IU HEALTH PAOLI HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1306 Worksheet S Peri od. From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: То 5/28/2019 12:19 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/28/2019 Time: 12:19 pm use only]Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο F 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

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

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

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH PAOLI HOSPITAL (15-1306) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. [X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. MI CHAEL CRAIG (Si aned) Officer or Administrator of Provider(s) CHIEF FINANCIAL OFFICER Title (Dated when report is electronically signed.) Date Title XVIII

	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-165, 599	-2, 093	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-26, 237	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.0) Total	0	-191, 836	-2, 093	0	0	200.00
Tho a	nove amounts represent "due to" or "due from"	the applicable	program for th	a alamant of t	he above comply	av indicated	

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

∍r'i	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTITICATION DA		in ovi d		N: 15-1306	F	Period: From 01/01 To 12/31		Part I Date/T	eet S-2 ime Pre 019 12:	epare
	1.00		00		3.00				4.00	2, 20, 2		
00	Hospital and Hospital Health Care Co Street: 642 WEST HOSPITAL ROAD	mplex Address: PO Box:										1.
	City: PAOLI	State: I	N Z	p Code	e: 474	54 Co	ount	y: ORANGE				2.
		Component Na	ame	CCN umber	CBS Numb	SA Provi	der	Date Certified	Т,	nt Syst 0, or	N)	
		1.00		2.00	3.0	0 4.0	0	5.00	V 6.00	XVIII 7.00		-
	Hospital and Hospital-Based Componen			2.00	3.0	<i>10</i> 4.0	10	5.00	0.00	17.00	0.00	
0	Hospi tal	IU HEALTH PAOLI		51306	999	15 1		07/01/2001	I N	0	Р	3
	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital -Based SNF Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA Separately Certified ASC Hospital -Based Hospice Hospital -Based Hospice	HOSPI TAL	1!	5Z306	999	15		07/01/2007	I N	0	Ν	4 5 6 7 8 9 10 11 12 13 14 15
00 00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other							From	· [Tc).	15 16 17 18 19
								1.00)		00	
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)							01/01/2	2018	12/31	/2018	20
00												
	Inpatient PPS Information					1.00		2.00)	3.	00	
	disproportionate share hospital adjus §412.106? In column 1, enter "Y" foi facility subject to 42 CFR Section §- hospital?) In column 2, enter "Y" foi Did this hospital receive interim una cost reporting period? Enter in colum the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost rep Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob	r yes or "N" for 412.106(c)(2)(Pic r yes or "N" for compensated care mn 1, "Y" for yes riod occurring pr " for no for the er October 1. (se requires final u port settlement? " for no, for the	no. Is thi ckle amendm no. payments f s or "N" for ior to Oct portion of ee instruct uncompensat (see instr	s for thi or no f ober 1 the c ions) ed car ouction of the	s or ost e s)	N		N				22
03	or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for i reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 413	ic reclassificati ds for delineatir olumn 1, "Y" for g period prior to no for the portio er October 1. (se 100 but not more	on from ur ng statisti yes or "N" o October 1 on of the c ee instruct than 499 b	ban to cal ar for n . Ente cost ions) peds (a	eas o r	Ν		N		٦	N	22.
00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	of admission, 2 i of identifying th method used in th	f census one days in the prior co <u>"N" for no</u>	ays, o this c st	r 3 ost			3 N				23
			In-State Medicaid paid days	In-St Medic el i gi unpa day	caid ble aid ys	Out-of State Medicaid paid days	I Me	State edi cai d l i gi bl e unpai d	Medicai HMO da <u>y</u>	ys Me)ther di cai d days	
	If this provider is an IPPS hospital, in-state Medicaid paid days in colum Medicaid eligible unpaid days in colu out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	C	2. (0	3.00	0	<u>4.00</u> 0	5.00	0	<u>6.00</u> (24.

OSPI ⁻	Financial Systems IU HEA AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	LTH PAOLI H	Provider CC	N: 15-1306	Period: From 01/0 To 12/3		Worksh Part I Date/1	<u>rm CMS-</u> neet S-2 ime Pre 2019 12:	2 epared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medi ca HMO da	ys Me	Other edicaid days	_
5.00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.0
	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	Urban/F	ural S		f Geogr	
					1.			00	
6.00 7.00 5.00	Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not was reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	rural. age) status r"2" for ru cation in d	at the end ural. If ap column 2.	l of the cos pplicable,	t	2 2 0			26. 0 27. 0 35. 0
5. 00	effect in the cost reporting period.					0			
					Begi n			i ng: 00	-
5. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subso	cript line	36 for numb		00	۷.	00	36.
7.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		c of period	le MDH etatu	c l	0			37.
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	ne MDH trans	sitional pa	yment in	3	0			37.
	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)	or yes or "I	N" for no.	(see					
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.
	enter subsequent dates.				Y/	N	Y	/N	
	1				1.	00	2.	00	1
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum ts in	in			N	39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Enter	∽"Y" for y					N	40.
						V 1.00	XVIII 2.00	_	-
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	·	·			N	N	N	45. 46.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. II	I and Wkst	. L-1, Pt.	I through				
7.00 3.00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital paymen Teaching Hospitals			2		N N	N N	N N	47. 48.
5.00	Is this a hospital involved in training residents in or "N" for no.				5	N			56.
. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon 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	r yes or "N" th of this ((", complete	' for no in cost report e Worksheet	n column 1. ing period?	lf column ' Enter "Y				57.
8. 00	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement fo	or physicia	ins' service	s as				58.
	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59.
9.00				NAHE 413.8 Y/N	35 Worksh Lin	e #	Qualif	Through ication on Code	
9.00									
9.00	,			1. 00	2.	00	3.	00	60.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TΑ	Provider CC		eriod: com 01/01/2018 o 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/28/2019 12:	pared
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.0
	column 1. (see instructions)						
I. 01	Enter the average number of unweighted primary care						61.0
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						
	instructions)						
I. 02	Enter the current year total unweighted primary care						61.
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
I. 03	Enter the base line FTE count for primary care						61.
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see instructions)						
I. 04	Enter the number of unweighted primary care/or						61.
	surgery allopathic and/or osteopathic FTEs in the						
05	current cost reporting period. (see instructions). Enter the difference between the baseline primary						61.
. 00	and/or general surgery FTEs and the current year's						
	primary care and/or general surgery FTE counts (line						
. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being						61.
	used for cap relief and/or FTEs that are nonprimary						
	care or general surgery. (see instructions)	Dro	arom Namo	Drogram Codo	Unweighted IME	Upwai abtad	
		PIC	ogram Name		5	Direct GME FTE	
						Count	
10	Of the FTFe in Line (1 OF energify each new program		1.00	2.00	3.00	4.00	(1
. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0.00	01.
	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.						
. 20	Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61.
	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.						
				I			
	ACA Descriptions ACCosting the Uselth Description and Co					1.00	
. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which	0.00	62
	your hospital received HRSA PCRE funding (see instruct	ctions)					
2. 01	Enter the number of FTE residents that rotated from a				your hospital	0.00	62.
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			115)			1
3. 00	Has your facility trained residents in nonprovider se	ettings	during this co			N	63.
	"Y" for yes or "N" for no in column 1. If yes, comple	ete line	s 64 through (Datio (ad. 1/	
				Unweighted FTEs		Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te			-
				4 . 0.0		3.00	
	Section 5504 of the ACA Rase Vear ETE Pacidents in Ma	opprovid	ler Settings	1.00 This base year	2.00		
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			1			
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit	r <u>e June</u> ty train	30, 2010. ed residents	1	is your cost r	eporting	64.
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor	r <u>e June</u> ty train n-primar	<u>30, 2010.</u> ed residents y care	This base year	is your cost r	eporting	64.
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit	<u>re June</u> ty train n-primar all non	<u>30, 2010.</u> ed residents y care provider	This base year	is your cost r	eporting	64.

SPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provi der	Fr	eriod: om 01/01/2018	Worksheet S-2 Part I	
			To	12/31/2018	Date/Time Pre 5/28/2019 12:	epared
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tai	4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in						
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)			Unweighted	Unwoi aktod	Ratio (col. 1/	
			FTEs	Unweighted FTEs in	(col. 1 + col.)	
			Nonprovi der	Hospi tal	2))	
			Site			4
Section 5504 of the ACA Current	Voar ETE Posidonts i	n Nonnrovidor Sottir	1.00	2.00	3.00	
beginning on or after July 1, 20		n Nonprovider Settin	igsLitective to		ing perious	
Enter in column 2 the number of	unweighted non-prima	rovider settings. ry care resident				
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	al. Enter in column :	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
FTEs that trained in your hospit (column 1 divided by (column 1 +	al. Enter in column column 2)). (see in	ry care resident 3 the ratio of structions)	FTEs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospit (column 1 divided by (column 1 + column 1 divided by (column 1 + experiment 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	al. Enter in column column 2)). (see in: Program Name	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospit (column 1 divided by (column 1 + column 1 divided by (column 1 + experiment of the second second second second second 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	al. Enter in column column 2)). (see in: Program Name	ry care resident 3 the ratio of structions) Program Code	FTEs Nonprovi der Si te 3.00	FTES in Hospital 4.00 0.00	(col. 3 + col. 4)) 5.00 0.000000	_
FTEs that trained in your hospit (column 1 divided by (column 1 + column 1 divided by (column 1 + expected by (column 1 + column 2, the program code. 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)	al. Enter in column : column 2)). (see in Program Name 1.00	ry care resident 3 the ratio of structions) Program Code	FTEs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00 0.000000	_
FTEs that trained in your hospit (column 1 divided by (column 1 + column 1 divided by (column 1 + column 1 divided by (column 1 + column 2, column 2, the program and 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)	al. Enter in column : column 2)). (see in Program Name 1.00 200 200 200 200 200 200 200 200 200	ry care resident 3 the ratio of structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	D 67.1
FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 +)))))))))))))))))))	Al. Enter in column column 2)). (see in Program Name 1.00 1.00 PS ychiatric Facility (the facility have an efore November 15, 20 lumn 2: Did this fac R 412.424 (d)(1)(iii) cate which program ye	ry care resident 3 the ratio of structions) Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 stain an IPF subp ning program in t yes or "N" for m 's in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	- - - - - - - - - - - - - - - - - - -
FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 +) .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) .00 Inpatient Psychiatric Facility F Enter "Y" for yes or "N" for no uf f line 70 is yes: Column 1: Dic recent cost report filed on or to 42 CFR 412. 424(d)(1)(ii)(c)) Cc program in accordance with 42 CF	al. Enter in column column 2)). (see in Program Name 1.00	ry care resident 3 the ratio of structions) Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTËs Nonprovi der Si te 3.00 0.00 intain an IPF subp sing program in t yes or "N" for m s cost reporting	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0 2.00 3.00 0 0 0 2.00 3.00	_

