PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLACKFORD HOSPITAL (15-1302) 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.

JONATHAN VANATOR (Si gned)

Officer or Administrator of Provider(s)

number of times reopened = 0-9.

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						
Hospi tal	0	-15, 255	-133, 097	0	0	1. 00
Subprovi der - IPF	0	0	0		0	2. 00
Subprovi der - IRF	0	0	0		0	3. 00
Swing bed - SNF	0	152, 564	0		0	5. 00
Swing bed - NF	0				0	6. 00
Total	0	137, 309	-133, 097	0	0	200. 00
	PART III - SETTLEMENT SUMMARY Hospital Subprovider - IPF Subprovider - IRF Swing bed - SNF	1.00	Cost Center Description	1.00 2.00 3.00	Cost Center Description	Cost Center Description

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. required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1302 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/24/2019 10:10 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 410 PILGRIM STREET 1.00 PO Box: 1.00 City: HARTFORD CITY State: IN Zi p Code: 47348 2.00 County: BLACKFORD 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 IU HEALTH BLACKFORD 151302 99915 02/10/2000 N 0 0 3.00 HOSPI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovider - (Other) Swing Beds - SNF 6.00 6.00 BLACKFORD COMMUNITY 0 157302 99915 02/10/2000 0 7.00 N 7 00 SWING BED 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22. 01 Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to 22 03 N N N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

	reporting period? In column 2, enter "Y" for yes or	"N" for no.						
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	el i gi bl e	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	1
24. 00	If this provider is an IPPS hospital, enter the	0	0	0	0	0	0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							

Ν

3

23.00

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost

ISPL I	Financial Systems IU HEALTH CAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	H BLACKFORD TA I	Provi der CC	N: 15-1302	Peri od				Form CMS- sheet S-:	
						2/31/	2018	Date 5/24	/Time Pro/ /2019 10	epare : 10 a
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicai eligibl unpaic	d e H	edica	ays	Other Medi cai d days	
00	If this provider is an IRF, enter the in-state	1.00	2. 00	3.00	4. 00	0	5. 00	0	6. 00	25.
. 00	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	U	U	Heba		al ¢		of Geogr	
					UI ba	1. 00	ai s	Date	2. 00	+
00	Enter your standard geographic classification (not wa 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	rural. age) status r"2" for r cation in	at the end ural. If ap column 2.	of the cos	st		2	2		26 27 35
	effect in the cost reporting period.		<u> </u>					_		\perp
					Beç	gi nni r 1. 00	ng:	E	ndi ng: 2. 00	-
00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb	er	1. 00			2.00	36
00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of portor	lc MDU ctatu	10		C			37
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	ne MDH tran:	sitional pa	nyment in	is		C			37
	accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	or yes or "	N" for no.	(see						
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38
	errer subsequent dates.					Y/N			Y/N	
						1. 00			2. 00	0.0
00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR $\S412.101(b)(2)(i)$ 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum nts in	n	N			N	39
00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobno in column 2, for discharges on or after October 1.	oer 1. Ente	r "Y" for y			N			N	40
							1. 00	0 2.		+
	Prospective Payment System (PPS)-Capital						1. 0	0 2.	00 3.00	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	·	·			ice	N N	N		45
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	t. L, Pt. I	II and Wkst	:. L-1, Pt.	I throug	ıh				
00	Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment Teaching Hospitals						N N			48
00	Is this a hospital involved in training residents in or "N" for no.		. 0		,		N			56
υO	If line 56 is yes, is this the first cost reporting process of the programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N th of this of (", completo , if applic	" for no in cost report e Worksheet cable.	n column 1. ing period? : E-4. If co	If colum PEnter Dumn 2 i	n 1 "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,			iiis service	:5 d5					58
00	Are costs claimed on line 100 of Worksheet A? If yes						N	<u> </u>		59
	rice ded to drained dr. Trite red dr. Werneriedt in Tr. Jee			NAHE 413.8		kshee ₋i ne #			s-Through i fi cati or	
				Y/N					erion Cod	
				1. 00		2. 00				

IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Worksheet S-2 Provi der CCN: 15-1302 Peri od: From 01/01/2018 To 12/31/2018 Part I Date/Time Prepared: 5/24/2019 10:10 am Y/N IME Direct GME IME Direct GME 3. 00 5.00 1.00 2.00 4.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61. 03

61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61. 03
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the					61. 04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line					61. 05
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61. 06
		Program Name	Program Code	Unweighted IME		
				FTE Count	Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
61. 10	Of the FTEs in line 61.05, specify each new program	1100	2.00	0.00		61. 10
	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					
61. 20	of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0. 00	0. 00	61. 20
	ACA Provisions Affecting the Health Resources and Ser	svicos Administration	(UDCA)		1.00	
62. 00	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trained in this cost		od for which	0.00	62. 00
62. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	Teaching Health Cent		your hospital	0.00	62. 01
	Teaching Hospitals that Claim Residents in Nonprovide			. 10 5 .		
63. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple				N	63. 00
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te		,,	
	D 550. C 101. D 575. D 1		1. 00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor		This base year	is your cost r	reporting	
64. 00	Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ry trained residents n-primary care all nonprovider I non-primary care n column 3 the ratio	0. 00	O. OC	0. 000000	64. 00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1302 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/24/2019 10:10 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems IU HEALTH BLACK HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	FORD HOSPITAL Provider CO		In Lie Period: From 01/01/2018 To 12/31/2018	u of Form CMS- Worksheet S-: Part I Date/Time Pro 5/24/2019 10:	2 epared:
				1. 00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	o and "N" for			N	80.00
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no. TEFRA Providers			g period? Enter	N N	81.00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87. 00			
1000(d)(1)(b)(v1): Litter 1 101 yes of N 101 110.			V	XI X	
			1. 00	2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospita	al services? E	nter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through	the cost repor	t either in	N	N	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du				N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicate 93.00 Does this facility operate an ICF/IID facility for purposes	able column.	, ,	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,			N	N	94. 00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app			0.00	0. 00	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for no	o in the	N	N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app			0.00	0.00	97. 00
98.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			N	Y	98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.			N	Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			N	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a crireimbursed 101% of inpatient services cost? Enter "Y" for ye			N 1	N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a			N n	Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 06
Rural Providers					105
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-	-inclusive meth	nod of paymen	t N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.		107. 00			
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	·	J	N		108. 00
	Physi cal	Occupati onal	<u> </u>	Respi ratory	
100 00 of this book to much fing an a cold are a contract of	1. 00 N	2.00	3.00	4.00	100.00
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IV	N	N	N	109. 00
ror yes or N for no for each therapy.					

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

1.00

N

110. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-1302	Peri od: From 01/01/2 To 12/31/2	2018 2018		S-2 Prepared: 10:10 am
		1. 00		2. 00	
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting period? Enter umn 1 is Y, enter the icipating in column 2.	N			111.0
			1. 00	2.00 3	. 00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for yes or is yes, enter "A" for yes or is yes, enter "A" for yes or is yes, enter "Y" for yes, enter "Y" for yes or is yes, enter "Y" for ye	If column 2 is "E", enter for long term care (inc b) based on the definition	rin column Ludes	N N		0 115. 0
17.00 sthis facility legally-required to carry malpractice insura		r "N" for	N		117. 0
18.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the polic	y is	1		118. 0
	Premi ums	Losses	5	Insurand	ce
	1.00	2.00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:	28, !	577	0		0 118. 0
		1. 00		2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu 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	le listing cost centers Harmless provision in ACA			N	118. C
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	lifies for the Outpatien ss? (see instructions)	t			121.6
21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	itable devices charged to	Y			121. 0
22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information				5. 00	122. (
25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no. If	N			125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2.		е			126. (
27.00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certification date				127. (
28.00 f this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2.					128. (
29.00 f this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		n			130. (
30.00 f this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu 31.00 f this is a Medicare certified intestinal transplant center,	ımn 2.				130. (
date in column 1 and termination date, if applicable, in column 32.00 of this is a Medicare certified islet transplant center, ente	ımn 2.				132. (
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, ente	er the certification date				133. (
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.					134. (
All Providers					
40.00 Are there any related organization or home office costs as de	efined in CMS Pub. 15-1.	Y		15H059) 140. C

							1/01/2018 2/31/2018		
1.00		2. 00					3. 00		
If this facility is part of a cha					he nai	me and	address	of the	
home office and enter the home of 141.00 Name: IU HEALTH, INC	Contractor name a		tractor numbe		ractor	r'e Mur	mber: 0810	11	141. 00
142.00 Street: 340 W. 10TH STREET	PO Box:	e. wi 5		Conti	actor	3 Nui	ilber. Ourc	<i>,</i> 1	142. 00
143. OOCi ty: INDIANAPOLIS	State:	ΙN		Zip	Code:		4620)4	143. 00
								1.00	
144.00 Are provider based physicians' co	sts included in Worksh	eet A?						Y	144. 00
							1. 00	2.00	4
145.00 If costs for renal services are c	laimed on Wkst A line	e 74 a	are the costs	for			1.00	2.00	145. 00
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	' for yes or "N" for no clude Medicare utiliza for no in column 2. gy changed from the pro n column 1. (See CMS Po	o in co tion fo eviousl	olumn 1. If corthis cost y filed cost	olumn 1 i reportino report?	9		N		146. 00
								1.00	
47.00 Was there a change in the statist								N	147. 00
48.00 Was there a change in the order o 49.00 Was there a change to the simplif					for r	20		N N	148. 0
147. Objects there a change to the SIIIIPITT	ca cost irriaring methor	G: LIILE	Part A	Part			itle V	Title XIX	147.00
			1.00	2.00			3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or								3. 13)	
55. 00 Hospi tal			N .	N			N	N	155. 0
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N I	N			N N	N N	156. 0 157. 0
58. OO SUBPROVI DER			N	N			IV	IN IN	158. 0
59. 00 SNF			N	N			N	N	159. 0
160.00 HOME HEALTH AGENCY			N	N			N	N N	160. 0
161.00 CMHC				N			N	N	161. 00
								1.00	
Multicampus 65.00 s this hospital part of a Multica	ampus hospital that ha	s one o	or more campu	ses in di	ffere	ent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Namo		County	Ctata	7i n	Codo	CDCA	ETE /Compus	
	Name 0		County 1.00	2. 00		Code 00	4. 00	FTE/Campus 5.00	-
66.00 If line 165 is yes, for each	Ü		1.00	2.00	J.	00	4.00		0 166. 0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									
								1.00	
Health Information Technology (HI	T) incentive in the Am	eri can	Recovery and	Rei nves	tment	Act		1.00	
67.00 Is this provider a meaningful use								Υ	167. 0
68.00 If this provider is a CAH (line 1				167 is '	'Y"),	enter	the		0168.0
reasonable cost incurred for the				16					4.0.0
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)						a nard	zui b		168. 0
69.00 If this provider is a meaningful						√"), e	nter the	0.0	0169. 0
transition factor. (see instruction						,,,		3. 0	
							gi nni ng	Endi ng	
70.00			6				1. 00	2.00	470 -
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and end	ing dat	te for the re	porting		01/	01/2018	03/31/2018	170. 0
							1. 00	2.00	-
71.00 If line 167 is "Y", does this pro	vider have any days for	rindiv	/i duals enrol	led in			Y		4 171. 0
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I,	line 2, col	. 6? Ente			-		

	Financial Systems I U HEALTH BLACK TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	FORD HOSPITAL Provider C	CN: 15-1302	Peri od:	u of Form CMS Worksheet S-	
103111	AL AND HOST THE HEALTH SAIL RETINDORSEMENT QUESTIONIALINE	Trovider c	ON. 13 1302	From 01/01/2018 To 12/31/2018	Part II Date/Time Pr 5/24/2019 10	epared:
	<u> </u>			Y/N	Date	
	Consert Instruction, Enter V for all VEC responses. Enter N	l for all NO ra	onences Ent	1.00	2. 00	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	i for all no re	sponses. Ente	er arr dates in t	ne	
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1. 0
	reporting period? If yes, enter the date of the change in c	column 2. (see	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 column voluntary or "I" for involuntary.		N			2. 0
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3. 0
			Y/N	Type	Date	
	Fire and Description		1.00	2. 00	3. 00	
5. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4.0
. 00	those on the filed financial statements? If yes, submit rec					0.0
			•	Y/N	Legal Oper.	
	la let i lairir			1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	s N		6.0
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	N N		7. 0 8. 0		
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10. 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V (N)	11. C
					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 period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
4. 00		ents waived? If	yes, see ins	structi ons.	N	14.0
5. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,			N	15. 0
		Y/N	t A Date	Par Y/N	тв Date	
		1.00	2.00	3. 00	4. 00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16. C
7. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for	Y	04/03/2019	Y	04/03/2019	17. 0
0.65	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	ļ.,.				40.5
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 0
9. 00		N		N		19. 0

Property		Financial Systems IU HEALTH BLACK				u of Form CM		
1.00 3.00 1.00 3.00 2.00 1.00 3.00 2.00 1.00 3.00 2.00 2.00 2.00 2.00 2.00 3.00 3.00 2.00 3.00	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-1302		Part II Date/Time P	repared:	
20.00 If I I Ine 16 or 17 is yes, were adjustments made to PSSR N N 20.00								
Report data for Other? Describe the other adjustments: 1	20.00	If line 14 or 17 is yes were adjustments made to DSOD		0			20.00	
1.00	20.00				IN	IN	20.00	
21.00 Was the cost report prepared only using the provider's N		,	Y/N	Date	Y/N	Date		
records? If yes, see instructions. COMPLETE BY COST RELIBEURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 1.00 22.00 Have changes occurred in the Medicare purposes? If yes, see instructions 1.00 1.00 1.00 1.00 22.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 1.00 1.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 1.00 1.00 1.00 2.00 1.0			_	2. 00		4. 00		
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27. 00 lass the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27. 00 copy. Interest Expense 28. 00 Were home office costs claimed on the cost reporting period? If yes, see instructions. 29. 00 lid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29. 00 lid the provider have a funded depreciation account? If yes, see instructions as funded depreciation account? If yes, see instructions. 30. 00 Has sexisting debt been replaced prior to its Scheduled maturity with new debt? If yes, see N 30. 00 linstructions. 31. 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 30. 00 instructions. 32. 00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see Instructions. 32. 00 If I line 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If no, see instructions. 34. 00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see Instructions. 35. 00 If I line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35. 00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35. 00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 36. 00 If line 34 is yes, see instructions. 36. 00 Were home office costs claimed on the cost report? 37. 00 If I line 36 is yes, has a home office cost statement been prepared by the home office? Y 37. 00 If line 36 is yes, has a home office cost statement been prepared by the home office? Y 37. 00 If line 36 is yes, was the fiscal year end of the home office? If yes, ye and the provider render services to other chain components? If yes, Y 39. 00 If line 36 is yes, did the provider render services to other chain components? If yes, yes,	26. 00		he cost report	ing period? I	f yes, see	N	26. 00	
Copy. Interest Expense								
Interest Expense 28.00 Nere new Ioans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions N 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 N 29.00 Did the provider have a funded depreciation account? If yes, see instructions N 29.00 Has debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Instructions N 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 30.00 Instructions N 29.00	27. 00		e cost reporti	ng period? If	yes, submit	N	27. 00	
28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 The period of the								
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		4						
report preparer in columns 1 and 2, respectively.	43.00		317-962-1093		RUTTER@I UHEALTI	H. ORG	43. 00	
		report preparer in columns 1 and 2, respectively.	1					

Heal th	Financial Systems IU HEALTH BLA	CKFORD HOSPITAL		In Lieu of Form CMS-2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1302		eriod: rom 01/01/2018	Worksheet S-2 Part II			
			T		Date/Time Pre 5/24/2019 10:	pared: 10 am		
		3. 00						
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	DIRECTOR, GOVERNMENT				41.00		
	held by the cost report preparer in columns 1, 2, and 3,	PROGRAMS						
	respectively.							
42.00	Enter the employer/company name of the cost report					42. 00		
	preparer.							
43.00	Enter the telephone number and email address of the cost					43.00		
	report preparer in columns 1 and 2, respectively.							

Health Financial Systems IU HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-1302

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 |

					0 12/31/2018	5/24/2019 10:	
						I/P Days / 0/P	TO alli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	15	5, 475	23, 064. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		15	5, 475	23, 064. 00	0	7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		15	- 470	22 044 00	0	13.00
14. 00	Total (see instructions)		15	5, 475	23, 064. 00	0	14.00
15. 00	CAH visits					U	15. 00
16. 00 17. 00	SUBPROVIDER - I PF						16. 00 17. 00
18. 00	SUBPROVI DER - I RF SUBPROVI DER						17. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	00.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	15				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0				32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Provider CCN: 15-1302

					0 12/31/2018	5/24/2019 10:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	703	2	961			1.00
2.00	HMO and other (see instructions)	131	34				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	972	0	972			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	288			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 675	2	2, 221			7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	1, 675	2	2, 221		99. 12	1
15. 00	CAH visits	0	0	C)		15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00 23. 00	HOME HEALTH AGENCY						23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)			C			24. 00
25. 00	CMHC - CMHC			C	,		25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	
27. 00	Total (sum of lines 14-26)		Ÿ		0.00		
28. 00	Observation Bed Days		0	227		77.12	28. 00
29. 00	Ambul ance Trips	1	Ĭ	22,			29.00
30. 00	Employee discount days (see instruction)	i i		C)		30.00
31. 00	Employee discount days - IRF			Č			31.00
32. 00	Labor & delivery days (see instructions)	0	0	C			32. 00
32. 01	Total ancillary labor & delivery room		٩	(32. 01
02.01	outpatient days (see instructions)						32.01
33. 00		0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
	· · · · · · · · · · · · · · · · · · ·	· '			•	•	

Provider CCN: 15-1302

					0 12/31/2018	Date/Time Prep 5/24/2019 10:	
		Full Time Equivalents		Di sch	arges		
	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	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		0	199 35		274	1. 00 2. 00
3. 00 4. 00 5. 00 6. 00 7. 00	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)				0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00	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	0.00	C	199	1	274	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 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	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. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges			0			33. 00 33. 01

