393, 937	29.00