HEBPITAL AND HEBPITAL HAD HEALTH CALL COMPLEX IDENTIFICATION DATA Provider CDD: 15-1305 Period of the complex		HEALTH PAOL	_I_HOSPITAL		. In Lie	u of Form CMS	6-2552-10
Image: The interpretation of the second se	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATIO	N DATA	Provider C	CN: 15-1306			-2
Instruction Instruction Instruction Instruction 00.00 5 this a long term care hospital (LiOP)* Enter "Y" for yes and "W" for no. N 80.00 10.00 5 this a long term care hospital (LiOP)* Enter "Y" for yes or "W" for no. N 80.00 10.00 10.00 10.00 10.00 10.00 N 80.00 10.00 10.00 10.00 10.00 10.00 N 80.00 10.00						Date/Time P	
Description Description N PC 00 is This a long trac carbon fload (LTQU)? Enter "Y Tor yes and "N" for no. N B0.0 B0.0 N B0.0 State (LTQ) N						572872019 1.	<u>2: 19 piii</u>
00.00 is this a long turn care hospital (LTOP)? Enter "Y" for yes and "N" for no. N 80.00 00.01 is this a LOPE c-located within another hospital for part or all of the cost reporting period? Enter N 81.00 00.01 is this a LOPE c-located within another hospital for part or all of the cost reporting period? Enter N 81.00 00.01 is this a LOPE c-located within another hospital for part or all of the cost report is then of the cost report of then. N 85.00 00.01 is this facility vestabilish a new Other subgrowing (excluded unit) under 42 CFR Section N 87.00 01.01 is this facility vestabilish a new Other subgrowing (excluded unit) under 42 CFR Section N 87.00 01.00 best of "V" for no in the applicable column. N N 90.00 01.01 best of "V" for no in the applicable column. N N 92.00 01.01 in part of xill column. N N 92.00 N 92.00 01.02 fill or V and XIX Services "N" for no in the applicable column. N N 92.00 01.01 in part or all of the column. N N 92.00 N 92.00 01.00 fin part or						1.00	
B1:00 Is this a LIDI co-located within another hospital for part or all of the cost reporting period? Enter N B1:00 UN_CONSERVENT Experiod decs Experiod decs N Section Set1.4 (Cost Set1.4		"Y" for ves	and "N" for	no		N	80.00
BEERA Providers Boto Is This a new hospital under 42 CPR Section 5413-40(f)(1)(1) TERA7 Enter "Y" for yes or "N" for no. N 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 86.00 80.00 8	81.00 Is this a LTCH co-located within another hospital	for part of	or all of the	cost reportir	ng period? Enter		
80.00 Is this a new hospital under 42 GPR Section \$413.40(7(1)(1) TEFRA? Enter 'Y' for yes or 'W' for no. 80.00 60 Did this facility establish a new Uther subprovide (excluded unit) under 42 GPR Section 80.00 613.40(7(1)(1)(7) Enter 'Y' for yes and 'W' for no. 80.00 613.40(7(1)(1)(7) Enter 'Y' for yes and 'W' for no. 80.00 613.40(7)(1)(1)(7) Enter 'Y' for yes and 'W' for no. 80.00 60.00 This this facility how file V and/or XIX through the cost report either in N N 90.00 Set his hospital relaburant for Title V and/or XIX through the cost report either in N N 90.00 91.00 Set his hospital relaburant for Title V and/or XIX through the cost report either in N N 90.00 92.00 Set his hospital relaburant for Title V and/or XIX through the cost report either in N N 90.00 91.00 Set his hospital relaburant for Title V and/or XIX through the cost report either in N N 90.00 92.00 Set his hospital in Particities (Cost Particities V and XIX) fitter N N 90.00 92.00 Set his hospital in the applicable column. 0.00 0.00 90.00 93.00 Set his hospital in the reduction percentage in the applicable column. 0.00							_
66.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 9413.40(7)(1)(1): Farmer "Y" for yes on "N" for no. 86.00 77.00 Is this hospital an extended neeplastic disease care hospital classified under section N 87.00 77.00 Is this hospital an extended neeplastic disease care hospital classified under section N 87.00 77.00 Is this hospital an extended neeplastic disease care hospital classified under section N 87.00 77.00 Is this facility have it the V and/or XIX inputient hospital services? Enter "Y" for yes or "N" for no. N Y 90.00 Does this facility have it the V and/or XIX inputient hospital services? Enter "Y" for yes N Y 90.00 91.00 Is this hospital release accepting in the XMF patients accepting in the applicable colum. N 92.00 91.00 Does this facility have are "I" for no in the applicable colum. N 93.00 92.00 It line V XIX Fateuce capital cost? Enter "Y" for yes, or "N" for no in the N N 94.00 95.00 It line V or XIX reduce capital cost? Enter "Y" for yes, or "N" for no in the N N 96.00 96.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, or "N" for no in the applicable colum. 0.00 0.00 97.00 It line V at XI follow Medicare (1110 XVIII) for the reporting of charges on West. N Y		40(f)(1)(i)	TEFRA? Ente	r "Y" for ves	s or "N" for no.	N	85.00
97.00 Ib s this hospital an extended neoplastic disease care hospital classified under section N 97.00 11166(2)(15)(12)(15)(12) N N N 97.00 90.00 Doos this facility have title V and/or XX inpatient hospital services? Enter "Y" for N Y 90.00 91.01 It is this hospital reliabured for title V and/or XX it hrough the cost report either in N Y 90.00 91.00 Is this hospital reliabured for title V and/or XX ithrough the cost report either in N N 91.00 92.00 No No Y 92.00 N 92.00 92.00 First hospital reliabured for title V and/or XX ithrough the cost report either in N N 92.00 92.00 No No P 92.00 N N 93.00 92.00 Does title V or XX rould coate classifie disease care "N" for no in the applicable colum. N 93.00 93.00 Dest title V or XX rould coate Citle Ter" "To for yes or "N" for no in N N 94.00 94.00 Dest title V or XX rould coate Citle Ter" To rys or "N" for no in N N 94.00 95.00 Dest title V or XX roule capital column N 98.00	86.00 Did this facility establish a new Other subprovid	ler (exclude					
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Ittle V and XIX Services 1.00 2.00 90.00 Does this facility have title V and/or XIX inputient hospital services? Enter "Y" for yes or "N" for no in the applicable colum. N Y 90.00 91.00 Is this hospital reliabursed for title V and/or XIX through the cost report either in Tul or in parts Enter "Y" for yes or "N" for no in the applicable colum. N Y 90.00 92.00 Does this facility parts and CPUID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable colum. N 92.00 90.00 best this V and Xix deduce capital cost? Enter "Y" for yes or "N" for no in the applicable colum. 0.00 0.00 93.00 90.00 best this V and Xix deduce capital cost? Enter "Y" for yes or "N" for no in the applicable colum. 0.00 0.00 96.00 90.00 best title V or XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable colum. 0.00 0.00 96.00 90.00 best title V or XIX follow Medicare (title XVIII) for the reporting of charges on WKst. N Y 98.00 91.00 best title V or XIX follow Medicare (title XVIII) for a citle access hespital (XMI) N Y 98.00 92.00 best title V or XIX follow Medicare (title XVIII) for a citle access hespital (XMI) N Y 98.01 93.00 best title V o					I	IN	87.00
Title V and XXX Services v							
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for provide the applicable colum. 90.00 91.00 Is this hospital relabursed for title V and/or XIX through the cost report either in N Full or in part? Enter "Y" for yes or "N" for no in the applicable colum. N 92.00 92.00 New Litle XIX MP patients occupying title XNII SWE beds (dual certification)? (see N V For yes or "N" for no in the applicable colum. N 92.00 93.00 Does this facility operates on ICT/ID facility for purposes of title V and XIX? Enter N N 93.00 N 93.00 90.00 Does title V or XIX reduce operates on ICT/ID facility for purposes of "N" for no in the Applicable colum. 0.00 0.00 94.00 90.01 Differed is "," enter the reduction percentage in the applicable colum. 0.00 0.00 95.00 90.00 Does title V or XIX follow Medicare (fitle XVIII) for the interns and residents post stepdom adjustemets on West. B, 1, col. 25? Enter "Y" for yes or "N" for no in colum 1 0.00 0.00 98.00 90.00 Dest title V or XIX follow Medicare (fitle XVIII) for the enters and residents post stepdom adjustemets collow of title XI. N Y 98.00 91.00 Dest title V or XIX follow Medicare (fitle XVIII) for a critical accusation of observation N Y 98.01 Y 98.02 92.01	Title V and XIX Services				1.00	2.00	