Heal th	Financial Systems IU HEALTH BLACKFORD) HOSPI TAL	In Lie	eu of Form CMS-2	2552-10			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1302	Peri od:	Worksheet S-1	0			
			From 01/01/2018 To 12/31/2018		nared.			
			10 12/01/2010	5/24/2019 10:				
				1.00				
	Uncompensated and indigent care cost computation							
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by line 202 colu	mn 8)	0. 422564	1.00			
2 00	Medicaid (see instructions for each line)			/E4 7/1	1 2 00			
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?			654, 761 N	2.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal pavments from Medi	cai d?		4. 00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	. 3		0	1			
6.00	Medi cai d charges			7, 473, 579				
7. 00	Medicaid cost (line 1 times line 6)			3, 158, 065	1			
8. 00	Difference between net revenue and costs for Medicaid program <pre>< zero then enter zero)</pre>	(line 7 minus sum of l	ines 2 and 5; if	2, 503, 304	8. 00			
	Children's Health Insurance Program (CHIP) (see instructions for	or each line)						
9.00	Net revenue from stand-alone CHIP	,		0	9.00			
10.00	Stand-alone CHIP charges			0				
11. 00	Stand-alone CHIP cost (line 1 times line 10)		0	1				
12. 00	Difference between net revenue and costs for stand-alone CHIP	if < zero then	0	12. 00				
	<pre>enter zero) Other state or local government indigent care program (see inst</pre>	tructions for each lin	e)		-			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13.00							
14.00	Charges for patients covered under state or local indigent care	d in lines 6 or	0	14. 00				
	10)							
15.00	State or local indigent care program cost (line 1 times line 14	: 15 -: 1:	0					
16. 00	Difference between net revenue and costs for state or local inc 13; if < zero then enter zero)	ine is minus iine	0	16. 00				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
17.00	instructions for each line)				17.00			
17. 00 18. 00	Private grants, donations, or endowment income restricted to for Government grants, appropriations or transfers for support of h			0	17. 00 18. 00			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Local		ms (sum of lines	2, 503, 304	1			
	8, 12 and 16)	Uni nsure	d Insured	Total (col. 1				
		patients		+ col . 2)				
		1.00	2. 00	3. 00				
	Uncompensated Care (see instructions for each line)		0.40	1 010 101				
20. 00	Charity care charges and uninsured discounts for the entire factive (see instructions)	cility 977,	348 40, 756	1, 018, 104	20.00			
21. 00	Cost of patients approved for charity care and uninsured discou	unts (see 412,	992 40, 756	453, 748	21. 00			
	instructions)	112	12,700					
22. 00	Payments received from patients for amounts previously written	off as 11,	136 803	11, 939	22. 00			
23. 00	charity care Cost of charity care (line 21 minus line 22)	401,	856 39, 953	441, 809	23 00			
23.00	cost of charity care (fine 21 militas fine 22)	401,	030 37, 733	441,007	23.00			
				1.00				
24. 00	Does the amount on line 20 column 2, include charges for patier		h of stay limit	N	24. 00			
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the charges for patients are considered as the charges for patients are charges for patients and the charges for patients are charges for patient	am's length of	0	25. 00				
26. 00	stay limit Total bad debt expense for the entire hospital complex (see ins		1, 563, 281	26. 00				
27. 00					1			
27. 01	Medicare allowable bad debts for the entire hospital complex (s		290, 975 447, 652	1				
28. 00	Non-Medicare bad debt expense (see instructions)	,		1, 115, 629	1			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	oense (see instruction	s)	628, 102	1			
	Cost of uncompensated care (line 23 column 3 plus line 29)	no 20)		1, 069, 911	1			
31.UU	0 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 3,573,215 31.00							

Heal th	Financial Systems I	U HEALTH BLACKFO	ORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eri od:	Worksheet A	
				Т		Date/Time Pre 5/24/2019 10:	
	Cost Center Description	Sal ari es	0ther		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	00100 NEW CAP REL COSTS-BLDG & FIXT		6, 326	6, 326	777, 337	783, 663	1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2. 00
3.00	00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	61, 388			1, 057, 547	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	652, 539	4, 389, 149			4, 915, 910	5. 00
7.00	00700 OPERATION OF PLANT	143, 783	1, 328, 621	1, 472, 404	-509, 725	962, 679	7. 00
9.00	00900 HOUSEKEEPI NG	168, 361	188, 262	356, 623	-82, 778	273, 845	9. 00
10.00	01000 DI ETARY	199, 446	208, 658	408, 104	-246, 011	162, 093	10.00
11. 00	01100 CAFETERI A	0	0	0	150, 459	150, 459	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	296, 527	80, 536	377, 063	-45, 546	331, 517	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 174	1, 174	214, 952	216, 126	14. 00
15.00	01500 PHARMACY	0	1, 426, 538	1, 426, 538	-566, 444	860, 094	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 645, 529	577, 380	2, 222, 909	-427, 727	1, 795, 182	30. 00
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	145, 539	154, 277	299, 816	-64, 957	234, 859	50. 00
53.00	05300 ANESTHESI OLOGY	0	89, 746		-4, 191	85, 555	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	594, 448	771, 266			1, 049, 332	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY		961, 966	961, 966	-14, 124	947, 842	60.00
60. 01	06001 BLOOD LABORATORY		701, 700	701, 700	11, 121	717, 012	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	٥	0	0	0	0	62. 00
65. 00	06500 RESPIRATORY THERAPY	500, 998	74, 655		-36, 114	539, 539	65. 00
65. 01	06501 SLEEP LAB	000, 770	, 1, 000	070,000	00, 111	007,007	65. 01
66. 00	06600 PHYSI CAL THERAPY	302, 062	41, 137	343, 199	-21, 319	321, 880	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	67, 964	41, 137			86, 478	
68. 00	06800 SPEECH PATHOLOGY	7, 552	0			7, 552	
69. 00	06900 ELECTROCARDI OLOGY	7,332	0		0	7, 332	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	l ~	٦	19, 190	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT		0	·	4, 120	4, 120	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	0	585, 518	585, 518	
76.00	03140 CARDI OLOGY		0	ľ		0 0	76.00
76. 00	07697 CARDI AC REHABI LI TATI ON	30, 964	7, 563			32, 826	
70. 97	OUTPATIENT SERVICE COST CENTERS	30, 904	7, 303	30, 327	-3, 701	32, 620	70.97
90. 00	09000 CLINIC	22.070	10.025	42.012	0 227	25 574	90. 00
	09100 EMERGENCY	32, 978	10, 935			35, 576	
91.00		2, 010, 471	1, 110, 243	3, 120, 714	-291, 115	2, 829, 599	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			<u> </u>			92. 00
112 00	SPECIAL PURPOSE COST CENTERS					0	112 00
	11300 I NTEREST EXPENSE	/ 700 1/1	0		-		113. 00
118.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	6, 799, 161	11, 489, 820	18, 288, 981	0	18, 288, 981	118.00
100.00	NONREI MBURSABLE COST CENTERS		0.700	0.400		0 (00	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 632	3, 632			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	6, 799, 161	11, 493, 452	18, 292, 613	0	18, 292, 613	₁ 200.00

Health FinancialSystemsIU HEALTH BIRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-1302 Peri od: From 01/01/2018 | Worksneet A | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

				To 12/31/2018 Date/Time Pr 5/24/2019 10	
	Cost Center Description	Adjustments	Net Expenses	372472017 10	. TO alli
			For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	72, 245	855, 908		1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0		2. 00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	116, 520	1, 174, 067		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-480, 819	4, 435, 091		5. 00
7.00	00700 OPERATION OF PLANT	61, 799	1, 024, 478		7. 00
9.00	00900 HOUSEKEEPI NG	0	273, 845		9. 00
10.00	01000 DI ETARY	0	162, 093		10. 00
11. 00	01100 CAFETERI A	-67, 952	82, 507		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	158, 150	489, 667		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	216, 126		14. 00
15.00	01500 PHARMACY	-168, 598	691, 496		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1, 795, 182		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-326	234, 533		50. 00
53.00	05300 ANESTHESI OLOGY	-85, 530	25	·	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	82, 978	1, 132, 310		54. 00
57. 00	05700 CT SCAN	0	0	l .	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	l .	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	l .	59. 00
60.00	06000 LABORATORY	0	947, 842	·	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	l .	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62. 00
65. 00	06500 RESPI RATORY THERAPY	1, 148	540, 687		65. 00
65. 01	06501 SLEEP LAB	0	0	l .	65. 01
66. 00	06600 PHYSI CAL THERAPY	-7, 809	314, 071	l .	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	86, 478		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	7, 552		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	l .	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19, 190	l .	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	4, 120	l .	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	585, 518		73. 00
76.00	03140 CARDI OLOGY	4 7/0	0	l .	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	-1, 760	31, 066		76. 97
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC		25 57/		- 00 00
90.00	09100 EMERGENCY	1 204 107	35, 576		90. 00 91. 00
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-1, 394, 187	1, 435, 412		91.00
92.00	SPECIAL PURPOSE COST CENTERS				92.00
113 00	11300 I NTEREST EXPENSE	O	0		113. 00
118.00	1 1	-1, 714, 141	16, 574, 840	l .	118. 00
1 10.00	NONREI MBURSABLE COST CENTERS	1, / 14, 141	10, 374, 040	I	1 10.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 632		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	o o	0,032	·	192. 00
200.00	1 1	-1, 714, 141	16, 578, 472		200. 00
200.00	1 1		10,0.0,172	I	1-00.00

| Peri od: | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/24/2019 10: 10 am Provider CCN: 15-1302

					5/24/2019 1	0: 10 am
		Increases				
	Cost Center	Li ne #	Salary	Other		
	2.00	3. 00	4. 00	5. 00		
1 00	A - CAFETERIA	11 00	0/ 011	E4 440		1 00
1. 00	CAFETERI A	11.00	9 <u>6, 0</u> 11 96, 011	5 <u>4, 4</u> 48 54, 448		1. 00
	B - MEDICAL SUPPLIES		96, 011	54, 448		
1. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	214, 514		1.00
2. 00	OPERATION OF PLANT	7. 00	o	92		2. 00
3. 00	NURSI NG ADMI NI STRATI ON	13. 00	o	77		3. 00
4.00	MEDICAL SUPPLIES CHARGED TO	71.00	O	19, 190		4. 00
	PATI ENTS					
5.00	IMPL. DEV. CHARGED TO	72. 00	0	4, 120		5. 00
	PATI ENT					
6. 00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9.00
11. 00		0.00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12.00
13. 00		0.00	Ö	0		13. 00
14. 00		0.00	Ö	0		14. 00
			 	237, 993		1
	C - DRUGS CHARGED TO PATIENTS	;				
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	438		1. 00
2.00	PHARMACY	15. 00	0	17, 117		2. 00
3.00	DRUGS CHARGED TO PATIENTS	73. 00	0	585, 518		3. 00
4.00		0.00	0	0		4. 00
5.00		0. 00	0	0		5. 00
6. 00		0. 00	0	0		6. 00
7. 00		0. 00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00		0.00	9	0		9. 00
	E - EMPLOYEE BENEFITS		0	603, 073		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 005, 075		1.00
2. 00	LWI LOTEL BENEFITS DELAKTIVENT	0.00	o	1,003,073		2. 00
3. 00		0.00	o	0		3. 00
4. 00		0.00	o	0		4. 00
5.00		0.00	O	0		5. 00
6.00		0.00	O	0		6. 00
7.00		0.00	O	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0. 00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
	0 PERRECLATION		0	1, 005, 075		
1. 00	F - DEPRECIATION NEW CAP REL COSTS-BLDG &	1.00	0	764, 816		1.00
1.00	FIXT	1.00	٥	704, 610		1.00
2.00		0.00	o	0		2. 00
3. 00		0.00	o	0		3. 00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0. 00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00				000		14. 00
	G - OUTPATIENT THERAPY		U_	704,010		
1. 00	OCCUPATI ONAL THERAPY	67. 00	18, 327	187		1.00
50	0		18, 327			1.00
	H - AUTO & PROPERTY INSURANCE		.0,027	.37		
1.00	NEW CAP REL COSTS-BLDG &	1.00	O	12, 521		1. 00
	FI XT]			
	0			12, 521		- 1
500.00	Grand Total: Increases	T	114, 338	2, 678, 113		500. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/24/2019 10: 10 am Provider CCN: 15-1302

						 5/24/2019 10: 10 am
		Decreases		0.11		
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.	
	6. 00 A - CAFETERI A	7. 00	8. 00	9. 00	10. 00	
1. 00	DI ETARY	10.00	96, 011	54, 448	0	1. 00
1.00	0		96, 011	54, 448		1.00
	B - MEDICAL SUPPLIES		70, 011	01, 110		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	223	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	O	158		2. 00
3.00	HOUSEKEEPI NG	9. 00	O	6, 497		3. 00
4.00	DI ETARY	10.00	o	1, 379		4. 00
5.00	PHARMACY	15. 00	o	1, 095	o	5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	58, 767	o	6. 00
7.00	OPERATING ROOM	50.00	0	36, 472	o	7. 00
8.00	ANESTHESI OLOGY	53.00	0	3, 873		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	27, 788	o	9. 00
10.00	RESPIRATORY THERAPY	65. 00	O	25, 916	o	10.00
11.00	PHYSI CAL THERAPY	66.00	0	1, 419	0	11. 00
12.00	CARDIAC REHABILITATION	76. 97	0	426	o	12. 00
13.00	CLINIC	90.00	0	4, 826	0	13.00
14.00	EMERGENCY	91. 00	0	69, 154	0	14. 00
	0		0	237, 993		
	C - DRUGS CHARGED TO PATIENTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 693		1. 00
2.00	PHARMACY	15. 00	0	555, 934		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	7, 453	0	3. 00
4.00	OPERATING ROOM	50.00	0	379	0	4. 00
5.00	ANESTHESI OLOGY	53.00	0	318	l .	5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	22, 362	0	6. 00
7.00	PHYSI CAL THERAPY	66. 00	0	30	I I	7. 00
8.00	CLINIC	90. 00	0	1, 072		8. 00
9. 00	EMERGENCY	<u>91.</u> 00		<u>6, 8</u> 32		9. 00
	0		0	603, 073		
	E - EMPLOYEE BENEFITS				_1	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	96, 530		1.00
2.00	OPERATION OF PLANT	7. 00	0	40, 604	l .	2.00
3.00	HOUSEKEEPI NG	9.00	0	75, 333	l 1	3.00
4.00	DI ETARY	10.00	0	85, 518	l 1	4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00	0	45, 623		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	332, 256	0	6.00
7.00	OPERATING ROOM	50.00	U	17, 633	l .	7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	105, 047	0	8. 00
9.00	RESPIRATORY THERAPY CARDIAC REHABILITATION	65. 00 76. 97	0	977 81		9.00
10. 00 11. 00	CLINIC	90.00	0			10.00
12.00	EMERGENCY	91.00	ol Ol	1, 367 204, 106	· ·	12.00
12.00	O	— — 91. 00		1, 005, 075		12.00
	F - DEPRECIATION		<u> </u>	1,005,075		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	ol	16, 569	9	1.00
2. 00	OPERATION OF PLANT	7. 00	Ö	469, 213		2.00
3. 00	HOUSEKEEPI NG	9. 00	0	948	l .	3. 00
4. 00	DI ETARY	10. 00	Ö	8, 655	l .	4. 00
5. 00	PHARMACY	15. 00	o	26, 532		5. 00
6. 00	ADULTS & PEDIATRICS	30.00	0	29, 251	o	6. 00
7. 00	OPERATING ROOM	50.00	0	10, 473	l .	7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	161, 185		8. 00
9. 00	LABORATORY	60.00	o	14, 124		9. 00
10. 00	RESPIRATORY THERAPY	65. 00	ol	9, 221	o	10.00
11. 00	PHYSI CAL THERAPY	66.00	ō	1, 356	I	11. 00
12. 00	CARDI AC REHABI LI TATI ON	76. 97	Ö	5, 194	l 1	12.00
13. 00	CLINIC	90.00	Ö	1, 072		13. 00
14.00	EMERGENCY	91.00	o	11, 023		14. 00
		+	0	764, 816		
	G - OUTPATIENT THERAPY				'	
1.00	PHYSI CAL THERAPY	66. 00	18, 327	187	0	1. 00
	0		18, 327	187		
	H - AUTO & PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1 <u>2, 5</u> 21	12	1. 00
	0		0	12, 521		
500.00	Grand Total: Decreases		114, 338	2, 678, 113		500.00

Provider CCN: 15-1302

					To 12/31/2018	Date/Time Prep 5/24/2019 10:	pared: 10 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	190, 324	0		0	0	1. 00
2.00	Land Improvements	259, 436	0		0	0	2. 00
3.00	Buildings and Fixtures	15, 007, 745	0		0	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equi pment	0	0		0	0	5. 00
6.00	Movable Equipment	5, 175, 072	694, 196		0 694, 196	1, 035, 039	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	20, 632, 577	694, 196		0 694, 196	1, 035, 039	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	20, 632, 577	694, 196		0 694, 196	1, 035, 039	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANALYSIS OF SUMMED IN SARITAL ASSE	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	190, 324	0				1. 00
2.00	Land Improvements	259, 436	0				2. 00
3.00	Buildings and Fixtures	15, 007, 745	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6. 00	Movable Equipment	4, 834, 229	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	20, 291, 734	0				8. 00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	20, 291, 734	0	l			10. 00

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part II	pared:
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9. 00	10.00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	6, 326	0)	0 0	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0)	0 0	0	2. 00
3.00 Total (sum of lines 1-2)	6, 326	0		0 0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14.00	15. 00				

0 0 0

6, 326 0 6, 326 1. 00 2. 00 3. 00

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

1.00 NEW CAP REL COSTS-BLDG & FIXT
2.00 NEW CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2018 Fo 12/31/2018		pared:
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
				(col . 1 - col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	20, 291, 734	0	20, 291, 73		0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0. 000000		2. 00
3.00	Total (sum of lines 1-2)	20, 291, 734		20, 291, 73			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0	(937, 118	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	(937, 118	0	3. 00
			SL	JMMARY OF CAPI	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 C						
1.00	NEW CAP REL COSTS-BLDG & FLXT	-93, 731	12, 521		0	855, 908	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00	Total (sum of lines 1-2)	-93, 731	12, 521		0	855, 908	3. 00

In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-1302 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/24/2019 10:10 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP -93, 731 NEW CAP REL COSTS-BLDG & 1. 00 В 1.00 11 REL COSTS-BLDG & FLXT (chapter lf i xt 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3 00 Investment income - other 0 3 00 0 00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evision and radio service 0.00 8.00 0 (chapter 21) 9.00 9.00 Parking lot (chapter 21) 0.00 -1, 369, 968 10.00 Provider-based physician A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00

1, 555, 548

-67, 952 CAFETERI A

ODI ETARY

FI XT

EQUI P

ORESPIRATORY THERAPY

0 *** Cost Center Deleted ***

ONEW CAP REL COSTS-BLDG &

ONEW CAP REL COSTS-MVBLE

O OCCUPATIONAL THERAPY

OADULTS & PEDIATRICS

OSPEECH PATHOLOGY

0 *** Cost Center Deleted ***

OPHYSICAL THERAPY

0

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

29.00

30.00

30.99

31.00

0.00

11.00

0.00

0.00

0.00

0 00

0.00

10.00

0 00

0.00

65 00

66.00

114.00

1.00

2.00

19.00

0.00

67.00

30.00

68.00

A-8-1

В

В

A - 8 - 3

A-8-3

A-8-3

A-8-3

(chapter 23) Related organization

and others

pati ents

pati ents

abstracts

books, etc.)

transactions (chapter 10)

Laundry and linen service

Cafeteria-employees and guests

Rental of quarters to employee

Sale of medical and surgical

Sale of drugs to other than

Sale of medical records and

Nursing and allied health

education (tuition, fees,

Vending machines Income from imposition of

interest, finance or penalty charges (chapter 21) Interest expense on Medicare

overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory

therapy costs in excess of limitation (chapter 14)

therapy costs in excess of limitation (chapter 14)

physicians' compensation

Depreciation - NEW CAP REL

Depreciation - NEW CAP REL

Non-physician Anesthetist

Adjustment for occupational

therapy costs in excess of limitation (chapter 14)

Hospice (non-distinct) (see

pathology costs in excess of limitation (chapter 14)