91.00 15 this hospital reinbursed for title V and/or XIX through the cost report either in full or in part2 Enter "V" for yes or "N" for no in the applicable colum. N 91.00 92.00 Are title XIX NP patients accupying title XVIII SNF beds (dual certification)? (see instructions) Enter "V" for yes or "N" for no in the applicable colum. N 92.00 93.00 Does this facility operate an ICF/ID facility for purposes of title V and XIX? Enter N 93.00 94.00 Does this facility operate an ICF/ID facility for purposes of title V and XIX? Enter N N 94.00 95.00 If iner reft the reduction percentage in the applicable colum. 0.00 0.00 0.00 95.00 N 96.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable colum. 0.00 0.00 97.00 97.01 Disc title V or XIX follow Medicare (title XIII) for the interms and residents post stapdown adjustnents on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title XIX. N Y 98.01 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation regimes on Wkst. N Y 98.02 98.02 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital N N		ent hospita	al services? E	nter "Y" for	N	Y	90.00
null or in part2 Enter "Y" for yes or "N" for no in the applicable column. N 92.00 20.00 Are title XIX N patients occupying title XVIII SNE beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. N 92.00 30.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the philicable column. N N 94.00 40.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the philicable column. 0.00 0.00 95.00 50.00 Dise title V or XIX reduce aperating cost? Enter "Y" for yes or "N" for no in the philicable column. 0.00 0.00 95.00 50.00 Dise title V or XIX follow Medicare (title XVIII) for the interns and residents post N N 98.00 51.00 Loss title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. N Y 98.01 50.00 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation N Y 98.01 50.00 Loss title V or XIX follow Medicare (title XVIII) for the calculation of observation N Y 98.02 60.00 Lite V or XIX follow Medicare (title XVIII) for a critical access hospital (CAU) N N 98.03 61.00 Lite V or XIX follow Medicare (title XVIII) for a critical access hospital (CAU) N N 98.03 62.00 Does title V or XIX follow Medicare (title X							
92.00 Are title XIX WF patients occupying title XVIII SWF beds (dual certification)? (see Instructions). Enter "Y" for yes or "N" for no in the applicable column. N 92.00 93.00 Does this facility operate an (CF/ID facility for purposes of title V and XIX? Enter N N N 93.00 94.00 Does this facility operate an (CF/ID facility for purposes of title V and XIX? Enter N N N 93.00 95.00 philoshe column. N N 94.00 96.00 philoshe column. 0.00					N	N	91.00
93.00 Does this facility operate an ICF/ID facility for purposes of title V and XIX? Enter N N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the napplicable column. 0.00 0.00 0.00 95.00 95.00 [F line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 0.00 0.00 95.00 96.00 [F line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 97.01 [F line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XWIII) for the Interns and residents post in the provide the title V. and in column 2 for title XIX. N Y 98.00 98.01 Does title V or XIX follow Medicare (title XWIII) for the calculation of observation in column 1 for title V. and in column 2 for title XIX. N Y 98.01 98.02 Does title V or XIX follow Medicare (title XVIII) for a CAH relnbursed 101% of no lin column 1 for title V, and in column 2 for title XIX. N Y 98.02 98.02 Does title V or XIX follow Medicare (title XVIII) for a CAH relnbursed 101% of no lin column 1 for title V, and in colum 2 for title XIX. N N 98.02 98.04 Obsect title V arX X follow Medicare (title XVIII) for a CAH relnbursed nor hor column 1 for	92.00 Are title XIX NF patients occupying title XVIII S	SNF beds (du	al certificat			N	92.00
"Y" for yes or "N" for no in the applicable column. N 94.00 400 Dbest title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 0.00 0.00 95.00 F line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 0.00 97.00 F line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 0.00 97.00 F line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 97.00 F line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.01 best title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. N Y 98.01 98.01 best title V or XIX follow Medicare (title XVIII) for the calculation of observation N Y 98.02 98.02 bbest title V or XIX follow Medicare (title XVIII) for a CAH reinbursed 101% of no in column 1 N Y 98.02 98.03 boest title V or XIX follow Medicare (title XVIII) for a CAH reinbursed 101% of no in column 1 N Y 98.02 98.03 boest title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on N N Y 98.03 98.04 boest title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance o				d VIVO Enton	N	N	02.00
applicable column. 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 95.00					N	IN	93.00
95:00 If 'line 94 is 'Y'', enter the reduction percentage in the applicable column. 0.00 0.00 0.00 95:00 96:00 Does title V or XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column. 0.00 0.00 95:00 97:00 IF line 96 is 'Y'', enter the reduction percentage in the applicable column. 0.00 0.00 97:00 97:01 IF line 96 is 'Y'', enter the reduction percentage in the applicable column. 0.00 0.00 97:00 97:01 IF line 96 is 'Y'', enter the reduction percentage in the applicable column. 0.00 0.00 97:00 98:00 Desettitle V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. N Y 98:00 98:00 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. N Y 98:01 98:02 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N N 98:03 98:03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N N 98:03 98:04 Does title V or XIX follow Medicare (title XVIII) for a column 1 for title V, and in column 1 for title V, and in column 2 for title XIX. N N 98:03 </td <td></td> <td>" for yes,</td> <td>and "N" for n</td> <td>o in the</td> <td>Ν</td> <td>N</td> <td>94.00</td>		" for yes,	and "N" for n	o in the	Ν	N	94.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. N 96.00 97.00 If line 96 is "V", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 257 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XVIII) for the reporting of charges on Wkst. N Y 98.00 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. N Y 98.01 69.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 897 Enter "Y" for yes or "N" for no in column 1 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 critical access hospital (CAH) N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) for a column 1 for title V, and in column 2 for title XIX. N N 98.04 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on N N Y 98.05 98.05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D. N <t< td=""><td></td><td>in the anr</td><td>licable colum</td><td>n</td><td>0.00</td><td>0.00</td><td>95 00</td></t<>		in the anr	licable colum	n	0.00	0.00	95 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 80.00 Desc title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 257 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.00 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. N Y 98.01 08.02 Desc title V, and in column 2 for title XIX. N Y 98.02 98.02 Desc title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV. I ine 897 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.02 98.04 Desc title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N N N 98.03 98.04 Desc title V or XIX follow Medicare (title XVIII) for a cAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.04 98.05 Desc title V or XIX follow Medicare (title XVIII) on a claun 1 for title V, and in column 2 for title XIX. N N 98.04 98.06 Desc title V or XIX follow Medicare (title XVIII) when cost reimburseed for Wkst. D, N </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stopdown adjustments on Wkst. B, Pt. 1. col. 257 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.00 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 17 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.01 98.02 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 17 Enter "Y" for yes or "N" for no in column 1 for title XIX. N Y 98.02 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N N Y 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 10% of N N N 98.03 98.05 Dittle V, and in colum 2 for title XIX N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 10% of N N N 98.03 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 42 Enter "Y" for yes or "N" for no in column 1 for title V, and in colum 2 for title XIX. N Y 98.05 98.06 Does title V or XIX follow Medicare (title XVIII) when cost rei							
stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title V, and in column 2 for title XX. Y 98.01 0.0 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 1 for title V, and in column 2 for title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1. Pt. IV. line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.02 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relnbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reinbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N 98.04 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wst. C, Pt. I. col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.05 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reinbursed for Wstst. D, Pts. I through IP? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 105.00 006.001 Fitle XI							
98. 01 Does title V or XIX Follow Medicare (title XVIII) for the reporting of charges on Wkst. N Y 98.01 02. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title 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 calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N Y 98.03 98. 03 Does title V or XIX follow Medicare (title XVIII) for a call reimbursed 101% of upstient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N N 98.03 98. 04 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wst. To rol in column 2 for title XIX. N N 98.05 98. 05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wst. D, N Y 98.05 98. 05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wst. D, N Y 98.05 98. 05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wst. D, N Y 98.05 98. 05 Does title V or XIX follo					IN IN	1	70.00
C. Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.02 98.04 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N 98.04 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on WKst. C, Pt. I, col. 47 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.06 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, N Y 98.06 98.06 Does title XIX. Providers N Y 98.06 98.06 Does this hospital qualify as a CAH? 105.00 106.00 106 for instructions) N Y 98.06 005.00 This facility qualifies as a CAH, has it elected the all-inclusive method							
1111e XIX. Y 98.02 Ooes title V or XIX follow Medicare (title XVIII) for the calculation of observation ped costs on Wkst. D. 1, Pt. IV. Line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.02 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) nor XIX follow Medicare (title XVIII) for a critical access hospital (CAH) nor XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on N Wst. C, Pt. 1, col. 47 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.05 98.05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.06 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in columa 2 for title XIX. N Y 98.06 98.06 Does title V or XIX follow Medicare (not in column 1 for title V, and in columa 2 for title XIX. N Y 98.05 98.06 Does title V or XIX follow Medicare (not in the XIX. </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>Y</td> <td>98.01</td>						Y	98.01
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complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as							110.00
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Health Financial Systems IU HEALTH PAOLI	HOSPITAL		l I	n Lieu	u of For	m CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN:		Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/28/20	me Pre	epared:
111.00 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.	st reporting per umn 1 is Y, ent ticipating in co	riod? Enter ter the olumn 2.	1.00 N		2. (00	111.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 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. 116.00 Is this facility classified as a referral center? Enter "Y" f	lf column 2 is t for long term s) based on the	"E", enter care (inclu definition	in column udes	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insura no.			"N" for	N			117.00
118.00 is the malpractice insurance a claims-made or occurrence poli claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if	the policy	is	1			118.00
		Premiums	Losse	5	Insur	ance	
		1.00	2.00		3. (
118.01 List amounts of malpractice premiums and paid losses:		43, 10		0			0118.01
118.02 Are malpractice premiums and paid losses reported in a cost c	center other the	an the	1.00 N		2.0)0	118.02
Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §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. 121.00 Did this facility incur and report costs for high cost implan	Harmless provis column 1, "Y" f alifies for the ts? (see instruc	sion in ACA For yes or Outpatient ctions)	N		N		119. 00 120. 00 121. 00
patients? Enter "Y" for yes or "N" for no.	Itable devices c	charged to	ľ				121.00
122.00Does 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.			Y		5.0	00	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N" fo	orno.lf	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent		cation date					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certifica	ation date					127.00
128.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certifica	ation date					128.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	⁻ the certificat	tion date in	n				129.00
130.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu		i cati on					130.00
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu	enter the cert	i fi cati on					131.00
132.00 If this is a Medicare certified islet transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certifica	ation date					132.00
133.00 If this is a Medicare certified other transplant center, ente in column 1 and termination date, if applicable, in column 2.		ation date					133.00
134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	e OPO number in	column 1					134.00