Physicians' assistant

Adjustment for speech

Adjustment for physical

Utilization review -

COSTS-BLDG & FLXT

COSTS-MVBLE EQUIP

instructions)

(chapter 21)

supplies to other than

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

29.00

30.00

30.99

31.00

	Financial Systems	<u> </u>	U HEALTH BLACK			eu of Form CMS-2	
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	narad:
					0 12/31/2010	5/24/2019 10:	
				Expense Classification on	Worksheet A	0,21,201,101	, o a
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
32.00	CAH HIT Adjustment for	A	-8, 971	NEW CAP REL COSTS-BLDG &	1.00	9	32. 00
	Depreciation and Interest			FI XT			
33.00	MARKETING/ADVERTISING COSTS	A	-4, 229	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
34.00	MI SCELLANEOUS I NCOME	В	-53, 101	ADMINISTRATIVE & GENERAL	5. 00	0	34. 00
35.00	MI SCELLANEOUS I NCOME	В	-1, 328	NURSING ADMINISTRATION	13.00	0	35. 00
36.00	MI SCELLANEOUS I NCOME	В	-175	PHYSI CAL THERAPY	66.00	0	36. 00
37.00	MI SCELLANEOUS I NCOME	В	-610	EMERGENCY	91.00	0	37. 00
38. 00	EMPLOYEE BENEFITS	A	-1, 005, 075	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38. 00
39.00	PTO EXPENSE ALLOCATION	A	-44, 626	ADMINISTRATIVE & GENERAL	5. 00	0	39. 00
40.00	CHARITY CONTRIBUTIONS	A	-325	ADMINISTRATIVE & GENERAL	5. 00	0	40. 00
41.00	PHYSICIAN MALPRACTICE	A	-18, 372	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
	I NSURANCE						
42.00	PHYSICIAN MALPRACTICE	A	-26, 058	EMERGENCY	91.00	0	42. 00
	I NSURANCE						
	HOSPITAL ASSESSMENT FEES	A	•	ADMINISTRATIVE & GENERAL	5. 00	l .	43. 00
44 00	TELEBUONE FOLLIDMENT	I A	27	DADLOLOCY DLACNOCTIC	E 4 00		1 44 00

-37 RADI OLOGY-DI AGNOSTI C

54.00

44.00 50.00

TELEPHONE EQUIPMENT

50.00 TOTAL (sum of lines 1 thru 49)

44.00

⁽Transfer to Worksheet A, column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

Provider CCN: 15-1302 Period: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/24/2019 10: 10 am

OTTICL	00313			To 12/31/2018	Date/Time Pre 5/24/2019 10:	
	Li ne No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column	
	1.00	2.00	3.00	4.00	5	
	A. COSTS I NCURRED AND ADJUSTI HOME OFFICE COSTS:	2.00 MENTS REQUIRED AS A RESULT OF	3.00 TRANSACTIONS WITH RELATED OF	4.00 RGANI ZATI ONS OR	5. 00 CLAI MED	
1.00		NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	174, 947	0	1. 00
2.00		EMPLOYEE BENEFITS DEPARTMENT		1, 121, 595	0	2. 00
3.00			HOME OFFICE	2, 605, 908	2, 434, 863	3. 00
4. 00 4. 01			RELATED PARTY RELATED PARTY	1, 027, 677 291, 065	983, 757 229, 266	4. 00 4. 01
4. 02	1		RELATED PARTY	170, 735	11, 257	4. 02
4.03	15. 00		RELATED PARTY	179, 884	348, 482	4. 03
4.04			RELATED PARTY	13, 342	13, 668	4. 04
4. 05			RELATED PARTY	145, 561	154, 961	4. 05
4. 06 4. 07			RELATED PARTY RELATED PARTY	33, 373 27, 396	24, 651 35, 030	4. 06 4. 07
4. 08	I		RELATED PARTY	25, 281	25, 281	4. 08
4. 09			RELATED PARTY	167, 032	167, 032	4. 09
4. 10			RELATED PARTY	117, 206	117, 206	4. 10
4. 11			RELATED PARTY	16, 258	16, 258	4. 11
4. 12		ł	RELATED PARTY	476, 694	476, 694	4. 12
4. 13			RELATED PARTY RELATED PARTY	9, 760	9, 760	4. 13
4. 14 4. 15			RELATED PARTY	5, 546 109, 591	5, 546 109, 591	4. 14 4. 15
4. 16			RELATED PARTY	901, 525	901, 525	4. 16
4. 17	1		RELATED PARTY	513, 675	513, 675	4. 17
4. 18	66.00	PHYSI CAL THERAPY	RELATED PARTY	302, 871	302, 871	4. 18
4. 19	1		RELATED PARTY	67, 964	67, 964	4. 19
4. 20			RELATED PARTY	7, 552	7, 552	4. 20
4. 21 4. 22	1		RELATED PARTY RELATED PARTY	28, 989 2, 290	28, 989 2, 290	4. 21 4. 22
4. 23	0.00		RELATED FARTI	2,290	2, 290	4. 22
4. 24	0.00			Ö	Ö	4. 24
4. 25	0.00			0	0	4. 25
4. 26	0.00			0	0	4. 26
4. 27	0.00			0	0	4. 27
4. 28 4. 29	0.00			0	0	4. 28 4. 29
4. 30	0.00				0	4. 29
4. 31	0.00				o	4. 31
4.32	0.00			0	0	4. 32
4.33	0.00			0	0	4. 33
4.34	0.00			0	0	4. 34
4. 35 4. 36	0.00			0	0	4. 35
4. 37	0.00				0	4. 36 4. 37
4. 38	0.00				o	4. 38
4.39	0.00			0	0	4. 39
4.40	0.00			0	0	4. 40
4. 41	0.00			0	0	4. 41
4.42	0.00				0	4. 42
4. 43 4. 44	0.00				0	4. 43 4. 44
4. 44	0.00				0	4. 44
4. 46	0.00				o	4. 46
4.47	0.00			0	O	4. 47
4. 48	0.00			0	0	4. 48
4. 49	0.00			0	0	4. 49
4. 50 5. 00	0.00	1	0	8, 543, 717	0 6, 988, 169	4. 50 5. 00
5.00	<u> </u>		<u> </u>	0,043,717	0, 700, 109	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.

1100 110 1	That her been posted to not know the first and the first and the should be that eated the column to this part.						
				Related Organization(s) and/	or Home Office		
	Symbol (1)	Name	Percentage of	Name	Percentage of	i	
			Ownershi p		Ownershi p		
	1. 00	2. 00	3. 00	4. 00	5. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:				

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1302	Peri od: Worksheet A-8-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					5/24/2019 10:	10 am
			Related Organi	zation(s) ar	nd/or Home Office	
Symbol (1)	Name	Percentage of	Nar	me	Percentage of	
		Ownershi p			Ownershi p	
1. 00	2.00	3. 00	4. 0	00	5. 00	

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 IU HEALTH 100.00	6. 00
7.00	В	0. 00 BALL HOSPI TAL 100. 00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

TATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1302	Perioa:	WORKSheet A-8-1
FFICE COSTS		From 01/01/2018	
		To 12/31/2018	Date/Time Prepared:
			E/24/2010 10 10 om

			5/24/2019 10:	10 am
		Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			INTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	174, 947			1. 00
2.00	1, 121, 595			2.00
3.00	171, 045	0		3.00
4.00	43, 920	0		4.00
4.01	61, 799	0		4. 01
4.02	159, 478			4. 02
4.03	-168, 598	0		4. 03
4.04	-326	0		4.04
4.05	-9, 400	0		4.05
4.06	8, 722	0		4.06
4.07	-7, 634			4. 07
4.08	0			4. 08
4. 09	0			4. 09
4. 10	0			4. 10
4. 11	0			4. 11
4. 12	0			4. 12
4. 13	Ö			4. 13
4. 14	0			4. 14
4. 15	0			4. 15
4. 16	0			4. 16
4. 17	0			4. 17
4. 18	0			4. 18
4. 19	0			4. 19
4. 20	0			4. 20
4. 21	0			4. 21
4. 22	Ö			4. 22
4. 23	0			4. 23
4. 24	0			4. 24
4. 25	0			4. 25
4. 26	0			4. 26
4. 27	0			4. 27
4. 28	0			4. 28
4. 29	0			4. 29
4. 29	0			4. 29
4. 30	0			
	0			4. 31
4.32	0			4. 32
4.33	0			4. 33
4.34	0			4. 34
4. 35				4. 35
4.36	0			4. 36
4. 37	0			4. 37
4. 38	0			4. 38
4. 39	0			4. 39
4.40	0	1		4. 40
4. 41	0			4. 41
4.42	0 0	0 0 0		4. 42
4. 43	0	0		4. 43
4.44		0		4. 44
4. 45	0	0		4. 45
4.46	0	0		4. 46
4. 47	0 0	0 0		4. 47
4. 48	0	0		4. 48
4.49	0	0		4. 49
4.50	0	0		4. 50
5.00	1, 555, 548			5.00

5.00 | 1,555,548 | * The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate and page tive amounts decrease cost For related organization or home office cost appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

STATEME OFFICE		RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1302	Peri od: From 01/01/2018	Worksheet A-8-1	
UFFICE				To 12/31/2018	Date/Time Prepare 5/24/2019 10:10	
	Related Organization(s) and/or Home Office					
	Type of Business					
	6. 00					
control part of	represent reasonable costs a	acilities, and supplies furnished as determined under section 1861 e cost report is considered incom	of the Social Security A	ct. Íf you do no	t provide all or	any
6.00	HOSPI TAL				6	6. 00
7.00	HOSPI TAL				7	7. 00
8.00					8	8. 00
9.00					9	9. 00
10.00					10	0. 00
100.00					100	0. 00

IU HEALTH BLACKFORD HOSPITAL

In Lieu of Form CMS-2552-10

- (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.

Health Financial Systems

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1302

					-	To 12/31/2018	Date/Time Pre 5/24/2019 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					·		Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00		ANESTHESI OLOGY	85, 530		0	_		1. 00
2.00		RADI OLOGY-DI AGNOSTI C	-92, 415			_		
3.00		RESPI RATORY THERAPY	10, 978			0	0	0.00
4.00		CARDIAC REHABILITATION	1, 760			0	0	
5.00		EMERGENCY	1, 884, 186	1, 367, 519	516, 667	0	0	5. 00
6.00	0. 00		0	(0	0	0	0.00
7.00	0.00		0	C	0	0	0	7. 00
8.00	0.00		0	C	0	0	0	8. 00
9.00	0.00		0	C	0	0	0	9. 00
10.00	0. 00		0	C	0	0	0	10.00
200.00			1, 890, 039					200. 00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8. 00	9.00	Educati on	12	14.00	
1. 00	1.00	2. 00 ANESTHESI OLOGY	8.00		12. 00	13.00	14.00	1. 00
2. 00		RADI OLOGY-DI AGNOSTI C		-	_	_	_	
3. 00		RESPI RATORY THERAPY		`	1	_		1
4. 00		CARDI AC REHABI LI TATI ON						1
5. 00		EMERGENCY						1
6. 00	0.00							1
7. 00	0.00							1
8. 00	0.00							8.00
9. 00	0.00							
10. 00	0.00							1
200.00	0.00					0	Ö	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		I denti fi er	Component	Limit	Di sal I owance	/ ray do timorre		
		- doint i i oi	Share of col.		Broarromanos			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00	53. 00	ANESTHESI OLOGY	0	C	0	85, 530		1. 00
2.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	C	0	-92, 415		2. 00
3.00	65. 00	RESPI RATORY THERAPY	0	(0	7, 574		3. 00
4.00		CARDIAC REHABILITATION	0	(0	1, 760		4. 00
5.00	91. 00	EMERGENCY	0	(0	1, 367, 519		5. 00
6.00	0.00		0	(0	0		6. 00
7.00	0.00		0	(0	0		7. 00
8.00	0.00	4	0	(0	0		8. 00
9.00	0.00	4	0	(0	0		9. 00
10.00	0.00		0	(0	_		10. 00
200.00			0	(0	1, 369, 968		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1302 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/24/2019 10:10 am CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** Subtotal for Cost FIXT **FOULP BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 855, 908 855, 908 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 0 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 174, 067 0 1, 174, 067 4.00 00500 ADMINISTRATIVE & GENERAL 0 5.00 5 00 4 435 091 109 020 4, 656, 790 112, 679 00700 OPERATION OF PLANT 0 7.00 1,024,478 162, 370 24,828 1, 211, 676 7.00 9.00 00900 HOUSEKEEPI NG 273, 845 16, 606 29, 072 319, 523 9.00 01000 DI ETARY 10.00 162,093 31, 033 0 17, 861 210, 987 10.00 01100 CAFETERI A 0 16, 579 127, 893 82, 507 28, 807 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 489, 667 3, 625 0 51, 204 544, 496 13.00 01400 CENTRAL SERVICES & SUPPLY 19, 070 0 235, 196 14.00 216, 126 14.00 01500 PHARMACY 691, 496 15.00 15.00 12, 958 0 704, 454 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 795, 182 140, 906 0 284, 147 2, 220, 235 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 62, 801 0 50.00 234, 533 25, 131 322, 465 50.00 53 00 05300 ANESTHESLOLOGY 25 0 25 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 132, 310 68, 226 0 102, 648 1, 303, 184 54.00 57.00 05700 CT SCAN 0 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 0 0 0 0 05900 CARDIAC CATHETERIZATION 59.00 0 Λ 59.00 06000 LABORATORY 947, 842 0 0 974, 043 60.00 26, 201 60.00 06001 BLOOD LABORATORY 0 0 60.01 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0 0 65.00 06500 RESPIRATORY THERAPY 540, 687 9, 926 86, 511 637, 124 65.00 06501 SLEEP LAB 65.01 65.01 66.00 06600 PHYSI CAL THERAPY 314,071 45, 176 0 48, 995 408, 242 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 86, 478 5, 330 14, 901 106, 709 67.00 1, 304 06800 SPEECH PATHOLOGY 68.00 7,552 8,856 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 19, 190 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 19, 190 71 00 C 0 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 4, 120 C 0 4, 120 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 585, 518 0 0 585, 518 73.00 03140 CARDI OLOGY 0 76.00 76.00 07697 CARDIAC REHABILITATION 0 40, 227 76.97 31,066 3, 814 5, 347 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 35, 576 28, 688 0 5, 695 69, 959 90.00 09100 EMERGENCY 0 347, 165 91.00 91 00 1 435 412 75. 144 1, 857, 721 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 16, 574, 840 849, 701 1, 174, 067 16, 568, 633 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 6, 207 0 9, 839 190. 00 3,632 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 C

0 200.00

0 201. 00

16, 578, 472 202. 00

0

0

1, 174, 067

855, 908

16, 578, 472

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Provider CCN: 15-1302

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
5/24/2019	10:10 am

					12, 01, 2010	5/24/2019 10:	10 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		& GENERAL	PLANT				
		5. 00	7. 00	9. 00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 656, 790					5. 00
7. 00	00700 OPERATION OF PLANT	473, 299	1, 684, 975				7. 00
9. 00	00900 HOUSEKEEPI NG	124, 810	47, 871	492, 204			9. 00
10.00	01000 DI ETARY	82, 415	89, 459	26, 896	409, 757		10. 00
11. 00	01100 CAFETERI A	49, 957	83, 040	24, 966	0	285, 856	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	212, 688	10, 448		0	10, 355	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	91, 871	54, 973	16, 528	0	0	14. 00
15.00	01500 PHARMACY	275, 170	37, 354	11, 231	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	867, 261	406, 187	122, 122	409, 757	110, 352	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	125, 960	181, 035	54, 429	0	8, 352	50.00
53.00	05300 ANESTHESI OLOGY	10	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	509, 043	196, 674	59, 131	0	34, 995	54. 00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	380, 476	75, 528	22, 708	0	32, 652	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	248, 870	28, 613	8, 603	0	23, 695	65. 00
65. 01	06501 SLEEP LAB	0	0	0	0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	159, 465	130, 228	39, 154	0	12, 622	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	41, 682	15, 365	4, 620	0	3, 552	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 459	0	0	0	265	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 496	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 609	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	228, 712	0	0	0	0	73. 00
76. 00	03140 CARDI OLOGY	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	15, 713	10, 995	3, 306	0	38	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	27, 327	82, 699	24, 864	0	2, 872	90. 00
91.00	09100 EMERGENCY	725, 654	216, 614	65, 126	0	46, 106	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 652, 947	1, 667, 083	486, 825	409, 757	285, 856	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 843	17, 892	5, 379	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
200.00	, ,						200. 00
201.00	1 9	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 656, 790	1, 684, 975	492, 204	409, 757	285, 856	202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part I
To 1/21/2019 Part II
To 1/21/2019 Part II Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1302

				To	12/31/2018	Date/Time Pre 5/24/2019 10:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown	To um
						Adjustments	
		13.00	14.00	15. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS	,					
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	704 400					11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	781, 128	222 5/2				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	398, 568				14.00
15. 00	01500 PHARMACY	0	1, 878	1, 030, 087			15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	472, 679	77, 657	10.700	4 (00 000	0	20.00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	472,679	//, 65/	12, 730	4, 698, 980	0	30. 00
50. 00	05000 OPERATING ROOM	34, 735	45, 458	586	773, 020	0	50.00
53. 00	05300 ANESTHESI OLOGY	34, 733	6, 639		7, 217	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		45, 784		2, 151, 436	0	54.00
57. 00	05700 CT SCAN		45, 784		2, 131, 430	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58.00
59. 00	05900 CARDIAC CATHETERIZATION		0	-1	0	0	59.00
60.00	06000 LABORATORY		16, 645	١	1, 502, 052	0	60.00
60. 01	06001 BLOOD LABORATORY		10, 043	0	1, 302, 032	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	62. 00
65. 00	06500 RESPIRATORY THERAPY	0	42, 098	0	989, 003	0	65.00
65. 01	06501 SLEEP LAB	0	.2, 0,0	0	0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	2, 033	Ö	751, 744	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	161	0	172, 089	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		12, 580	0	68.00
69. 00	06900 ELECTROCARDI OLOGY		0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	30, 961	0	57, 647	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	6, 647	0	12, 376	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	1, 000, 103	1, 814, 333	0	73. 00
76.00	03140 CARDI OLOGY	o	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	700	0	70, 979	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	21, 119	7, 902	1, 831	238, 573	0	90. 00
91. 00	09100 EMERGENCY	252, 595	114, 002	11, 669	3, 289, 487	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
118.00		781, 128	398, 565	1, 030, 087	16, 541, 516	0	118. 00
40-	NONREI MBURSABLE COST CENTERS	1		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3	1	36, 956		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
200.00	1 1	_	=		0		200.00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	781, 128	398, 568	1, 030, 087	16, 578, 472	0	202. 00