All Providers 140.00Are there any related organization or home office costs as de		- 1F 1	Y		15H0	050	140.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX		PROVI HOSPITAL Provider CC	N: 15-1306				2 epared:
1.00		2. 00			3.00	572072019 12	. 17 piii
If this facility is part of a chai			uah 143 th	e name ar		of the	
home office and enter the home off 41. 00 Name: INDI ANA UNI VERSI TY HEALTH		l contractor numbe	er.				141.0
		SERVI CES					
42.00 Street: 340 WEST TENTH STREET	PO Box:						142.0
43.00 City: INDIANAPOLIS	State:	IN	Zip Co	de:	4620)4	143.0
						1.00	_
	te included in Membra	+ 40				1.00	144 (
44.00 Are provider based physicians' cos	ts included in worksnee	I A?				Y	144.0
					1.00	2.00	-
45.00 If costs for renal services are cl	aimed on Wkst. A, line	74, are the costs	for				145.0
inpatient services only? Enter "Y"				s			
no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"	for no in column 2.						
46.00 Has the cost allocation methodolog	y changed from the prev	iously filed cost	report?		N		146. (
Enter "Y" for yes or "N" for no in	column 1. (See CMS Pub	. 15-2, chapter 4	0, §4020)	lf			
yes, enter the approval date (mm/d	d/yyyy) in column 2.						
						1.00	
17.00 Was there a change in the statisti						N	147.0
18.00Was there a change in the order of						N	148.0
19.00Was there a change to the simplifi	ed cost finding method?	<u>Enter "Y" for ye</u>	s or "N" ·	<u>for no.</u>		N	149.
		Part A	Part	3	Title V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or "	<u>N" for no for each comp</u>	onent for Part A		B. (See 4		1 1	
55.00 Hospi tal		N	N		N	N	155.
56.00 Subprovider - IPF		N	N		N	N	156.0
57.00 Subprovider - IRF		N	N		N	N	157. (
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N	N		N	N	159.0
60.00HOME HEALTH AGENCY		N	N		N	N	160. 0
61.00 CMHC			N		N	N	161. C
							_
						1.00	
Multicampus						I	-
65.00 s this hospital part of a Multica	mpus hospital that has	one or more campu	ses in di	ferent C	BSAs?	N	165.0
Enter "Y" for yes or "N" for no.	N	0		7' 0 1	00004		_
-	Name	County	State	Zip Code		FTE/Campus	-
(/ 00 lf line 1/F is yes, for each	0	1.00	2.00	3.00	4.00	5.00	01//
66.00 If line 165 is yes, for each campus enter the name in column						0.0	0 166. (
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 (HIT) incentive in the Amer	ican Recovery and	Reinvest	ment Act			167.0
Health Information Technology (HIT 57.00Ls this provider a meaningful user						I Y	
57.00 Is this provider a meaningful user	under §1886(n)? Enter	"Y" for yes or "	N" for no		er the	Y	1168.
57.00 is this provider a meaningful user 58.00 if this provider is a CAH (line 10	under §1886(n)? Enter 5 is "Y") and is a mean	"Y" for yes or " ingful user (line	N" for no		er the		1168.0
57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct	"Y" for yes or " ingful user (line ions)	N" for no 167 is "'	("), ente			
57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is n	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d	"Y" for yes or " ingful user (line ions) loes this provider	N" for no 167 is " qualify	("), ente [°] or a har			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or "	"Y" for yes or " ingful user (line ions) oes this provider N" for no. (see i	N" for no. 167 is "' qualify nstruction	("), ente for a har is)	dshi p	N	168. (
67.001s this provider a meaningful user 68.001f this provider is a CAH (line 10 reasonable cost incurred for the H 68.011f this provider is a CAH and is n	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a	"Y" for yes or " ingful user (line ions) oes this provider N" for no. (see i	N" for no. 167 is "' qualify nstruction	("), ente for a har is)	dshi p	N	168. (
 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful u 	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a	"Y" for yes or " ingful user (line ions) oes this provider N" for no. (see i	N" for no. 167 is "' qualify nstruction	("), ente For a har hs) s "N"),	dshi p	N	1168. (168. (00169. (
 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful u 	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a	"Y" for yes or " ingful user (line ions) oes this provider N" for no. (see i	N" for no. 167 is "' qualify nstruction	("), ente For a har hs) s "N"),	dship enter the	N 0. 0	168. (
 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii)? 59.00 If this provider is a meaningful u transition factor. (see instruction) 	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a ns)	"Y" for yes or " ingful user (line ions) ioes this provider N" for no. (see i nd is not a CAH (N" for no 167 is "' qualify nstruction line 105	("), ente For a har ns) s "N"), B	rdship enter the eginning	N O. O Endi ng	168. ()0169. (
 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii)? 69.00 If this provider is a meaningful u 	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a ns)	"Y" for yes or " ingful user (line ions) ioes this provider N" for no. (see i nd is not a CAH (N" for no 167 is "' qualify nstruction line 105	("), ente For a har ns) s "N"), B	rdship enter the eginning 1.00	N 0. 0 Endi ng 2. 00	168.
 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii)? 59.00 If this provider is a meaningful u transition factor. (see instructio 70.00 Enter in columns 1 and 2 the EHR b 	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a ns)	"Y" for yes or " ingful user (line ions) ioes this provider N" for no. (see i nd is not a CAH (N" for no 167 is "' qualify nstruction line 105	("), ente For a har ns) s "N"), B	rdship enter the eginning 1.00 /01/2018	N 0. 0 Endi ng 2. 00	168. ()0169. (
 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii)? 59.00 If this provider is a meaningful u transition factor. (see instructio 70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy) 	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a ns) eginning date and endin	"Y" for yes or " ingful user (line ions) loes this provider N" for no. (see i nd is not a CAH (g date for the re	N" for no 167 is "` qualify nstruction line 105 i porting	("), ente For a har ns) s "N"), B	rdshi p enter the egi nni ng 1.00 //01/2018 1.00	N 0. 0 Endi ng 2. 00 03/31/2018 2. 00	168. ()0169. (
 b7.00 Is this provider a meaningful user is a CAH (line 10 reasonable cost incurred for the H exception under §413.70(a) (6) (ii)? b9.00 If this provider is a meaningful u transition factor. (see instructio period respectively (mm/dd/yyyy) b71.00 If line 167 is "Y", does this provider is period respectively (mm/dd/yyyy) 	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a ns) eginning date and endin ider have any days for	"Y" for yes or " ingful user (line ions) loes this provider N" for no. (see i nd is not a CAH (g date for the re individuals enrol	N" for no 167 is "' qualify nstruction line 105 i porting led in	("), ente For a har is) s "N"), <u>Ba</u> 01	rdship enter the eginning 1.00 /01/2018	N 0. 0 Endi ng 2. 00 03/31/2018 2. 00	168. 00169.
 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii)? 9.00 If this provider is a meaningful u transition factor. (see instructio 0.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy) 	under §1886(n)? Enter 5 is "Y") and is a mean IT assets (see instruct ot a meaningful user, d Enter "Y" for yes or " ser (line 167 is "Y") a ns) eginning date and endin ider have any days for eported on Wkst. S-3, P	"Y" for yes or " ingful user (line ions) oes this provider N" for no. (see i nd is not a CAH (g date for the re individuals enrol 't. I, line 2, col	N" for no 167 is "' qualify nstruction line 105 porting led in . 6? Enter	("), ente For a har ns) s "N"), Bi 01	rdshi p enter the egi nni ng 1.00 //01/2018 1.00	N 0. 0 Endi ng 2. 00 03/31/2018 2. 00	168. 00169.

iospi t.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2018 To 12/31/2018 Y/N	Worksheet S-2 Part II Date/Time Pre 5/28/2019 12: Date	epared:
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ente			
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in o			N		1.00
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of 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	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		N N	•		
1.00	Column 1: Were the financial statements prepared by a Cerr Accountant? Column 2: If yes, enter "A" for Audited, "C" to or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4.00
5.00	Are the cost report total expenses and total revenues diffe		N			5.00
	those on the filed financial statements? If yes, submit rea	conciliation.		Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities			1.00	2.00	
b. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	5	ne provider is			6.00
7.00 3.00	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.		l during the	N N		7.00
9.00	Are costs claimed for Interns and Residents in an approved	0	al education	Ν		9.0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current	Ν		10.00
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11. 0
					Y/N	_
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			st reporting	Y N	12. 0 13. 0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	°yes, see ins	tructions.	N	14.0
5.00	Did total beds available change from the prior cost reporti		<u>yes, see inst</u> t A		N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data	1	1			
6.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16.0
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/03/2019	Y	04/03/2019	17.00
8.00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		Ν		18.0
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		Ν		19.0

Health Financial System

ΙΙΙ ΗΓΔΙΤΗ ΡΔΟΙΙ ΗΟΥΡΙΤΔΙ

Health Financial Systems IU HEALTH PAC	OLI HOSPITAL		In Lie	eu of Form CMS	8-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2018 Fo 12/31/2018	Worksheet S Part II Date/Time P	-2 repared:
)/ /N	5/28/2019 12	2:19 pm
		iption	Y/N	Y/N	_
20.00 f ine 16 or 17 is yes, were adjustments made to PS&R)	1.00 N	3.00 N	20.00
Report data for Other? Describe the other adjustments:			IN	IN	20.00
Report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's	N	2100	N		21.00
records? If yes, see instructions.					
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHLIDRENS H	OSPLTALS)		1.00	_
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00
23.00 Have changes occurred in the Medicare depreciation expense	due to apprais	als made durir	ng the cost	N	23.00
reporting period? If yes, see instructions.			0		
24.00 Were new leases and/or amendments to existing leases entered	ed into during	this cost repo	orting period?	N	24.00
If yes, see instructions					
25.00 Have there been new capitalized leases entered into during	the cost repor	ting period? I	f yes, see	N	25.00
instructions.					
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during th	he cost reporti	ng period? If	yes, see	N	26.00
instructions.	a aaat manamtin	a noniod2 lf.	ioo oubmit	N	27.00
27.00 Has the provider's capitalization policy changed during the	e cost reportin	ig period? if y	es, submit	N	27.00
copy. Interest Expense				L	
28.00 Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost r	reporting	N	28.00
period? If yes, see instructions.		ing the cost i	oportring		20.00
29.00 Did the provider have a funded depreciation account and/or	bond funds (De	bt Service Res	serve Fund)	N	29.00
treated as a funded depreciation account? If yes, see instr					
30.00 Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see	N	30.00
instructions.					
31.00 Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see	N	31.00
instructions.					
Purchased Servi ces				1	
32.00 Have changes or new agreements occurred in patient care ser		d through cont	tractual	N	32.00
arrangements with suppliers of services? If yes, see instru		a ta compotiti	va bidding? If		22.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app	pried pertainin	ig to competiti	ve brodring? IT		33.00
no, see instructions. Provider-Based Physicians				<u> </u>	-
34.00 Are services furnished at the provider facility under an ar	rrangement with	nrovi der-base	ed physicians?	Y	34.00
If yes, see instructions.	i i ungemente un tri		ou physi or ans.		01.00
35.00 If line 34 is yes, were there new agreements or amended exi	isting agreemen	its with the pr	rovi der-based	Y	35.00
physicians during the cost reporting period? If yes, see in		···· ··· ··· ··· ···			
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00 Were home office costs claimed on the cost report?			Y		36.00
37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		37.00
If yes, see instructions.		6			
38.00 If line 36 is yes, was the fiscal year end of the home off			N		38.00
the provider? If yes, enter in column 2 the fiscal year end			N I		20.00
39.00 If line 36 is yes, did the provider render services to othe	er charn compon	ients? IT yes,	N		39.00
40.00 If line 36 is yes, did the provider render services to the	home office?	If yos soo	Ν		10.00
40.00 If line 36 is yes, did the provider render services to the instructions.	nome office?	11 yes, see	IN		40.00
				1	
		<u></u>	2	00	
	1.	00			
Cost Report Preparer Contact Information	1.	00	2.		
Cost Report Preparer Contact Information 41.00 Enter the first name, Last name and the title/position	1. RHONDA	00	UTTER		41.00
		00			41.00
41.00 Enter the first name, last name and the title/position		00			41.00
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,					41.00
 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 	RHONDA		UTTER		42.00
 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 	RHONDA			H. ORG	