			10 12/31/2018 Date/11me Pro	epared: :10 am
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7.00	00700 OPERATION OF PLANT			7. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS			13.00
30. 00	03000 ADULTS & PEDIATRICS	4, 698, 980		30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	4, 070, 700		30.00
50. 00	05000 OPERATING ROOM	773, 020		50.00
53. 00	05300 ANESTHESI OLOGY	7, 217		53. 00
54. 00	05400 RADI OLOGY – DI AGNOSTI C			54. 00
57. 00	05700 CT SCAN	2, 151, 436 0		57. 00
58.00		0		58.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)			
59. 00	05900 CARDI AC CATHETERI ZATI ON	1 502 052		59. 00
60.00	06000 LABORATORY	1, 502, 052		60.00
60. 01	06001 BLOOD LABORATORY	0		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		62. 00
65. 00	06500 RESPI RATORY THERAPY	989, 003		65. 00
65. 01	06501 SLEEP LAB	0		65. 01
66. 00	06600 PHYSI CAL THERAPY	751, 744		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	172, 089		67. 00
68. 00	06800 SPEECH PATHOLOGY	12, 580		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	57, 647		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	12, 376		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 814, 333		73. 00
76. 00	03140 CARDI OLOGY	0		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	70, 979		76. 97
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	238, 573		90. 00
91.00	09100 EMERGENCY	3, 289, 487		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 I NTEREST EXPENSE			113. 00
118.00		16, 541, 516		118. 00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	36, 956		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		192. 00
200.00		0		200.00
201.00	, ,	0		201.00
202.00		16, 578, 472		202.00
	, , , ,			•

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1302

				10	12/31/2018	Date/IIme Pre 5/24/2019 10:	
			CAPI TAL REI	ATED COSTS		372472017 10.	TO dill
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	·	Assigned New	FLXT	EQUI P		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	1					
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	_	0	0	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	109, 020		109, 020	0	5. 00
7. 00	00700 OPERATION OF PLANT	0	162, 370		162, 370	0	7. 00
9.00	00900 HOUSEKEEPI NG	0	16, 606		16, 606	0	9.00
10.00	01000 DI ETARY	0	31, 033		31, 033	0	10.00
11. 00	01100 CAFETERI A	0	28, 807	0	28, 807	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	3, 625		3, 625	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	19, 070		19, 070	0	14. 00
15. 00	01500 PHARMACY	0	12, 958	0	12, 958	0	15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		440.004		440.004		
30. 00	03000 ADULTS & PEDI ATRI CS	0	140, 906	0	140, 906	0	30.00
F0 00	ANCILLARY SERVICE COST CENTERS				(0.004		F0 00
50.00	05000 OPERATING ROOM	0	62, 801	0	62, 801	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	68, 226		68, 226	0	54. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	26, 201	0	26, 201	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	O	0	0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0	9, 926	0	9, 926	0	65.00
65. 01 66. 00	06501 SLEEP LAB	0	U 4E 174	T	45 17/	0	65. 01 66. 00
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	45, 176 5, 330		45, 176 5, 330	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	3, 330 0		0, 330	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
71. 00		0	0		o O	0	71.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	o O	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o O	0	73.00
76. 00	03140 CARDI OLOGY	0	0	0	0	0	76.00
76. 00	l l	0	3, 814	0	3, 814	0	76.00
70. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	l U	3, 814	U U	3, 814	0	76.97
90. 00	09000 CLINIC	l	28, 688	0	28, 688	0	90.00
90.00	09100 EMERGENCY					0	90.00
91.00	1	U U	75, 144	۷	75, 144 0	Ü	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				<u> </u>		92.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE				1		112 00
113.00	l l	o	040 701	0	040 701	0	113. 00 118. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	l d	849, 701	U U	849, 701	0	1118.00
100.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	4 207	0	4 207		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		6, 207	0	6, 207		190.00
200.00	1 1	١	0		0		200. 00
200.00	1 1		Ō	_	0		200.00
201.00		o	855, 908	0	855, 908		201.00
202.00	I TOTAL (Suil TITIES TTO LITTUUGIT 201)	١	000, 900	ı Y	000, 900	U	1202.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1302

				То	12/31/2018	Date/Time Pre 5/24/2019 10:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	TU alli
	cost center bescription	& GENERAL	PLANT	HOUSEKEELLING	DILIANI	CALLILITA	
		5.00	7. 00	9.00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	109, 020					5. 00
7. 00	00700 OPERATION OF PLANT	11, 081	173, 451				7. 00
9.00	00900 HOUSEKEEPI NG	2, 922	4, 928				9. 00
10.00	01000 DI ETARY	1, 929	9, 209		43, 507		10.00
11. 00	01100 CAFETERI A	1, 170			o	39, 765	11. 00
13. 00	01300 NURSING ADMINISTRATION	4, 979			ol	1, 440	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 151	5, 659		ol	0	1
15. 00	01500 PHARMACY	6, 442	3, 845		o	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-,	5,010		-,	-	1
30.00	03000 ADULTS & PEDIATRICS	20, 300	41, 811	6, 071	43, 507	15, 351	30.00
	ANCILLARY SERVICE COST CENTERS		,	2, 2	,		1
50.00	05000 OPERATING ROOM	2, 949	18, 636	2, 704	o	1, 162	50.00
53. 00	05300 ANESTHESI OLOGY	0	0		ol	. 0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 918	20, 246	2, 938	ol	4, 868	
57. 00	05700 CT SCAN	0	0	-,	ol	0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ö	o	ol	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö	o	ol	0	59.00
60.00	06000 LABORATORY	8, 908	7, 775	1, 128	ol	4, 542	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	o	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	o	ol	0	62. 00
65.00	06500 RESPIRATORY THERAPY	5, 826	2, 945	427	ol	3, 296	65. 00
65. 01	06501 SLEEP LAB	0	0	o	ol	0	65. 01
66.00	06600 PHYSI CAL THERAPY	3, 733	13, 406	1, 945	o	1, 756	66. 00
67.00	06700 OCCUPATIONAL THERAPY	976	1, 582	230	o	494	67. 00
68.00	06800 SPEECH PATHOLOGY	81	0	O	o	37	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	O	o	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	175	0	O	o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	38	0	O	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 355	0	O	o	0	73. 00
76.00	03140 CARDI OLOGY	0	0	O	o	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	368	1, 132	164	o	5	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	640	8, 513	1, 235	0	400	90. 00
91.00	09100 EMERGENCY	16, 989	22, 298	3, 236	o	6, 414	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	108, 930	171, 609	24, 189	43, 507	39, 765	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	90	1, 842	267	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o	0	192. 00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	109, 020	173, 451	24, 456	43, 507	39, 765	202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1302

				To	12/31/2018	Date/Time Prep 5/24/2019 10:			
Cost Center Description		NURSI NG	CENTRAL	PHARMACY	Subtotal	Intern &	TO dill		
		ADMI NI STRATI ON	SERVICES &			Residents Cost			
			SUPPLY			& Post			
						Stepdown			
						Adjustments			
		13.00	14.00	15. 00	24.00	25. 00			
	GENERAL SERVICE COST CENTERS				,				
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1. 00		
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00		
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00		
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00		
7. 00	00700 OPERATION OF PLANT						7. 00		
9. 00	00900 HOUSEKEEPI NG						9. 00		
10. 00	01000 DI ETARY						10. 00		
11. 00	01100 CAFETERI A						11. 00		
13. 00	01300 NURSING ADMINISTRATION	11, 276					13. 00		
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	27, 701				14. 00		
15. 00	01500 PHARMACY	0	131	23, 934			15. 00		
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				000 440				
30. 00	03000 ADULTS & PEDIATRICS	6, 824	5, 397	296	280, 463	0	30. 00		
EO 00	ANCI LLARY SERVI CE COST CENTERS	F01	2 150	1.4	01 02/	0	FO 00		
50.00	05000 OPERATING ROOM	501	3, 159		91, 926		50.00		
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	461 3, 182	13 61	474 111, 439	0	53. 00 54. 00		
54.00	05700 CT SCAN		3, 182		111, 439	0	54.00		
58.00	1		0	0	0	0	58.00		
59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION		0	0	0	0	59.00		
60.00	06000 LABORATORY		1, 157	0	49, 711	0	60.00		
60. 00	06001 BLOOD LABORATORY		1, 137	0	49, 711	0	60.00		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	62. 00		
65. 00	06500 RESPIRATORY THERAPY		2, 926		25, 346	0	65.00		
65. 01	06501 SLEEP LAB		2, 720	0	23, 340	0	65. 01		
66. 00	06600 PHYSI CAL THERAPY		141	0	66, 157	Ö	66.00		
67. 00	06700 OCCUPATI ONAL THERAPY		11	Ö	8, 623	Ö	67. 00		
68. 00	06800 SPEECH PATHOLOGY		0	0	118	Ö	68. 00		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	2, 152		2, 327	0	71. 00		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	462	0	500	0	72.00		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	_	28, 591	0	73. 00		
76. 00	03140 CARDI OLOGY	o	0	- 1	20,071	0	76. 00		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	49	Ö	5, 532	0	76. 97		
	OUTPATIENT SERVICE COST CENTERS	, -,							
90.00	09000 CLI NI C	305	549	43	40, 373	0	90.00		
91.00	09100 EMERGENCY	3, 646	7, 924	271	135, 922	0	91. 00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00		
	SPECIAL PURPOSE COST CENTERS								
113.00	11300 I NTEREST EXPENSE						113. 00		
118.00		11, 276	27, 701	23, 934	847, 502	0	118. 00		
NONREI MBURSABLE COST CENTERS									
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		8, 406		190. 00		
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00		
200.00	1 1				0		200. 00		
201.00		0	0	0	0		201. 00		
202.00	TOTAL (sum lines 118 through 201)	11, 276	27, 701	23, 934	855, 908	0	202. 00		

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1302

			To 12/31/2018	Date/Time Prepared: 5/24/2019 10:10 am
	Cost Center Description	Total		37 247 2017 10. 10 aiii
		26.00		
	GENERAL SERVICE COST CENTERS	<u> </u>		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7.00	00700 OPERATION OF PLANT			7. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	280, 463		30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATI NG ROOM	91, 926		50.00
53.00	05300 ANESTHESI OLOGY	474		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	111, 439		54. 00
57. 00	05700 CT SCAN	0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		59. 00
60.00	06000 LABORATORY	49, 711		60. 00
60. 01	06001 BLOOD LABORATORY	0		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		62. 00
65. 00	06500 RESPI RATORY THERAPY	25, 346		65. 00
65. 01	06501 SLEEP LAB	0		65. 01
66. 00	06600 PHYSI CAL THERAPY	66, 157		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	8, 623		67. 00
68. 00	06800 SPEECH PATHOLOGY	118		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 327		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	500		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	28, 591		73. 00
76. 00	03140 CARDI OLOGY	0		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	5, 532		76. 97
	OUTPATIENT SERVICE COST CENTERS	40.070		
	09000 CLINIC	40, 373		90.00
91.00	09100 EMERGENCY	135, 922		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
440.00	SPECIAL PURPOSE COST CENTERS			112.00
	11300 I NTEREST EXPENSE	0.47 500		113.00
118. 00		847, 502		118. 00
100.00	NONREI MBURSABLE COST CENTERS	0.407		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 406		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		192. 00
200.00	1 1	0		200. 00
201.00		0 0 0 0		201. 00
202.00	TOTAL (sum lines 118 through 201)	855, 908		202. 00

		IU IILALIII BLACK		ON 45 4000 B		u or rorm cws	
COST A	LLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-1302 P	eri od:	Worksheet B-1	
					rom 01/01/2018		
				1	o 12/31/2018		
						5/24/2019 10:	10 am
		CAPITAL REI	LATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	'	FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE	(DOLLAR VALUE)			(ACCUM. COST)	
			(DOLLAR VALUE)			(ACCOWL COST)	
		FEET)		(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS		•	•			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	36, 130					1.00
		00, 100					1
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	6, 799, 161			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 602	0	652, 539	-4, 656, 790	11, 921, 682	5. 00
7.00	00700 OPERATION OF PLANT	6, 854	0	143, 783	0	1, 211, 676	7. 00
9. 00	00900 HOUSEKEEPI NG	701	l .			319, 523	1
							1
10. 00	01000 DI ETARY	1, 310		103, 435		210, 987	1
11. 00	01100 CAFETERI A	1, 216	0	96, 011	0	127, 893	11. 00
13.00	01300 NURSING ADMINISTRATION	153	0	296, 527	0	544, 496	13.00
	01400 CENTRAL SERVICES & SUPPLY	805		1		235, 196	
		547	l .	-			1
15. 00	01500 PHARMACY	547		1	U	704, 454	15. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS		1	1			1
30.00	03000 ADULTS & PEDIATRICS	5, 948	0	1, 645, 529	0	2, 220, 235	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 651	0	145, 539	0	322, 465	50.00
	05300 ANESTHESI OLOGY	2,031					1
53. 00		_		1	_	25	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 880	0	594, 448	0	1, 303, 184	54.00
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	١		0	o o	1
		1 101			0	_	1
60. 00	06000 LABORATORY	1, 106	1 0	1	0	974, 043	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	d d	0	Ō	62. 00
65. 00	06500 RESPI RATORY THERAPY	419	Ō			637, 124	1
		417					1
65. 01	06501 SLEEP LAB	0	0	1	U	0	
66. 00	06600 PHYSI CAL THERAPY	1, 907	0	283, 735	0	408, 242	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	225	0	86, 291	0	106, 709	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	7, 552		8, 856	1
69. 00	06900 ELECTROCARDI OLOGY			7,002		0,000	1
		0			0		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1 0	1	ol O	19, 190	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4, 120	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	ol c	0	585, 518	73. 00
	03140 CARDI OLOGY	0	Ö	1	o o		1
		1/1		1			1
76. 97	07697 CARDI AC REHABI LI TATI ON	161		30, 964	0	40, 227	76. 97
	OUTPATIENT SERVICE COST CENTERS	,					1
90.00	09000 CLI NI C	1, 211	0	32, 978	0	69, 959	90.00
91.00	09100 EMERGENCY	3, 172	0	2, 010, 471	0	1, 857, 721	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1					92.00
72.00	SPECIAL PURPOSE COST CENTERS		l				72.00
			1				4
113.00	11300 NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	35, 868	0	6, 799, 161	-4, 656, 790	11, 911, 843	118. 00
	NONREI MBURSABLE COST CENTERS						1
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	262	0	C	0	0 830	190. 00
		202		-			
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	1	0	U	192. 00
200.00	, ,						200. 00
201.00	Negative Cost Centers			1			201.00
202.00	Cost to be allocated (per Wkst. B,	855, 908	0	1, 174, 067	1	4, 656, 790	202 00
50	Part I)		I	', ', ', ', ',		1, 555, , , 6	
202 00		22 (00/7/	0 000000	0 170/70		0.200415	202 00
203.00		23. 689676	0. 000000	0. 172678	1	0. 390615	
204.00	Cost to be allocated (per Wkst. B,			0	1	109, 020	204. 00
	Part II)]		1			
205.00	Unit cost multiplier (Wkst. B, Part	1		0.000000)	0. 009145	205.00
206 00		1					206 00
206. 00		1					206. 00
0.5-	(per Wkst. B-2)	1					
207.00		1					207. 00
	Parts III and IV)						

| Period: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1302

				To	12/31/2018		
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	5/24/2019 10: NURSI NG	10 am
		PLANT	(SQUARE	(TOTAL PATIENT		ADMI NI STRATI ON	
		(SQUARE	FEET)	DAYS)		(5751.0)	
		FEET) 7. 00	9. 00	10.00	11. 00	(FTE' S) 13. 00	
	GENERAL SERVICE COST CENTERS	7.00	7.00	10.00	11.00	13.00	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	24, 674					5. 00 7. 00
	00900 HOUSEKEEPI NG	701	23, 973				9.00
	01000 DI ETARY	1, 310					10.00
11. 00	01100 CAFETERI A	1, 216	1, 216	0	7, 564		11. 00
	01300 NURSING ADMINISTRATION	153	153		274	2, 811	13. 00
	01400 CENTRAL SERVICES & SUPPLY	805			0		14.00
	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	547	547	0	0	0	15. 00
	03000 ADULTS & PEDIATRICS	5, 948	5, 948	961	2, 920	1, 701	30.00
	ANCILLARY SERVICE COST CENTERS			,	,	,	
	05000 OPERATING ROOM	2, 651	2, 651		221	125	ł
	05300 ANESTHESI OLOGY	0	0	-	0	1	53. 00
	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	2, 880	2, 880 0	1	926 0	0	54. 00 57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	Ö	o o	0	1	59. 00
60.00	06000 LABORATORY	1, 106	1, 106	0	864	0	60. 00
	06001 BLOOD LABORATORY	0	0		0		60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0		62.00
	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	419	419 0	1	627 0	0	65. 00 65. 01
	06600 PHYSI CAL THERAPY	1, 907	1, 907	-	334	0	66.00
	06700 OCCUPATI ONAL THERAPY	225	225		94	Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	7	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATTENTS	0	0		0	0	73.00
	03140 CARDI OLOGY	0	Ö		0	Ö	76. 00
	07697 CARDIAC REHABILITATION	161	161	0	1	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	T		т _т			
	09000 CLI NI C	1, 211	1, 211		76	l	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 172	3, 172	0	1, 220	909	91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 I NTEREST EXPENSE						113. 00
118. 00		24, 412	23, 711	961	7, 564	2, 811	118. 00
	NONREI MBURSABLE COST CENTERS	2/2	2/2		0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	262	262 0		0	1	190. 00 192. 00
200.00	Cross Foot Adjustments	0		,	O	l	200. 00
201.00							201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 684, 975	492, 204	409, 757	285, 856	781, 128	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	68. 289495			37. 791645	l	
204. 00	Cost to be allocated (per Wkst. B, Part II)	173, 451	24, 456	43, 507	39, 765	11, 276	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	7. 029707	1. 020148	45. 272633	5. 257139	4. 011384	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	<pre>(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,</pre>						207. 00
	Parts III and IV)						

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1302 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/24/2019 10:10 am Cost Center Description CENTRAL PHARMACY SERVICES & (COSTED SUPPLY REQUIS.) (COSTED REQUIS.) 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00900 HOUSEKEEPI NG 9 00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 247,040 14.00 15.00 01500 PHARMACY 1, 164 603, 073 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 48, 133 7, 453 30 00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 28, 176 343 50.00 05300 ANESTHESI OLOGY 53 00 4 115 318 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 28, 378 1, 537 54.00 57.00 05700 CT SCAN 57.00 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 0 59 00 60.00 06000 LABORATORY 10, 317 0 60.00 06001 BLOOD LABORATORY 60.01 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06500 RESPIRATORY THERAPY 26, 093 0 65.00 65 00 65.01 06501 SLEEP LAB 0 65.01 06600 PHYSI CAL THERAPY 66.00 1, 260 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 100 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 19, 190 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 72.00 72.00 4, 120 0 73 00 0 585, 518 73 00 03140 CARDI OLOGY 76.00 76.00 07697 CARDIAC REHABILITATION 76. 97 434 0 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4.898 1.072 90.00 91.00 09100 EMERGENCY 70,660 6,832 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 247, 038 603, 073 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 398, 568 1,030,087 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1.613374 1.708064 203.00 Cost to be allocated (per Wkst. B, 204.00 27, 701 204.00 23, 934 Part II) 0.039687 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.112132 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/24/2019 10:	pared: 10 am
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3.00	4. 00	5. 00	

Total Cost				11111	AVIII	nospi tai		
CFrom Wisst. B, Part I, col. 26) 2.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 3.00 4.00 5.00 3.00								
NPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		Cost Center Description			Total Costs		Total Costs	
NPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00				Adj .		Di sal I owance		
INPATI ENT ROUTINE SERVICE COST CENTERS 4, 698, 980 4, 698, 980 0 0 0 0 0 0 0 0 0								
IMPATIENT ROUTINE SERVICE COST CENTERS 3,698,980 4,698,980 0 0 0 30.00								
30.00 03000 ADULTS & PEDIATRICS			1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			_					1
50, 00 05000 OPERATI NC ROOM 773, 020 773, 020 0 0 50, 00 53 00 05300 ANESTHESI OLOGY 7, 217 7, 217 0 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 2, 151, 436 2, 151, 436 0 0 0 0 54 00 55 00 0 0 0 0 0 0	30. 00		4, 698, 980)	4, 698, 980	0	0	30.00
53. 00 05300 ANESTHESI OLOGY 7, 217 7, 217 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 151, 436 2, 151, 436 0 0 54. 00 55. 00 05700 CT SCAN 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58. 00 59. 00 05900 CARDIA C CATHETERI ZATI ON 0 0 0 0 58. 00 60. 00 06000 LABORATORY 1, 502, 052 1, 502, 052 0 0 60. 01 60. 01 06001 BLOOD LABORATORY 1, 502, 052 1, 502, 052 0 0 60. 01 60. 01 06001 BLOOD LABORATORY 9, 0 0 0 0 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 989, 003 0 989, 003 0 0 65. 00 65. 01 06501 SLEEP LAB 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 751, 744 0 751, 744 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 172, 089 0 172, 089 0 66. 00 68. 00 06800 SPECE PATHOLOGY 12, 580 0 12, 580 0 0 6800 SPECE PATHOLOGY 12, 580 0 12, 580 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 151, 436 0 0 54. 00 0 0 0 0 0 0 0 0 0						0	0	
57. 00 05700 CT SCAN 0 0 0 0 0 0 0 57. 00		1	1	1		0	0	1
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)			2, 151, 436)	2, 151, 436	0	0	
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 59.00			C)	0	0	0	
60. 00 06000 LABORATORY 1,502,052 1,502,052 0 0 60. 00 60. 00 60. 01 60. 01 80.00 LABORATORY 0 0 0 0 0 0 0 0 0			C)	0	0	0	
Color Colo	59. 00		C)	0	0	0	59. 00
62. 00	60.00		1, 502, 052		1, 502, 052	0	0	60.00
65. 00	60. 01	06001 BLOOD LABORATORY	C)	0	0	0	60. 01
65. 01 06501 SLEEP LAB 0 0 0 0 0 0 0 0 0 0 65. 01 66. 00 66.00 66.00 PHYSI CAL THERAPY 751, 744 0 751, 744 0 751, 744 0 0 66. 00	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C)	0	0	0	62. 00
66. 00 06600	65.00	06500 RESPI RATORY THERAPY	989, 003	0	989, 003	0	0	65. 00
67. 00 06700 0CCUPATI ONAL THERAPY 172, 089 0 172, 089 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 12, 580 0 12, 580 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0	65. 01	06501 SLEEP LAB	C	0	0	0	0	65. 01
68. 00 06800 SPEECH PATHOLOGY 12,580 0 12,580 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 57,647 57,647 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 12,376 12,376 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 1,814,333 1,814,333 0 0 73. 00 76. 00 03140 CARDI OLOGY 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 70,979 70,979 0 0 76. 97 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 238,573 238,573 0 0 90. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 489,918 489,918 0 200. 00 Subtotal (see instructions) 17,031,434 0 17,031,434 0 0 200. 00 201. 00 Less Observati on Beds 489,918 489,918 0 201. 00	66.00		751, 744	. 0	751, 744	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 71. 00 771. 00 771. 00 772. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 57, 647 57, 647 0 0 71. 00 72. 00 72. 00 72. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 12, 376 12, 376 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 0 0 0 0 0 0 0 0 0	67.00	06700 OCCUPATI ONAL THERAPY	172, 089	0	172, 089	0	0	67.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 57, 647 57, 647 0 0 0 71. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 7	68. 00	06800 SPEECH PATHOLOGY	12, 580	0	12, 580	0	0	68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 12, 376 12, 376 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 0 0 0 0 0 73. 00 74. 00 0 0 0 0 0 0 74. 00 74. 00 0 0 0 0 0 74. 00 74. 00 0 0 0 0 0 74. 00 74.	69. 00	06900 ELECTROCARDI OLOGY	C		0	0	0	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 1,814,333 1,814,333 0 0 73.00 76. 00 03140 CARDI OLOGY 0 0 0 0 76. 97 07697 CARDI AC REHABILITATION 70,979 70,979 0 0 76.97 90. 00 09100 CLI NI C 238,573 238,573 0 0 91.00 91. 00 09100 BERRGENCY 3,289,487 3,289,487 0 91.00 92. 00 SPECIAL PURPOSE COST CENTERS 92.00 113. 00 SUBTORNA STREET EXPENSE 113.00 200. 00 Subtotal (see instructions) 17,031,434 0 17,031,434 0 201. 00 Less Observation Beds 489,918 489,918 0 201. 00 CARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	57, 647	1	57, 647	0	0	71.00
76. 00 03140 CARDI OLOGY 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 70, 979 70, 979 0 0 76. 97 00 76. 97 00 076. 97 00 076. 97 00 00 00 00 00 00 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12, 376	,	12, 376	0	0	72.00
76. 97 07697 CARDI AC REHABI LI TATI ON 70, 979 70, 979 0 0 0 76. 97 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 238, 573 238, 573 0 0 90. 00 91. 00 91. 00 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART) 489, 918 489, 918 0 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 NTEREST EXPENSE 200. 00 Subtotal (see instructions) 17, 031, 434 0 17, 031, 434 0 0 201. 00 201. 00 Less Observati on Beds 489, 918 489, 918 0 201. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	1, 814, 333		1, 814, 333	0	0	73.00
OUTPATIENT SERVICE COST CENTERS	76.00	03140 CARDI OLOGY	C)	0	0	0	76. 00
90. 00 09000 CLINIC 238, 573 238, 573 0 0 90. 00 91. 00 91. 00 92. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 489, 918 489, 918 0 92. 00 92. 00 92. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 17, 031, 434 0 17, 031, 434 0 0 200. 00 201. 00 Less Observation Beds 489, 918 489, 918 0 201. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	70, 979		70, 979	0	0	76. 97
91. 00 09100 EMERGENCY 3, 289, 487 3, 289, 487 0 0 91. 00 92. 00 9		OUTPATIENT SERVICE COST CENTERS						1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 489, 918 489, 918 0 92. 00	90.00	09000 CLI NI C	238, 573	1	238, 573	0	0	90.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 17,031,434 0 17,031,434 0 0 200.00 201.00 Less Observation Beds 489,918 489,918 0 201.00	91.00	09100 EMERGENCY	3, 289, 487	1	3, 289, 487	0	0	91.00
113.00 1300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 17,031,434 0 17,031,434 0 201.00 Less Observation Beds 489,918 13.00 17,031,434 0 201.00 201	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	489, 918	8	489, 918		0	92.00
200.00 Subtotal (see instructions) 17,031,434 0 17,031,434 0 0 200.00 201.00 Less Observation Beds 489,918 489,918 0 201.00		SPECIAL PURPOSE COST CENTERS		•				1
200.00 Subtotal (see instructions) 17,031,434 0 17,031,434 0 0 200.00 201.00 Less Observation Beds 489,918 489,918 0 201.00	113.00	11300 I NTEREST EXPENSE						113. 00
201.00 Less Observation Beds 489,918 489,918 0 201.00	200.00	Subtotal (see instructions)	17, 031, 434	. 0	17, 031, 434	0		
202.00 Total (see instructions) 16,541,516 0 16,541,516 0 0 202.00	201.00				489, 918		0	201.00
	202.00	Total (see instructions)	16, 541, 516	0	16, 541, 516	0	0	202. 00

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/24/2019 10:	pared: 10 am
		Title	: XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpatient	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	

			Charges	<u> </u>			
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	2, 899, 835		2, 899, 835			30. 00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	18, 950	995, 709			0. 000000	
	300 ANESTHESI OLOGY	1, 236	23, 329			0.000000	
	400 RADI OLOGY-DI AGNOSTI C	292, 878	6, 368, 154	6, 661, 032		0.000000	
	700 CT SCAN	0	0	0	0. 000000	0.000000	
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0. 000000	0.000000	
	900 CARDI AC CATHETERI ZATI ON	0	0	0	0.000000	0.000000	
	000 LABORATORY	629, 977	3, 853, 976	4, 483, 953	0. 334984	0.000000	
	001 BLOOD LABORATORY	0	0	0	0.000000	0.000000	
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	
	500 RESPI RATORY THERAPY	486, 166	1, 007, 216	1, 493, 382	0. 662257	0.000000	65.00
65. 01 06	501 SLEEP LAB	0	0	0	0.000000	0.000000	65. 01
66. 00 06	600 PHYSI CAL THERAPY	245, 559	839, 088	1, 084, 647	0. 693077	0.000000	66. 00
67. 00 06	700 OCCUPATI ONAL THERAPY	92, 764	55, 646	148, 410	1. 159551	0.000000	67. 00
68. 00 06	800 SPEECH PATHOLOGY	13, 684	532	14, 216	0. 884918	0.000000	68. 00
69. 00 06	900 ELECTROCARDI OLOGY	0	0	0	0.000000	0.000000	69. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89	59, 275	59, 364	0. 971077	0.000000	71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENT	0	13, 823	13, 823	0. 895319	0.000000	72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	1, 776, 752	3, 703, 824	5, 480, 576	0. 331048	0.000000	73. 00
76. 00 03	140 CARDI OLOGY	0	0	0	0.000000	0.000000	76. 00
76. 97 07	697 CARDIAC REHABILITATION	0	304, 979	304, 979	0. 232734	0.000000	76. 97
OU.	TPATIENT SERVICE COST CENTERS]
90.00 09	000 CLI NI C	0	1, 247, 274	1, 247, 274	0. 191276	0. 000000	90. 00
91.00 09	100 EMERGENCY	145, 555	13, 024, 208	13, 169, 763	0. 249776	0.000000	91.00
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 570	1, 041, 583	1, 045, 153	0. 468752	0.000000	92.00
SPI	ECIAL PURPOSE COST CENTERS						
113. 00 11	300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	6, 607, 015	32, 538, 616	39, 145, 631			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	6, 607, 015	32, 538, 616	39, 145, 631			202. 00

Health Financial Systems	IU HEALTH BLACKFO	RD HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1302	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/24/2019 10:10 am
		Title XVIII	Hospi tal	Cost
C+ C+	DDC 1+!+			

				5/24/2019 10:10 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
65. 01 06501 SLEEP LAB	0. 000000			65. 01
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 PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03140 CARDI OLOGY	0. 000000			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>			
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1			1

Health Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/24/2019 10:	oared: 10 am
		Ti tl	e XIX	Hospi tal	Cost	
·		·		Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
20 00 03000 ADULTS & DEDLATRICS	4 400 000		4 400 00	0	4 400 000	20.00

					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 698, 980		4, 698, 980	0	4, 698, 980	30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	773, 020		773, 020	0	773, 020	
53. 00	05300 ANESTHESI OLOGY	7, 217		7, 217	0	7, 217	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 151, 436		2, 151, 436	0	2, 151, 436	54. 00
57.00	05700 CT SCAN	0		0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60.00	06000 LABORATORY	1, 502, 052		1, 502, 052	0	1, 502, 052	60.00
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	989, 003	0	989, 003	0	989, 003	65.00
65. 01	06501 SLEEP LAB	0	0	0	0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	751, 744	0	751, 744	0	751, 744	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	172, 089	0	172, 089	0	172, 089	67.00
68. 00	06800 SPEECH PATHOLOGY	12, 580	0	12, 580	0	12, 580	68. 00
69.00	06900 ELECTROCARDI OLOGY	0		0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	57, 647		57, 647	0	57, 647	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12, 376		12, 376	0	12, 376	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 814, 333		1, 814, 333	0	1, 814, 333	73. 00
76.00	03140 CARDI OLOGY	0		0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	70, 979		70, 979	0	70, 979	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	238, 573		238, 573	0	238, 573	90.00
91.00	09100 EMERGENCY	3, 289, 487		3, 289, 487	0	3, 289, 487	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	489, 918		489, 918		489, 918	92. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	17, 031, 434	0	17, 031, 434	0	17, 031, 434	200.00
201.00	Less Observation Beds	489, 918		489, 918		489, 918	201. 00
202.00	Total (see instructions)	16, 541, 516	0	16, 541, 516	0	16, 541, 516	202. 00

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/24/2019 10:	pared: 10 am
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. (+ col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	

			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
I NPATI	IENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2, 899, 835		2, 899, 835			30.00
ANCI LI	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	18, 950	995, 709	1, 014, 659	0. 761852	0.000000	50.00
53.00 05300	ANESTHESI OLOGY	1, 236	23, 329	24, 565	0. 293792	0.000000	53. 00
54.00 05400	RADI OLOGY-DI AGNOSTI C	292, 878	6, 368, 154	6, 661, 032	0. 322988	0.000000	54. 00
57.00 05700	CT SCAN	o	0	0	0. 000000	0.000000	57. 00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	o	0	0	0. 000000	0.000000	58. 00
59.00 05900	CARDI AC CATHETERI ZATI ON	o	0	0	0. 000000	0.000000	59. 00
60.00 06000	LABORATORY	629, 977	3, 853, 976	4, 483, 953	0. 334984	0.000000	60.00
60. 01 06001	BLOOD LABORATORY	0	0	0	0. 000000	0.000000	60. 01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0. 000000	0.000000	62.00
65.00 06500	RESPI RATORY THERAPY	486, 166	1, 007, 216	1, 493, 382	0. 662257	0.000000	65. 00
65. 01 06501	SLEEP LAB	0	0	0	0. 000000	0.000000	65. 01
66.00 06600	PHYSI CAL THERAPY	245, 559	839, 088	1, 084, 647	0. 693077	0.000000	66.00
67.00 06700	OCCUPATI ONAL THERAPY	92, 764	55, 646			0.000000	67.00
68.00 06800	SPEECH PATHOLOGY	13, 684	532	14, 216	0. 884918	0.000000	68. 00
69.00 06900	ELECTROCARDI OLOGY	o	0	l	0. 000000	0.000000	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	89	59, 275	59, 364		0.000000	71. 00
	IMPL. DEV. CHARGED TO PATIENT	0	13, 823			0.000000	72. 00
	DRUGS CHARGED TO PATIENTS	1, 776, 752	3, 703, 824			0.000000	
	CARDI OLOGY	0	0	0	0. 000000	0.000000	
	CARDI AC REHABI LI TATI ON	o	304, 979	304, 979		0.000000	
	TIENT SERVICE COST CENTERS						
90.00 09000		0	1, 247, 274	1, 247, 274	0. 191276	0.000000	90.00
	EMERGENCY	145, 555	13, 024, 208			0. 000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	3, 570	1, 041, 583			0. 000000	
	AL PURPOSE COST CENTERS	2,0.0	., , 000	., ., ., .,	2: :37,02	21 22 3000	1
	INTEREST EXPENSE						113. 00
	Subtotal (see instructions)	6, 607, 015	32, 538, 616	39, 145, 631			200.00
	Less Observation Beds	2,00,70.0	12, 000, 0.0	21,110,001			201. 00
202. 00	Total (see instructions)	6, 607, 015	32, 538, 616	39, 145, 631			202. 00
202.00	rotal (see riisti deti olis)	0,007,015	32, 330, 010	37, 143, 031			1202.00

Health Financial Systems	IU HEALTH BLACKF	ORD HOSPITAL	In Lie	u of Form CMS-25	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1302	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepa 5/24/2019 10:10	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio				
	11.00				

Cost Center Description PPS Inpatient	
Rati o	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS	30.00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0. 000000	50.00
53. 00 05300 ANESTHESI OLOGY 0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000	54.00
57. 00 05700 CT SCAN 0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000	59. 00
60. 00 06000 LABORATORY 0. 000000	60.00
60. 01 06001 BLOOD LABORATORY 0. 000000	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000	62. 00
65. 00 06500 RESPI RATORY THERAPY 0. 000000	65. 00
65. 01 06501 SLEEP LAB 0. 000000	65. 01
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 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000	73. 00
76. 00 03140 CARDI 0LOGY 0. 000000	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0. 000000	90. 00
91. 00 09100 EMERGENCY 0. 000000	91. 00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000	92. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE	113. 00
200.00 Subtotal (see instructions)	200. 00
201.00 Less Observation Beds	201.00
202.00 Total (see instructions)	202. 00

Heal th Fi	nancial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL		L COSTS	Provi der C		Peri od:	Worksheet D	
					From 01/01/2018 To 12/31/2018		nared·
						5/24/2019 10:	10 am
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost		to Charges	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	
	CILLARY SERVICE COST CENTERS		T	T	- T		
	OOO OPERATING ROOM	91, 926				0	
	300 ANESTHESI OLOGY	474				0	53. 00
	400 RADI OLOGY-DI AGNOSTI C	111, 439	6, 661, 032				54. 00
	700 CT SCAN	0	0	0. 00000		0	57. 00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000		0	58. 00
	900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59. 00
	000 LABORATORY	49, 711	4, 483, 953			3, 012	60.00
	001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000		0	62. 00
65. 00 06	500 RESPI RATORY THERAPY	25, 346	1, 493, 382	0. 01697	2 196, 520	3, 335	65. 00
	501 SLEEP LAB	0	0	0.00000	0	0	65. 01
66. 00 06	600 PHYSI CAL THERAPY	66, 157	1, 084, 647	0. 06099	4 33, 815	2, 063	66. 00
67. 00 06	700 OCCUPATI ONAL THERAPY	8, 623	148, 410	0. 05810	9, 669	562	67. 00
68. 00 06	800 SPEECH PATHOLOGY	118	14, 216	0.00830	1 4, 639	39	68. 00
69.00 06	900 ELECTROCARDI OLOGY	0	0	0.00000	0	0	69. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 327	59, 364	0. 03919	9 0	0	71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENT	500	13, 823	0. 03617	2 0	0	72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	28, 591	5, 480, 576	0.00521	7 553, 455	2, 887	73. 00
76. 00 03	140 CARDI OLOGY	0	0	0.00000	0	0	76. 00
76. 97 07	697 CARDIAC REHABILITATION	5, 532	304, 979	0. 01813	9 0	0	76. 97
OU	TPATIENT SERVICE COST CENTERS						
90.00 09	000 CLI NI C	40, 373	1, 247, 274	0. 03236	9 0	0	90.00
91.00 09	100 EMERGENCY	135, 922	13, 169, 763	0. 01032	1 0	0	91.00
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)	29, 241	1, 045, 153	0. 02797	8 0	0	92.00
200.00	Total (lines 50 through 199)	596, 280	36, 245, 796		1, 204, 117	14, 145	200. 00

THROUGH COSTS

			1	0 12/31/2018	5/24/2019 10:	
		Ti tl e	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65. 00
65. 01 06501 SLEEP LAB	0	0	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00 03140 CARDI OLOGY	0	0	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
91. 00 09100 EMERGENCY	0	0	0	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0)	0		0	92. 00
200.00 Total (lines 50 through 199)	0) O	1 0	0	0	200. 00

Health Financial Systems	RD HOSPITAL	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1302	Peri od:	Worksheet D

From 01/01/2018 Part IV
To 12/31/2018 Date/Time Prepared: THROUGH COSTS 5/24/2019 10:10 am Title XVIII Hospi tal Cost All Other Total Cost Ratio of Cost Cost Center Description Total Total Charges to Charges (from Wkst. C, Medi cal (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) and 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 014, 659 0.000000 50.00 53. 00 | 05300 | ANESTHESI OLOGY 24, 565 0.00000053.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 6, 661, 032 0.000000 54.00 54.00 05700 CT SCAN 0 0 0.000000 57.00 57.00 OI 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0.000000 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0.000000 59.00 60.00 06000 LABORATORY 0 4, 483, 953 0.000000 60.00 0 0 06001 BLOOD LABORATORY 0.000000 60 01 60 01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 1, 493, 382 0.000000 65.00 0 0.000000 65.01 06501 SLEEP LAB 65.01 06600 PHYSI CAL THERAPY 0 1, 084, 647 0.000000 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 148, 410 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 14, 216 68.00 06900 ELECTROCARDI OLOGY 69.00 69 00 0.000000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 59, 364 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 13, 823 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 5, 480, 576 0.000000 73.00 03140 CARDI OLOGY 0 76.00 Ω 0.000000 76 00 07697 CARDIAC REHABILITATION 76.97 0 0 0 304, 979 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 1, 247, 274 0.000000 90.00 0 0 0 13, 169, 763 91. 00 09100 EMERGENCY 0 0 0 0.000000 91.00 92.00 |09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 1, 045, 153 0.000000 92.00

36, 245, 796

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH BLACKFOR	RD HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1302	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2018	
			To 12/31/2018	Date/Time Prepared:
				5/24/2019 10 10 am

THROUGH COSTS				rom 01/01/2018 o 12/31/2018	Part IV Date/Time Pre 5/24/2019 10:	pared: 10 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	0	(0	0	50. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	134, 287	(0	0	54. 00
57. 00 05700 CT SCAN	0. 000000	0	(0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0	(0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	(0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	271, 732	(0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	(0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	(0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	196, 520	(0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0	(0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	33, 815	(0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	9, 669	(0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	4, 639		o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		o	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		ol	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		ol	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	553, 455		ol	0	73. 00
76. 00 03140 CARDI OLOGY	0. 000000	. 0	1 (ol	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	1 (ol	0	76. 97
OUTPATIENT SERVICE COST CENTERS				-,		
90. 00 09000 CLI NI C	0. 000000	0	(0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		ol	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		o	0	92.00
200.00 Total (lines 50 through 199)		1, 204, 117		o o	0	200. 00

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1302 Peri od: Worksheet D From 01/01/2018 Part V 12/31/2018 Date/Time Prepared: 5/24/2019 10:10 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 761852 366, 677 0 50.00 53.00 05300 ANESTHESI OLOGY 0. 293792 10, 628 0 0 0 0 0 0 0 0 0 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 322988 2, 015, 282 0 54 00 0 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0.000000 0 0 59.00 06000 LABORATORY 0. 334984 0 60.00 1, 116, 362 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 0 0 62.00 06500 RESPIRATORY THERAPY 0 662257 414, 592 65 00 65 00 0 06501 SLEEP LAB 65.01 0.000000 0 65.01 66.00 06600 PHYSI CAL THERAPY 0.693077 343, 186 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 1.159551 67.00 21.861 0 68.00 06800 SPEECH PATHOLOGY 0.884918 266 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.000000 C 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 971077 15, 178 0 71.00 71.00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 0.895319 0 8, 675 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.331048 1, 794, 110 262 0 73.00 76.00 03140 CARDI OLOGY 0.000000 0 0 0 76.00 07697 CARDIAC REHABILITATION 0 0 76. 97 76.97 0. 232734 0 161, 206 OUTPATIENT SERVICE COST CENTERS 90 00 90.00 09000 CLINIC 0.191276 0 511, 917 0 91.00 09100 EMERGENCY 0. 249776 0 3, 020, 084 480 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.468752 377, 311 0 Subtotal (see instructions) 0 10, 177, 335 0 200. 00 200.00 742 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 10, 177, 335 0 202.00

742

Health Financial Systems	RD HOSPITAL	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1302	Peri od: From 01/01/2018	Worksheet D

From 01/01/2018 Part v To 12/31/2018 Date/Time Prepared: 5/24/2019 10:10 am Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 279, 354 50.00 53.00 05300 ANESTHESI OLOGY 3, 122 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 650, 912 0 54.00 05700 CT SCAN 0 57.00 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 0 60.00 373, 963 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 0 06500 RESPIRATORY THERAPY 65 00 274, 566 65 00 65.01 06501 SLEEP LAB 65.01 66.00 06600 PHYSI CAL THERAPY 237, 854 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 25, 349 67.00 0 06800 SPEECH PATHOLOGY 68.00 235 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 14, 739 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 7, 767 0 72.00 07300 DRUGS CHARGED TO PATIENTS 593, 937 87 73.00 73.00 76.00 03140 CARDI OLOGY 0 76.00 76. 97 07697 CARDIAC REHABILITATION 37, 518 0 76. 97 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 97, 917 91.00 09100 EMERGENCY 754, 345 120 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 176, 865 92.00 200. 00 200.00 Subtotal (see instructions) 3, 528, 443 207 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges 202.00 Net Charges (line 200 - line 201) 3, 528, 443 207 202.00

Health Financial Systems	IU HEALTH BLACKFO	RD HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1302	Peri od:	Worksheet D

Part V Date/Time Prepared: From 01/01/2018 To 12/31/2018 Component CCN: 15-Z302 5/24/2019 10:10 am Title XVIII Swing Beds - SNF Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 761852 0 50.00 53.00 05300 ANESTHESI OLOGY 0. 293792 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 322988 0 0 54 00 0 0 0 57.00 05700 CT SCAN 0.000000 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 0 0 59.00 0 06000 LABORATORY 0. 334984 0 60.00 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 62.00 0 62.00 06500 RESPIRATORY THERAPY 0. 662257 0 65 00 65 00 0 06501 SLEEP LAB 65.01 0.000000 0 65.01 66.00 06600 PHYSI CAL THERAPY 0.693077 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 1. 159551 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0.884918 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 971077 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0.895319 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0.331048 0 73.00 73.00 0 76.00 03140 CARDI OLOGY 0.000000 0 0 76.00 07697 CARDIAC REHABILITATION 0. 232734 0 0 0 0 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.191276 0 0 0 0 91.00 09100 EMERGENCY 0. 249776 0 0 0 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.468752 0 0 0 200.00 200.00 Subtotal (see instructions) 0 0 Less PBP Clinic Lab. Services-Program 201.00 201.00

0

0 202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	IU HEALTH BLA	ACKFOR	D HOSPITAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COS	T	Provider Co	CN: 15-1302	Perio	od:	Worksheet D	
						01/01/2018		
			Component (CCN: 15-Z302	To	12/31/2018	Date/Time Pre	
							5/24/2019 10:	10 am_
	_		Title	XVIII	Swi ng	Beds - SNF	Cost	
		Costs						
Cost Center Description	Cost		Cost					

					12, 21, 21,	5/24/2019 10:	10 am
			Titl∈	XVIII	Swing Beds - SNF	Cost	
	·	Cos	sts				
	Cost Center Description	Cost	Cost	1			
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	0)			50. 00
	05300 ANESTHESI OLOGY	0	0)			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00	05700 CT SCAN	0	0				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0)			59. 00
60.00	06000 LABORATORY	0	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65.00	06500 RESPI RATORY THERAPY	0	0				65. 00
65. 01	06501 SLEEP LAB	0	0				65. 01
66.00	06600 PHYSI CAL THERAPY	0	0				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	O				67. 00
68.00	06800 SPEECH PATHOLOGY	0	0				68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	Ö				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
76.00	03140 CARDI OLOGY	0	Ö				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	Ö				76. 97
	OUTPATIENT SERVICE COST CENTERS			•			1
90.00	09000 CLI NI C	0	C				90.00
91.00	09100 EMERGENCY	0	Ö				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
200.00		0	O				200. 00
201.00		0					201.00
	Only Charges						
202.00		0	O)			202. 00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1302	Peri od: From 01/01/2018	
		To 12/31/2018	Date/Time Prepared: 5/24/2019 10:10 am
	Title XVIII	Hospi tal	Cost

		T: +1 o V/////	Hooni tol	5/24/2019 10:	10 am
	Cost Center Description	Title XVIII	Hospi tal	Cost	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	oveluding newbern)		2, 448	1. 00
2. 00	Inpatient days (including private room days and swing-bed days) Inpatient days (including private room days, excluding swing-b			1, 188	2.00
3. 00	Private room days (excluding swing-bed and observation bed day		ivate room davs.	0	3.00
0.00	do not complete this line.	p.	. varo i com dayo,		0.00
4.00	Semi-private room days (excluding swing-bed and observation be			961	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	972	5. 00
	reporting period	om daya) after December	21 of the cost		/ 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember	31 OF the Cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	288	7. 00
	reporting period	3 , 3			
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			700	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	703	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private r	oom days)	972	10.00
	through December 31 of the cost reporting period (see instruct				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	confy (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room davs)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	129. 14	19. 00
17.00	reporting period	s through becember 31 or	the cost	127. 14	1 7. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions			4, 698, 980	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	4, 696, 960	22.00
22.00	5 x line 17)		9 po ou (22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	21 of the cost reporti	na nominal (lina	37, 192	24.00
24.00	7 x line 19)	31 of the cost reporti	ng perrod (Trile	37, 192	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
27.00	x line 20)			2 125 001	27 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2, 135, 001 2, 563, 979	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Tric 21 minus rine 20)		2, 303, 717	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34. 00
35.00					35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 563, 979	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ISTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			2, 158. 24	38. 00
39. 00	Program general inpatient routine service cost per drem (see			1, 517, 243	39.00
40. 00	Medically necessary private room cost applicable to the Progra	•		1, 317, 243	40.00
	Total Program general inpatient routine service cost (line 39	•		1, 517, 243	
			·	•	

Heal th	Financial Systems	IU HEALTH BLACKF	FORD HOSPITAL		In Lie	eu of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST			CN: 15-1302	Period: From 01/01/2018	Worksheet D-1		
				20.01.1	To 12/31/2018	5/24/2019 10:		
	Cost Center Description	Total Inpatient Cost	Total			Program Cost (col. 3 x col.		
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00		
42. 00	NURSERY (title V & XIX only)						42. 00	
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00	
44. 00	CORONARY CARE UNIT						44. 00	
45.00	BURN INTENSIVE CARE UNIT						45. 00	
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00	
47.00	Cost Center Description						47.00	
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Line 200)			1. 00 486, 519	48. 00	
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		2, 003, 762	1	
50. 00	Pass through costs applicable to Program inp	atient routine :	services (from	n Wkst. D, sur	n of Parts I and	0	50. 00	
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (fr	rom Wkst. D, s	sum of Parts II	0	51. 00	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	ding capital re	lated, non-phy	sician anesth	netist, and	0		
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-	
54. 00	Program discharges					0	54. 00	
55. 00	Target amount per discharge					l	55. 00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raot amount (ino 56 minus	lino 52)	0		
58. 00	Bonus payment (see instructions)	ing cost and tai	rget amount (i	THE 30 IIITHUS	111le 33)	0	1	
59. 00								
60. 00	market basket 00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
	If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00	
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target			
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00	
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			o o		
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	na period (See	2, 097, 809	64. 00	
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	3		•	3 1	0		
	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi				, ,			
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	•		, ,	3,	2, 097, 809		
67. 00	(line 12 x line 19)	3			. 3.	0		
69. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)			•	orting period	0	68. 00	
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00	
70. 00	Skilled nursing facility/other nursing facil)		70. 00	
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72. 00 73. 00	
74. 00	Total Program general inpatient routine serv						74. 00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)		costs (from V	Vorksheet B, F	Part II, column		75. 00	
76. 00	Per diem capital related costs (line 75 ÷ li						76.00	
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00	
79. 00	Aggregate charges to beneficiaries for exces		rovi der record	ls)			79. 00	
80.00	Total Program routine service costs for comp		ost limitation	n (line 78 mir	nus line 79)		80.00	
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00	
83. 00	Reasonable inpatient routine service costs (83. 00	
84. 00	Program inpatient ancillary services (see in	structions)					84. 00	
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00	
55.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					I	33.00	
87. 00	Total observation bed days (see instructions)					87. 00	
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (se		iine 2)			2, 158. 23 489, 918		
_ ,. 50	(30)						,	

Health Financial Systems	Ith Financial Systems IU HEALTH BLACKFORD				In Lieu of Form CMS-25		
COMPUTATION OF INPATIENT OPERATING COST	OMPUTATION OF INPATIENT OPERATING COST			Peri od:	Worksheet D-1		
				From 01/01/2018 To 12/31/2018			
		Title	XVIII	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2. 00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	280, 463	4, 698, 980	0. 05968	6 489, 918	29, 241	90.00	
91.00 Nursing School cost	0	4, 698, 980	0.00000	0 489, 918	0	91.00	
92.00 Allied health cost	0	4, 698, 980	0.00000	0 489, 918	0	92.00	
93.00 All other Medical Education	0	4, 698, 980	0. 00000	0 489, 918	0	93. 00	

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1302		Worksheet D-1 Date/Time Prepared: 5/24/2019 10:10 am	
	Title XIX	Hospi tal	Cost	

		Title XIX	Hospi tal	5/24/2019 10: Cost	10 am_
	Cost Center Description	TI LIE XIX	1103pi tai	Cost	
	DADT I ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 448	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 188	
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ad days)		961	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	972	
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through Docombor	21 of the cost	288	7. 00
7.00	reporting period	ii days) tiii dugii beceiibei	31 Of the Cost	200	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3°	1 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 newborn days)	the Program (excluding	swing-bed and	2	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc-				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		n room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frict during private	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
	after December 31 of the cost reporting period (if calendar ye			_	
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	0	
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost		17. 00
10.00	reporting period				10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of 1	tne cost		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	129. 14	19. 00
	reporting period	-			
20. 00	Medical drate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		4, 698, 980	21 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	•
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	and 31 of the cost reporting	na period (line	37, 192	24 00
	7 x line 19)		.g p (,	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			2, 135, 001	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 563, 979	•
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			, ,	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
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	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0.00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost did	fferential (line	2, 563, 979	
	27 minus line 36)	,		, -, ,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			2 150 24	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		2, 158. 24 4, 316	
40. 00	Medically necessary private room cost applicable to the Progra	•		4, 310	
	Total Program general inpatient routine service cost (line 39	•		4, 316	41. 00

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CN: 15-1302	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1	
				VI V		5/24/2019 10:	
	Cost Center Description	Total Inpatient Cost	Total			Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)					3.22	42. 00
40.00	Intensive Care Type Inpatient Hospital Units					ı	40.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGI CAL INTENSI VE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		2, 711 7, 027	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	n of Parts I and	0	50. 00
51. 00	III) Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	,				0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-phy	sician anestl	netist, and	0	53. 00
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	•
	Target amount (line 54 x line 55)	ing cost and to	ract amount (ino E/ minuo	ling E2)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	The 56 III hus	11 ne 53)	0	•
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	updated and co	ompounded by the		
	market basket					0.00	60.00
	0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
(2.00	amount (line 56), otherwise enter zero (see	instructions)					42.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 d	of the cost re	eporting period	0	67. 00
	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			•	orting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil)		70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (I					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line		(lino 14 v li	ne 3E)			72. 00 73. 00
74.00	Medically necessary private room cost applic Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)				Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital -related costs (line 9 x line	•					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi den record	ls)			78. 00 79. 00
80. 00	Total Program routine service costs for comp				nus line 79)		80. 00
	Inpatient routine service cost per diem limi		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		,				84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					227	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			2, 158. 23	1
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				489, 918	89. 00

Health Financial Systems	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CC		Peri od:	Worksheet D-1		
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared: 10 am_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	280, 463	4, 698, 980	0. 05968	6 489, 918	29, 241	90.00
91.00 Nursing School cost	0	4, 698, 980	0.00000	0 489, 918	0	91.00
92.00 Allied health cost	0	4, 698, 980	0.00000	0 489, 918	0	92.00
93.00 All other Medical Education	0	4, 698, 980	0. 00000	0 489, 918	0	93. 00

I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 15-1302	Peri od:	Worksheet D-3	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared: 10 am
		Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
LNE	DATIENT POUTING CERVICE COCT OFNITERS		1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS DOO ADULTS & PEDIATRICS		1	1, 303, 842		20.00
	CILLARY SERVICE COST CENTERS			1, 303, 842		30.00
	OOO OPERATING ROOM		0. 7618	52 0	0	50.00
	300 ANESTHESI OLOGY		0. 2937		0	53.0
	400 RADI OLOGY-DI AGNOSTI C		0. 3229		43, 373	
	700 CT SCAN		0.0000	· ·	0	
58. 00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)		0.0000	00 0	0	58.0
59. 00 059	900 CARDI AC CATHETERI ZATI ON		0.0000	00	0	59.0
	DOO LABORATORY		0. 3349	84 271, 732	91, 026	60.0
50. 01 060	001 BLOOD LABORATORY		0.0000		0	60.0
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	62.0
	500 RESPIRATORY THERAPY		0. 6622	· ·	130, 147	65.0
	501 SLEEP LAB		0.0000		0	65.0
	PHYSI CAL THERAPY		0. 6930		23, 436	
	700 OCCUPATI ONAL THERAPY		1. 1595		11, 212	
	BOO SPEECH PATHOLOGY		0. 8849		4, 105	
	900 ELECTROCARDI OLOGY		0.0000		0	69.0
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 9710		0	71. 0 72. 0
	200 IMPL. DEV. CHARGED TO PATIENT 300 DRUGS CHARGED TO PATIENTS		0. 8953 0. 3310		0 183, 220	
	140 CARDI OLOGY		0. 0000	· ·	163, 220	76.0
	697 CARDI AC REHABI LI TATI ON		0. 0000		0	76. 0
	TPATIENT SERVICE COST CENTERS		0. 2327	34 0	0	70. 9
	DOO CLINIC		0. 1912	76 0	0	90.0
	100 EMERGENCY		0. 2497		0	91.0
	200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4687	- 1	0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)			1, 204, 117	486, 519	
201. 00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 0
202. 00	Net charges (line 200 minus line 201)	,		1, 204, 117		202. 0

					6.5	
Health Financial Systems IU HEALTH BLACKFORI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		ON 15 1202	Peri		u of Form CMS-3 Worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1302		n 01/01/2018	worksneet D-3	
	Component	CCN: 15-Z302	To	12/31/2018	Date/Time Pre	
					5/24/2019 10:	10 am
	Title			ng Beds - SNF		
Cost Center Description		Ratio of Cos	t	Inpati ent	Inpatient	
		To Charges			Program Costs (col. 1 x col.	
				chai ges	2)	
		1.00		2. 00	3, 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				0		30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM		0. 7618		0	0	
53. 00 05300 ANESTHESI OLOGY		0. 29379		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 32298		61, 098	19, 734	54.00
57. 00 05700 CT SCAN		0.00000		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	0	59. 00
60. 00 06000 LABORATORY		0. 33498		190, 618	63, 854	60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	0	62. 00
65. 00 06500 RESPI RATORY THERAPY		0. 6622		157, 627	104, 390	
65. 01 06501 SLEEP LAB		0.00000		0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY		0. 6930		144, 471	100, 130	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		1. 1595		53, 182	61, 667	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 8849		5, 837	5, 165	
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 9710		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS		0.8953		722.750	0	72.00
		0. 33104		722, 750	239, 265	
76. 00 03140 CARDI OLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON		0.00000		0	0	76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS		0. 23273	34	U	0	76.97
90. 00 09000 CLINIC		0. 1912	76	0	0	90.00
91. 00 09100 EMERGENCY		0. 2497		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 46875	-	0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		5007	_	1, 335, 583	594, 205	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	1		0	2, 200	201. 00
202.00 Net charges (line 200 minus line 201)	,			1, 335, 583		202. 00
			'		1	•

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT P	rovider C		Peri od:	Worksheet D-3	;
			From 01/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared:
	Ti tl	e XIX	Hospi tal	Cost	10 aiii
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1		4
30. 00 03000 ADULTS & PEDI ATRI CS			3, 360		30.0
ANCI LLARY SERVI CE COST CENTERS		0.7/405	- 0		1
50. 00 05000 0PERATING ROOM		0. 76185		0	1
53. 00 05300 ANESTHESI OLOGY		0. 29379		0	1 00.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN		0. 32298 0. 00000			
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	1 0
59. 00 05900 MAGNETTC RESUNANCE TWAGTING (WRT)		0.00000		0	
50. 00 06000 LABORATORY		0. 33498		300	
50. 01 06001 BL00D LABORATORY		0. 00000		0	1
52. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	
55. 00 06500 RESPIRATORY THERAPY		0.66225			
55. 01 06501 SLEEP LAB		0.00000		0	
66. 00 06600 PHYSI CAL THERAPY		0. 69307		0	66. (
57. 00 06700 OCCUPATI ONAL THERAPY		1. 15955		0	
58. 00 06800 SPEECH PATHOLOGY		0. 88491		0	1
59. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 97107		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 89531		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 33104		301	
76. 00 03140 CARDI OLOGY		0.00000		0	1
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 23273		0	
OUTPATIENT SERVICE COST CENTERS		0.20270	, . ₁		1 / 0.
PO. 00 09000 CLINIC		0, 19127	76 0	0	90. (
11. 00 09100 EMERGENCY		0. 24977		1, 412	
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 46875		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			9, 395	2, 711	
201.00 Less PBP Clinic Laboratory Services-Program only charges (ine 61)		0		201.
Net charges (line 200 minus line 201)	/		9, 395		202. (

Component CCN: 15-2302 From 17/01/2018 Date/Time Preparation Title XIX Swing Beds - SNF Cost Cost		ACKFORD HOSPITAL	ON 45 4000		eu of Form CMS-	
Component CCN: 15-Z302 To	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C				
Title XIX Swing Beds - SNF Cost		Component				pared:
NPATIENT ROUTINE SERVICE COST CENTERS					5/24/2019 10:	10 am
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00		Ti tl				
NAME NAME	Cost Center Description					
NPATI ENT ROUTINE SERVICE COST CENTERS			To Charges			
I. NPATI ENT ROUTI NE SERVI CE COST CENTERS 0 3.00				Charges		
INPATI ENT ROUTINE SERVICE COST CENTERS 0 30 30 30 30 30 30 30			1.00	0.00		
30.00	INDATI ENT DOUTINE CEDVI CE COCT CENTEDO		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS			1			30.00
50.00 05000 OPERATING ROOM 0.761852 0 0 50 50 05300 ANESTHESI DLOGY 0.293792 0 0 53 53 00 05300 ANESTHESI DLOGY 0.5400 RADI OLOGY-DI AGNOSTI C 0.322988 0 0 54 57 00 05700 CT SCAN 0.000000 0 0 57 58 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 58 59 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59 00 00 00 00						30.00
53.00 05300 ANESTHESI OLOGY 0. 293792 0 0 53 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 322988 0 0 54 57.00 05700 CT SCAN 0. 0000000 0 0 57 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 0000000 0 0 58 59.00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0 0 59 60.01 06000 LABORATORY 0. 334984 0 0 60 60.01 06001 BLOOD LABORATORY 0. 000000 0 0 60 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000 0 0 62 65.01 06500 RESPI RATORY THERAPY 0. 662257 0 0 65 65.01 06500 PHYSI CAL THERAPY 0. 693077 0 0 66 65.01 06600 PHYSI CAL THERAPY 0. 693077 0 0 67 68.00 06800 SPEECH PATHOLOGY 0. 884918 <t< td=""><td></td><td></td><td>0 76105</td><td>2 0</td><td></td><td>50.00</td></t<>			0 76105	2 0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.322988 0 0 54 57. 00 05700 CT SCAN 0.000000 0 0 57 58. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59 60. 00 06000 LABORATORY 0.334984 0 0 60 60. 01 BLOOD LABORATORY 0.000000 0 0 60 62. 00 06200 BLOOD LABORATORY 0.000000 0 0 60 62. 00 06200 BLOOD LABORATORY 0.000000 0 0 60 60 62. 00 06200 BLOOD LABORATORY 0.000000 0 0 60 60 60 0 0 0 60 60 60 0 0 0 60 60 60 0 0 0 60 60 60 0 0 0 66 65 0 0 0 66 65 0 0 0 0 66 65 65 0 0					_	
57. 00 05700 CT SCAN 0.000000 0 0 57 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 58 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 58 60. 01 06000 LABORATORY 0.334984 0 0 60 60. 01 06001 BLOOD LABORATORY 0.000000 0 0 60 62. 00 062200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 62 65. 01 06500 RESPIRATORY THERAPY 0.662257 0 0 65 65. 01 06501 SLEEP LAB 0.000000 0 0 65 66. 01 06600 PHYSI CAL THERAPY 0.693077 0 0 66 67. 00 06700 OCCUPATI ONAL THERAPY 1.159551 0 0 67 68. 00 08800 SPECCH PATHOLOGY 0.884918 0 0 68 69. 00 06900 ELECTROCARDI OLOGY 0.895319 0						1
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0.000000 0 0 58 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59 60. 00 06000 LABORATORY 0.000000 0 0 60 60. 01 06001 BLOOD LABORATORY 0.000000 0 0 60 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 62 65. 00 06500 RESPI RATORY THERAPY 0.662257 0 0 65 65. 01 06501 SLEEP LAB 0.000000 0 0 65 66. 00 06600 PHYSI CAL THERAPY 0.693077 0 0 66 67. 00 06700 OCCUPATI ONAL THERAPY 1.159551 0 0 67 68. 00 06800 SPEECH PATHOLOGY 0.884918 0 0 68 69. 00 O6900 ELECTROCARDI OLOGY 0.000000 0 0						
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59 60. 00 06000 LABORATORY 0.334984 0 0 60 60. 01 06001 BLOOD LABORATORY 0.000000 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 60 65. 00 06500 RESPI RATORY THERAPY 0.662257 0 0 65 65. 01 06501 SLEEP LAB 0.000000 0 0 65 66. 00 06600 PHYSI CAL THERAPY 0.693077 0 0 66 67. 00 06700 OCCUPATI ONAL THERAPY 1.159551 0 0 66 68. 00 06800 SPECCH PATHOLOGY 1.159551 0 0 67 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 68 69. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.971077 0 71 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.331048 0 0 72 76. 97 07697 CARDI AC REHABI LI TATI ON 0.232734 0					_	1
60. 00 06000 LABORATORY						
60. 01 06001 BLOOD LABORATORY 0.000000 0 0 60			1		Ō	
65. 00			1		0	60. 01
65. 01 06501 SLEEP LAB 0.000000 0 0 65 66. 00 06600 PHYSI CAL THERAPY 0.693077 0 0 66 67. 00 06700 OCCUPATI ONAL THERAPY 1.159551 0 0 67 68. 00 06800 SPEECH PATHOLOGY 0.884918 0 0 68 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.971077 0 0 71 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.895319 0 0 72 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.331048 0 0 73 76. 00 03140 CARDI OLOGY 0.000000 0 0 76 76. 97 OT697 CARDI AC REHABI LI TATI ON 0.232734 0 0 76 90. 00 09000 CLI NI C 0.191276 0 0 90 91. 00 09100 EMERGENCY 0.249776 0 0 91 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.468752 0 0 92 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.468752 0 0 92 93. 00 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	0 0	0	62.00
66. 00 06600 PHYSI CAL THERAPY 0.693077 0 0 66 67. 00 06700 OCCUPATI ONAL THERAPY 1.159551 0 0 67 68. 00 06800 SPECH PATHOLOGY 0.884918 0 0 68 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69 671. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.971077 0 0 71 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.895319 0 0 72 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.331048 0 0 73 76. 00 03140 CARDI OLOGY 0.000000 0 0 0 76 76. 97 07697 CARDI AC REHABI LI TATI ON 0.232734 0 0 76 90. 00 09000 CLI NI C 0.191276 0 0 90 91. 00 09100 EMERGENCY 0.249776 0 0 91 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.468752 0 0 92	65. 00 06500 RESPI RATORY THERAPY		0. 66225	7 0	0	65.00
67. 00 06700 OCCUPATIONAL THERAPY	65. 01 06501 SLEEP LAB		0.00000	0 0	0	65. 01
68. 00 06800 SPEECH PATHOLOGY 0. 884918 0 0 68 69. 00 06900 ELECTROCARDI OLOGY 0. 0000000 0 0 0 69 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 971077 0 0 71 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0. 895319 0 0 72 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 331048 0 0 73 76. 00 03140 CARDI OLOGY 0. 000000 0 0 76 76. 00 07400 CARDI AC REHABI LI TATI ON 0. 232734 0 0 76 77. 00 09000 CLI NI C 0. 191276 0 0 91 91. 00 09100 EMERGENCY 0. 249776 0 0 91 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 468752 0 0 92			0. 69307	7 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.971077 0 0 71 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.895319 0 0 72 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.331048 0 0 73 76. 00 03140 CARDI OLOGY 0.000000 0 0 76 77. 00 07407 CARDI AC REHABI LI TATI ON 0.232734 0 0 76 10 00 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0	67. 00 06700 OCCUPATI ONAL THERAPY		1. 15955	1 0	0	67. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 971077 0 0 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0. 895319 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 331048 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 331048 0 0 73. 00 07400 CARDI OLOGY 0. 000000 0 0 76. 00 07697 CARDI AC REHABI LI TATI ON 0. 232734 0 0 76. 00 07400 CLI NI C 0. 000000 CLI NI C 0. 191276 0 0 091. 00 09100 EMERGENCY 0. 249776 0 0 91. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0. 468752 0 0 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART)					0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT			1		0	07.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 331048 0 0 73 76. 00 03140 CARDI OLOGY 0. 000000 0 0 76 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 232734 0 0 76 0. 07997 CARDI AC REHABI LI TATI ON 0. 232734 0 0 0 76 0. 09000 CLI NI C 0 09100 EMERGENCY 0. 249776 0 0 91 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 468752 0 0 92			1		0	1 , 00
76. 00					0	72. 00
76. 97 O 7697 CARDI AC REHABI LI TATI ON O. 232734 O O 76 OUTPATI ENT SERVI CE COST CENTERS 90. 00 O 9000 CLI NI C O O 0 0 91 91. 00 O 9100 EMERGENCY O. 249776 O O 92 92. 00 O 9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) O . 468752 O O 92					0	73. 00
OUTPATIENT SERVICE COST CENTERS			1		_	70.00
90. 00			0. 23273	4 0	0	76. 97
91. 00 09100 EMERGENCY 0. 249776 0 91 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 468752 0 0 92					1	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.468752 0 92						
					_	
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (sum of lines 50 through 94 and 96 through 98	1)	0. 46875		_	92.00

92.00 | 09200 | SERVATION BEDS (NON-DISTINCT PART)
200.00 | Total (sum of lines 50 through 94 and 96 through 98)
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 | Net charges (line 200 minus line 201)

0 91.00 0 92.00 0 200.00 201.00 202.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1302	Peri od: Worksheet E From 01/01/2018 Part B To 12/31/2018 Date/Ti me Prepared: 5/24/2019 10:10 am

			10 12/31/2018	5/24/2019 10:	
		Title XVIII	Hospi tal	Cost	TO dill
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			3, 528, 650	1.0
	Medical and other services (see Fistructions) Medical and other services reimbursed under OPPS (see instruct	tions)		3, 528, 650	1
	OPPS payments			0	1
00	Outlier payment (see instructions)			0	4.0
- 1	Outlier reconciliation amount (see instructions)			0	
	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	1
	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
- 1	Transitional corridor payment (see instructions)			0.00	1
	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	1
0. 00	Organ acqui si ti ons			0	10. (
	Total cost (sum of lines 1 and 10) (see instructions)			3, 528, 650	11. (
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable charges Ancillary service charges			1 0	12. (
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)			1
	Total reasonable charges (sum of lines 12 and 13)	07)		l o	
	Customary charges				
	Aggregate amount actually collected from patients liable for p			0	
5. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e		n a chargebasis	0	16. (
7. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	9)		0. 000000	17.
- 1	Total customary charges (see instructions)			0.000000	1
	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19.
	instructions)				
	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.
	instructions) Lesser of cost or charges (see instructions)			3, 563, 937	21.
	Interns and residents (see instructions)			3, 303, 737	1
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	->		20 427	ا مد
	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	•	uctions)	29, 427 1, 793, 466	1
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			1, 741, 044	
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
- 1	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.
1	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 741, 044 176	1
	Subtotal (line 30 minus line 31)			1, 740, 868	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			1
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			414, 670	1
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	suctions)		269, 536 308, 073	1
	Subtotal (see instructions)	uctions)		2, 010, 404	1
	MSP-LCC reconciliation amount from PS&R			0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions	5)			39.
1	Demonstration payment adjustment amount before sequestration			0	1
	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			2, 010, 404	
	Sequestration adjustment (see instructions)			40, 208	
	Demonstration payment adjustment amount after sequestration			0	1
. 00	Interim payments			2, 103, 293	41.
1	Tentative settlement (for contractors use only)			0	
1	Balance due provider/program (see instructions)	account the CMC Dub 15 2	chantor 1	-133, 097	1
	Protested amounts (nonallowable cost report items) in accordar §115.2	ice with this Pub. 15-2,	спартег Т,	165, 045	44.
Į.	TO BE COMPLETED BY CONTRACTOR			0	90.
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	
). 00 . 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	1
0. 00 1. 00 2. 00	Original outlier amount (see instructions)				92.

Health Financial Systems 1 U HEALT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1302

Solution Settlement to Program Solution Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the dots of the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the dots of the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the dots of the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount (balance due) based on the cost report. (1) Settlement amount						5/24/2019 10: 1	10 am
1.00			Title	XVIII	Hospi tal	Cost	
1.00			Inpatien	it Part A	Par	rt B	
1.00			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
Total interim payments paid to provider 1,765,714 2,043,993 1,00 2,00							
Interfim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or neter a zero.	1. 00	Total interim payments paid to provider					1. 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							
Services rendered in the cost reporting period. If none, write "NONE" or netrer a zero write "NONE" or netrer a zero that separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00						2.00
### WORLER OF enter a zero **NONE** or ente							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 3.50 ADJUSTMENTS TO PROVIDER 3.50 Browled to Program 4.00 0 0 0 0 3.05 Provider to Program 4.00 0 0 0 3.05 Browled to Program 4.00 0 0 0 3.55 3.53 3.54 4.00 0 0 0 0 3.55 3.53 3.54 4.00 0 0 0 0 3.55 3.59 4.00 0 0 3.55 3.50 4.00 0 0 0 3.55 3.50 4.00 0 0 0 3.55 3.50 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 0 3.55 3.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3 00						3 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) NONE" o	0.00						0.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider ADJUSTMENTS TO PROVIDER 08/14/2018 56,400 08/14/2018 59,300 3.01 3.02 3.03 3.03 3.04 3.05 3.06							
ADJUSTMENTS TO PROVIDER				I			
3.02 0	3. 01		08/14/2018	56, 40	08/14/2018	59, 300	3. 01
3.03 0							
3.04				l .	~	- 1	
3.05				•			
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.50 0 0 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.53 3.53 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.59 3.						1	
ADJUSTMENTS TO PROGRAM	3.03	Provider to Program		<u> </u>	J	0	3. 03
3.51 3.52 0	3 50				า	0	3 50
3.52 3.53 3.54 3.99 3.52 3.53 3.54 3.99 3.50-3.98 3.50-3.99 3.50-3.9		ADSOSTMENTS TO TROOTONIN					
3.53 3.54 0 0 0 0 0 3.53 3.54 3.54 0 0 0 0 0 0 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 5.00 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,114 2,103,293 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR					~	1 - 1	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 56,400 59,300 3.59 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,114 2,103,293 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR						1	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3.99 3.9							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,114 2,103,293 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 M1-3 40 minus sum of lines		•		1	
A.00 Total inferim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 77			30, 40	J	37, 300	3. 77
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 5.01 5.02 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 0 5.02 5.03 Provider to Program 5.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 5.59 5.50-5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 5.59 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4 00			1 822 11.	4	2 103 293	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	1. 00			1,022,11	•	2, 100, 270	1. 00
TO BE COMPLETED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER S. 00 S. 02 S. 03 S. 00 S. 0							
5.00				I.			
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5. 00						5. 00
Write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
TENTATI VE TO PROVIDER					•		
5.02 0	5. 01					0	5. 01
Provider to Program						l ol	5. 02
TENTATI VE TO PROGRAM 0	5.03				0	o	5. 03
TENTATI VE TO PROGRAM 0		Provider to Program			•		
5.51	5.50				O	0	5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 0 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 15, 255 133, 097 6. 02 7. 00 Total Medicare program liability (see instructions) 1, 806, 859 1, 970, 196 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 51				o	o	5. 51
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 52				0	o	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines				l ol	5. 99
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		5. 50-5. 98)					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6.00						6.00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 15, 255 133, 097 6.02 1, 806, 859 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01				O	o	6. 01
7.00 Total Medicare program liability (see instructions) 1,806,859 1,970,196 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.02	SETTLEMENT TO PROGRAM		15, 25	5	133, 097	6. 02
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total Medicare program liability (see instructions)		1, 806, 85	9	1, 970, 196	7. 00
Number (Mo/Day/Yr) 0 1.00 2.00							
0 1.00 2.00							
8.00 Name of Contractor 8.00			()			
	8.00	Name of Contractor	<u> </u>				8. 00

Health Financial Systems 10 HE.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		'			5/24/2019 10:	10 am
				wing Beds - SNF		
		Inpatier	it 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		2, 489, 576		0	1. 00
2.00	Interim payments payable on individual bills, either)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)]
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		[C		0	
3.02			C		0	3. 02
3.03			[C		0	3. 03
3.04			C		0	3. 04
3. 05			C		0	3. 05
	Provi der to Program		-	1		
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	
3.52			C		0	
3.53			C		0	3. 53
3.54	Cultural (1: 2 01 2 40 1:		C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		2, 489, 576		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 409, 370		0	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					1
5.00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			"	ļ.	1
5. 01	TENTATI VE TO PROVI DER		C)	0	5. 01
5.02			l c)	0	5. 02
5.03			[c)	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C)	0	5. 51
5. 52			C)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
,	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
/ 01	the cost report. (1)		150.574		0	/ 01
6. 01	SETTLEMENT TO PROVIDER		152, 564			6. 01
6. 02	SETTLEMENT TO PROGRAM		2 4 4 2 4 4 0		0	
7. 00	Total Medicare program liability (see instructions)		2, 642, 140	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor	·		1.00	2.00	8. 00
5. 55	1.10.10	ı		T.	I	1 0.00

Heal th	Financial Systems IU	J HEALTH BLACKFORD HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	From 01/01/2018 To 12/31/2018			Worksheet E-1 Part II Date/Time Pre 5/24/2019 10:	pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD	COST REPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION	AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §	§4102 from Wkst. S-3, Pt. I col. 15 line	14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 su	um 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 su	um 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 line 20			6.00
7. 00	CAH only - The reasonable cost incurred for th line 168	ne purchase of certified 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 instructi	ons)			9. 00
10.00					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & C				
30.00	Initial/interim HIT payment adjustment (see in	nstructions)			30.00
	Other Adjustment (specify)	,			31.00
	21.00 Other hay determine (specify)				

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

30. 00 31. 00 32. 00

Health Financial Systems	IU HEALTH BLACKFOR	RD HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1302	Peri od:	Worksheet E-2
			From 01/01/2018	
		Component CCN: 15-Z302	To 12/31/2018	Date/Time Prepared:

		Component Con. 13-2302		5/24/2019 10:	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	PUTATION OF NET COST OF COVERED SERVICES				
	atient routine services - swing bed-SNF (see instructions)		2, 118, 787	0	
	atient routine services - swing bed-NF (see instructions)				2.
	Ilary services (from Wkst. D-3, col. 3, line 200, for Part		600, 147	0	3.
	t V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
	diem cost for interns and residents not in approved teachi	ing program (see		0. 00	4.
1	tructions)		070	0	
	gram days erns and residents not in approved teaching program (see in	netrueti ene)	972	0	
	ization review - physician compensation - SNF optional met			U	7.
	total (sum of lines 1 through 3 plus lines 6 and 7)	thod only	2, 718, 934	0	1
	nary payer payments (see instructions)		2, 710, 734	0	
	total (line 8 minus line 9)		2, 718, 934	0	1
	uctibles billed to program patients (exclude amounts applic	cable to physician	2, 710, 734	0	1
	fessional services)	cable to physician		Ü	Ί'''
1.	total (line 10 minus line 11)		2, 718, 934	0	12.
1	nsurance billed to program patients (from provider records)) (exclude coinsurance	27, 470	0	1
	physician professional services)		,		
	of Part B costs (line 12 x 80%)			0	14.
5. 00 Subt	total (enter the lesser of line 12 minus line 13, or line 1	14)	2, 691, 464	0	15.
6. 00 OTHE	ER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.
6. 50 Pi or	neer ACO demonstration payment adjustment (see instructions	s)			16.
6. 55 Rura	al community hospital demonstration project (§410A Demonstr	ration) payment	0		16.
adj u	ustment (see instructions)				
	onstration payment adjustment amount before sequestration		0	0	
	owable bad debts (see instructions)		7, 072	0	
1 -	usted reimbursable bad debts (see instructions)		4, 597	0	
1	owable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	
	al (see instructions)		2, 696, 061	0	
	uestration adjustment (see instructions)		53, 921	0	
	onstration payment adjustment amount after sequestration)		0 400 57(0	
1	erim payments		2, 489, 576	0	
4	tative settlement (for contractor use only)	and 21)	152 544	0	
4	ance due provider/program (line 19 minus lines 19.01, 20, a	•	152, 564	0	
	tested amounts (nonallowable cost report items) in accordar oter 1, §115.2	nce with two Pub. 15-2,	87, 690	U	7 23
	Il Community Hospital Demonstration Project (§410A Demonstr	cation) Adjustment			
	this the first year of the current 5-year demonstration per	riod under the 21st			200
	tury Cures Act? Enter "Y" for yes or "N" for no.	Trod drider the 21st			200
	Reimbursement				
	care swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line			201
66 ((title XVIII hospital))				
02.00 Medi	care swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	e		202
200	(title XVIII swing-bed SNF))				
03. 00 Tota	al (sum of lines 201 and 202)				203
04.00 Medi	care swing-bed SNF discharges (see instructions)				204
	outation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonstr	ati on	
peri					۱
	care swing-bed SNF target amount				205
	care swing-bed SNF inpatient routine cost cap (line 205 ti				206
	istment to Medicare Part A Swing-Bed SNF Inpatient Reimburs gram reimbursement under the §410A Demonstration (see instr				1207
1 -	,	•	1		207
I .	care swing-bed SNF inpatient service costs (from Wkst. E-2	z, cor. i, sum of lines	'		208
and		ctions)			209
	ustment to Medicare swing-bed SNF PPS payments (see instruc	CTI Offs)			210
	erved for future use parision of PPS versus Cost Reimbursement				1210
	al adjustment to Medicare swing-bed SNF PPS payment (line 2	200 plus lino 210) (200			215
	ar adjustment to medicale swilly-bed sixt ffs payment (LITE 2	20/ prus rine 210/ (See	1		1210

Health Financial Systems	IU HEALTH BLACKFO	RD HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	- SWING BEDS	Provider CCN: 15-1302	Peri od: From 01/01/2018	Worksheet E-2
		Component CCN: 15-Z302		

		Component Con. 13-2302	10 12/31/2010	5/24/2019 10: 10 am
		Title XIX	Swing Beds - SNF	Cost
	· · · · · · · · · · · · · · · · · · ·		Part A	Part B
			1. 00	2. 00
1	COMPUTATION OF NET COST OF COVERED SERVICES			
- 1	Inpatient routine services - swing bed-SNF (see instructions)		0	1. (
	Inpatient routine services - swing bed-NF (see instructions)		0	2.0
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· · ·	0	3.0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins			
	Per diem cost for interns and residents not in approved teachi	ng program (see	0.00	4.0
- 1	instructions)			
	Program days	notrupti ono)	0	5. (
- 1	Interns and residents not in approved teaching program (see in	•	0	6. (
	Utilization review - physician compensation - SNF optional met	thod only	0	8.0
1	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		0	9. (
1	Subtotal (line 8 minus line 9)		0	10.0
1	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	11. (
	professional services)	cable to physician		11.3
1	Subtotal (line 10 minus line 11)		0	12. (
1	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	0	13. (
	for physician professional services)	, (exe. aue est tieur aitee		
	80% of Part B costs (line 12 x 80%)		0	14. (
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	14)	0	15. (
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•	0	16. (
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		16. 5
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment		16. 5
	adjustment (see instructions)			
16. 99	Demonstration payment adjustment amount before sequestration		0	16. 9
17. 00	Allowable bad debts (see instructions)		0	17. (
- 1	Adjusted reimbursable bad debts (see instructions)		0	17. (
- 1	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	18. 0
- 1	Total (see instructions)		0	19. (
	Sequestration adjustment (see instructions)		0	19. (
	Demonstration payment adjustment amount after sequestration)		0	19. (
1	Interim payments		0	20. (
1	Tentative settlement (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	0	21. (
1	Protested amounts (nonallowable cost report items) in accordan	•	0	23.0
	chapter 1, §115.2	ice with cms rub. 15-2,	0	23. (
H-	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment		
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st		200. (
	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod andor the Elec		200.
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line		201. (
	66 (title XVIII hospital))			
	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	ne	202. (
1	200 (title XVIII swing-bed SNF))			
1	Total (sum of lines 201 and 202)			203. (
	Medicare swing-bed SNF discharges (see instructions)			204. (
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5-year demonst	ration
	peri od)			205 (
	Medicare swing-bed SNF target amount	mas Lina 204)		205. 0 206. 0
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs			200. (
	Program reimbursement under the §410A Demonstration (see instr			207. (
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	•	1	207. (
	and 3)	z, cor. r, sum or rifles	'	200. (
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)		209. (
209 00		J L I OI IJ/	1	· · · · · · · · · · · · · · · · · · ·
				1210 (
210.00	Reserved for future use	·		210. (
210.00		209 plus line 210) (see		210. 0

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1302	From 01/01/2018	Worksheet E-3 Part V Date/Time Prepared: 5/24/2019 10:10 am
	Title XVIII	Hosni tal	Cost

				5/24/2019 10:	10 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			2, 003, 762	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
3.00	Organ acqui si ti on	,		0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			2, 003, 762	4. 00
5.00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 023, 800	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			_,,	
	Reasonable charges				
7.00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	
10.00	Customary charges			0	10.00
11. 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge hasis	0	11. 00
12.00	Amounts that would have been realized from patients liable for			0	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)		ii a charge basi s	O	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	,		0. 000000	13 00
14. 00	Total customary charges (see instructions)			0.000000	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	v if line 14 evceeds li	no 6) (soo	0	
13.00	instructions)	y II IIIIe 14 exceeds II	(366	U	13.00
16. 00	Excess of reasonable cost over customary charges (complete onl	vifline 6 exceeds lin	e 14) (see	0	16. 00
10.00	instructions)	y II IIIle o execeds IIII	0 11) (300	J	10.00
17. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	4011 0113)		J	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4	1 line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	1, 11116 17)		2, 023, 800	
20. 00	Deductibles (exclude professional component)			196, 908	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 826, 892	
23. 00	Coi nsurance			0	
24. 00	Subtotal (line 22 minus line 23)			1, 826, 892	
25. 00	Allowable bad debts (exclude bad debts for professional service	res) (see instructions)		25, 910	
26. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistractions)		16, 842	
27. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		15, 945	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	4611 6113)		1, 843, 734	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 043, 734	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	-)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration	5)		0	
30.00	Subtotal (see instructions)			1, 843, 734	
30. 00	Sequestration adjustment (see instructions)			36, 875	
30. 01	Demonstration payment adjustment amount after sequestration			30, 873	30. 01
30. 02				-	
31.00	Interim payments Tentative settlement (for contractor use only)			1, 822, 114 0	31.00
32.00	Tentative settlement (for contractor use only) Balance due provider/program (line 30 minus lines 30.01, 30.02	2 21 and 22)		-15, 255	
34. 00	Protested amounts (nonallowable cost report items) in accordan		chantar 1		
34.00	§115. 2	ice with two Pub. 15-2,	Chapter I,	65, 246	34.00
	3110.2		l	l	

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

Provider CCN: 15-1302 Period: From 01/0

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/24/2019 10:10 am

——————————————————————————————————————					5/24/2019 10:	10 am_
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4.00	
	CURRENT ASSETS	1			1	
1.00	Cash on hand in banks	4, 774, 511		_	_	1.00
2. 00 3. 00	Temporary i nvestments Notes receivable	0	0	_	0	2. 00 3. 00
4. 00	Accounts receivable	2, 004, 576	1	0	0	4.00
5. 00	Other receivable	-978, 504		o o	ő	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	237, 532	2 0	0	0	7. 00
8. 00	Prepai d expenses	109, 628	1	0	0	8. 00
9.00	Other current assets	0	0	_	0	9.00
10. 00 11. 00	Due from other funds Total current assets (sum of Lines 1 10)	4 147 742	0	_	0	10. 00 11. 00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	6, 147, 743	0	0	0] 11.00
12. 00	Land	190, 324	. 0	0	0	12. 00
13. 00	Land improvements	259, 436		_		13. 00
14.00	Accumulated depreciation	-253, 313	1	0	0	14. 00
15.00	Bui I di ngs	15, 007, 745	0	0	0	15. 00
16. 00	Accumulated depreciation	-8, 858, 275	1	0	0	16. 00
17. 00	Leasehold improvements	0	0	_	0	17. 00
18.00	Accumulated depreciation	0	0	_	0	18.00
19.00	Fixed equipment Accumulated depreciation	0	0	0	0	19.00
20. 00 21. 00	Automobiles and trucks	0		0	0	20.00
22. 00	Accumulated depreciation	0		0	0	22.00
23. 00	Major movable equipment	4, 835, 811	1	0	ő	23. 00
24. 00	Accumulated depreciation	-3, 149, 486	1	Ō	ō	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	_	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0 000 040	0	_	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	8, 032, 242	2 0	0	0	30. 00
31. 00	Investments	1 0	0	0	0	31.00
32. 00	Deposits on Leases		o o	_		32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	0	0	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	0	0	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	14, 179, 985	0	0	0	36. 00
	CURRENT LI ABI LI TI ES		1		1	
37. 00	Accounts payable	751, 646		0	_	37. 00 38. 00
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	514, 942		0	0	39.00
40. 00	Notes and Loans payable (short term)			0	0	40.00
41. 00	Deferred income			0	ő	41.00
42. 00	Accel erated payments	0		_		42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1, 968, 796		0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	3, 235, 384	0	0	0	45. 00
47.00	LONG TERM LIABILITIES	1	J		1 0	1 47 00
46.00	Mortgage payable	0	0	_	_	46. 00 47. 00
47. 00 48. 00	Notes payable Unsecured Loans			_		48.00
49. 00	Other long term liabilities	20, 384		_		49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	20, 384		_		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	3, 255, 768				51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	10, 924, 217				52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0	1	56.00
57.00	Plant fund balance - invested in plant				0 0	57. 00 58. 00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion		1			30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	10, 924, 217	'n	n	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	14, 179, 985		Ö	Ö	60.00
	59)		[

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1302

					To	12/31/2018	Date/Time Pro 5/24/2019 10:	
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		12, 641, 430			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-1, 707, 853 10, 933, 577			0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	10, 733, 377		0	0		
5. 00	, , , , , , , , , , , , , , , , , , ,	O			0		C	
6.00		0			0		C	
7.00		0			0		C	
8. 00 9. 00					0			
10. 00	Total additions (sum of line 4-9)		0		Ŭ	0	1	10.00
11.00	Subtotal (line 3 plus line 10)		10, 933, 577			0		11. 00
12.00	NET INTERCOMPANY TRANSACTIONS	9, 358			0		C	1
13.00	ROUNDI NG	2			0		C	
14. 00 15. 00		0			0		C	
16. 00					0			1
17. 00		0			0		C	17. 00
18. 00	Total deductions (sum of lines 12-17)		9, 360			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10, 924, 217			0		19. 00
	Islieet (Title II IIII lius II lie 10)	Endowment Fund	PI ant	Fund				
1 00	Is a contract to the contract	6. 00	7. 00	8. 00				1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8. 00			0					8.00
9.00]	0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) NET INTERCOMPANY TRANSACTIONS	0	0		0			11. 00 12. 00
13. 00	ROUNDING		0					13.00
14. 00			0					14. 00
15. 00			0					15. 00
16.00			0					16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		0			17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00

Health Financial Systems IU STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1302

		T		Date/Time Pre 5/24/2019 10:		
	Cost Center Description	I npati ent	Outpati ent	Total	10 0	
	·	1.00	2. 00	3. 00		
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	1, 830, 431		1, 830, 431	1. 00	
2.00	SUBPROVIDER - IPF				2. 00	
3.00	SUBPROVI DER - I RF				3. 00	
4.00	SUBPROVI DER				4. 00	
5.00	Swing bed - SNF	1, 069, 404		1, 069, 404	5. 00	
6.00	Swing bed - NF	0		0	6. 00	
7.00	SKILLED NURSING FACILITY				7. 00	
8. 00	NURSING FACILITY				8. 00	
9.00	OTHER LONG TERM CARE				9. 00	
10. 00	Total general inpatient care services (sum of lines 1-9)	2, 899, 835		2, 899, 835	10. 00	
44.00	Intensive Care Type Inpatient Hospital Services				44 00	
11. 00	INTENSIVE CARE UNIT				11. 00	
12.00	CORONARY CARE UNIT				12.00	
13.00	BURN INTENSIVE CARE UNIT				13.00	
	SURGICAL INTENSIVE CARE UNIT				14. 00	
15. 00	OTHER SPECIAL CARE (SPECIFY)	0		0	15. 00	
16. 00	Total intensive care type inpatient hospital services (sum of lines	0		0	16. 00	
17. 00	11-15) Total inpatient routine care services (sum of lines 10 and 16)	2, 899, 835		2, 899, 835	17. 00	
18. 00	Ancillary services	3, 558, 055	17, 225, 552	20, 783, 607	18. 00	
19. 00	Outpatient services	149, 125	15, 313, 065	15, 462, 190		
20. 00	RURAL HEALTH CLINIC	147, 123	13, 313, 003	13, 402, 170	20.00	
	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00	
22. 00	HOME HEALTH AGENCY		٩	O	22. 00	
23. 00	AMBULANCE SERVI CES				23. 00	
24. 00	CMHC				24. 00	
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00	
26. 00	HOSPI CE				26. 00	
27. 00	OTHER (PHYSICIAN REVENUE)	0	1, 570, 266	1, 570, 266	27. 00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	6, 607, 015	34, 108, 883	40, 715, 898		
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		18, 292, 613		29. 00	
30.00	ADD (SPECIFY)	0			30. 00	
31.00		0			31. 00	
32. 00		0			32. 00	
33. 00		0			33. 00	
34. 00		0			34. 00	
35. 00		0			35. 00	
36. 00	Total additions (sum of lines 30-35)	_	0		36. 00	
37. 00	DEDUCT (SPECIFY)	0			37. 00	
38. 00		0			38. 00	
39. 00		0			39. 00	
40.00		0			40.00	
41. 00	T-t-1 d-d-t-t-1 (1: 27 41)	0			41. 00	
42. 00	Total deductions (sum of lines 37-41)	r	10 202 (12		42.00	
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)	'	18, 292, 613		43. 00	
	TO WASE U-S, TITIE 4)	I	ļ		I	

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-2552-10						
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1302	Peri od:	Worksheet G-3		
0	EIN OF REPERIORS AND EAR EMBES		From 01/01/2018			
			To 12/31/2018	Date/Time Prep 5/24/2019 10:		
				372472017 10.	TO alli	
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ie 28)		40, 715, 898	1. 00	
2.00	Less contractual allowances and discounts on patients' accoun			24, 348, 035	2. 00	
3.00	Net patient revenues (line 1 minus line 2)			16, 367, 863	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		18, 292, 613	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)	,		-1, 924, 750	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	Revenue from meals sold to employees and guests			0	14.00	
15. 00	Revenue from rental of living quarters			ol	15. 00	
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		ol	16. 00	
17. 00	Revenue from sale of drugs to other than patients	•		ol	17. 00	
18. 00				ol	18. 00	
19.00	0 Tuition (fees, sale of textbooks, uniforms, etc.)			ol	19. 00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			ol	20. 00	
21. 00	Rental of vending machines			0	21. 00	
22. 00	Rental of hospital space			0	22. 00	
23. 00	Governmental appropriations			0	23. 00	
24. 00	OTHER (MISCELLANEOUS INCOME)			216, 897		
	Total other income (sum of lines 6-24)			216, 897		
	Total (line 5 plus line 25)			-1, 707, 853		
	OTHER EVENUES (SPECIEV)			,,,,,,,		

0 27.00

-1, 707, 853 29. 00

28.00

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

27. 00 OTHER EXPENSES (SPECIFY)