Heal th	Financial Systems IU HEALTH	PAOL	I HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: '	Period: From 01/01/2018	Worksheet S-2 Part II	
					Date/Time Pre 5/28/2019 12:	pared: 19 pm
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	C	I RECTOR			41.00
	held by the cost report preparer in columns 1, 2, and 3	,				
	respecti vel y.					
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 cos	t				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems	IU HEALTH PAOL		N 45 400/		u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	al data	Provider CC	IN: 15-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Prep 5/28/2019 12:	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	24	8, 7	60 13, 968. 00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0 0	5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		24	8, 7	60 13, 968. 00	0	7.00
8.00 9.00 10.00 11.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31. 00	O		0 0.00	0	8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF	43.00	24	8, 7	60 13, 968. 00	0 0 0	12.00 13.00 14.00 15.00 16.00
17.00 17.00 18.00 19.00 20.00	SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY						17.00 17.00 18.00 19.00 20.00
21.00 22.00 23.00 24.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE	101. 00				0	21.00 22.00 23.00 24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24. 10 25. 00
26.00 26.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	88. 00 89. 00	24			0 0	26.00 26.25
27.00 28.00 29.00 30.00 31.00 32.00 32.01	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		24 0		0	0	27.00 28.00 29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2018 To 12/31/2018		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	178	28 280	58	12		2.00
3.00	HMO I PF Subprovi der	0	0				3.00
I. 00	HMO I RF Subprovi der	o	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	92	0	ç	2		5.00
o. 00	Hospital Adults & Peds. Swing Bed NF		0		5		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	270	28	70	9		7.00
3.00	INTENSIVE CARE UNIT	0	0		0		8.00
9.00	CORONARY CARE UNI T						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGICAL INTENSIVE CARE UNIT						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		31	20			13.00
4.00	Total (see instructions)	270	59	91		125.54	14.00
5.00	CAH visits	0	0		0		15.00
6.00	SUBPROVIDER - IPF						16.00
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVIDER						18.0
9.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	•
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPI CE				~		24.0
24.10	HOSPICE (non-distinct part)				2		24.10
25.00	CMHC - CMHC		0		0 0.00	0.00	25.00
26.00	RURAL HEALTH CLINIC	0	0		0 0.00		•
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00 28.00	Total (sum of lines 14-26) Observation Bed Days		11	69		125.54	27.0
29.00	Ambul ance Trips	0	11	05	'4		29.00
30.00	Employee discount days (see instruction)	0			0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	0		0		32.00
32.00 32.01	Total ancillary labor & delivery room	0	0		0		32.00
J∠. UI	outpatient days (see instructions)						32.0
3. 00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	0					33.0

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CCN: 15-1306		Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Prep 5/28/2019 12:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 25.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER - INF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER - INF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER - INF SUBPROVIDER - IRF SUBPROVIDER - INF SUBPROVIDER - IRF SUBPROVIDER - IRF	0. 00 0. 00 0. 00 0. 00	0		14.00 23 18 140 0 0 54 23 54 23	360	$\begin{array}{c} 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 25\end{array}$
27.00 28.00 29.00 30.00 31.00 32.00 32.01 33.00	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) LTCH non-covered days	0.00			0		27.00 28.00 29.00 30.00 31.00 32.00 32.01 33.00

Heal th	Financial Systems IU HEALTH PAOLI HC	DSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der	CCN: 15-1306	Period:	Worksheet S-1	0
				From 01/01/2018 To 12/31/2018		
					1.00	
	Uncompensated and indigent care cost computation				1.00	-
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by	line 202 colum	n 8)	0. 371627	1.00
1.00	Medicaid (see instructions for each line)	lucu by	11110 202 001 0		0.071027	1.00
2.00	Net revenue from Medicaid				4, 185, 281	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa			ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medic	cai d		0	
6.00 7.00	Medicaid charges Medicaid cost (line 1 times line 6)				15, 985, 325 5, 940, 578	
7.00 8.00	Difference between net revenue and costs for Medicaid program (I	ling 7 m	ninus sum of li	nes 2 and 5 if	1, 755, 297	
0.00	< zero then enter zero)				1,755,277	0.00
	Children's Health Insurance Program (CHIP) (see instructions for	r each I	ine)		1	4
9.00	Net revenue from stand-al one CHIP				0	
	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	1
	Difference between net revenue and costs for stand-alone CHIP (I	line 11	minus line Q.	if < zero then		
12.00	enter zero)		initido fritico /,		0	12.00
	Other state or local government indigent care program (see instr	ructions	for each line)		
13.00	Net revenue from state or local indigent care program (Not inclu				0	
14.00	Charges for patients covered under state or local indigent care	program	n (Not included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line 14)	`			0	15.00
16.00	Difference between net revenue and costs for state or local indi		are program (Li	ne 15 minus line	-	
101.00	13; if < zero then enter zero)	gone oc	i o program (ri			
	Grants, donations and total unreimbursed cost for Medicaid, CHIF	o and st	ate/local indi	gent care progra	ms (see	1
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fur	odina ch	arity care		0	17.00
	Government grants, appropriations or transfers for support of he				0	
	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)			s (sum of lines	1, 755, 297	
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	L
	Uncompared Constructions for each line)		1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	ility	1, 732, 0	16 62, 526	1, 794, 542	20.00
20.00	(see instructions)	iiity	1,752,0	02, 320	1,774,342	20.00
21.00	Cost of patients approved for charity care and uninsured discour	nts (see	e 643, 6	64 62, 526	706, 190	21.00
22.00	instructions) Payments received from patients for amounts previously written o	off as	6,8	77 1,400	8, 277	22.00
~~~~~	chari ty care					
23.00	Cost of charity care (line 21 minus line 22)		636, 7	87 61, 126	697, 913	23.00
					1.00	<u> </u>
24.00	Does the amount on line 20 column 2, include charges for patient	t days b	eyond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the			m's length of	0	25.00
	stay limit	-		-		
	Total bad debt expense for the entire hospital complex (see inst				2, 846, 489	
	Medicare reimbursable bad debts for the entire hospital complex				837, 267	
27.01 28.00	Medicare allowable bad debts for the entire hospital complex (se Non-Medicare bad debt expense (see instructions)	ee instr	uctions)		1, 288, 103 1, 558, 386	
28.00 29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	anco (co	a instructions	)	1, 029, 974	
	Cost of uncompensated care (line 23 column 3 plus line 29)	ense (se	e instructions	)	1, 029, 974	
	Total unreimbursed and uncompensated care cost (line 19 plus lir	ne 30)			3, 483, 184	
2.700						

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	IU HEALTH PAOL F EXPENSES	HOSPITAL Provider CO	CN: 15-1306 Pe	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
			Fi To	rom 01/01/2018		pared:
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	-	547, 892	547, 892 870, 988	1.00 2.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 3.00 00300 OTHER CAP REL COSTS		0	-	870, 988 0	870, 988	3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	12, 761	176, 795	-	1, 395, 018	1, 584, 574	4.00
5.00 00500 ADMI NI STRATI VE & GENERAL	428, 028	6, 390, 580		-151, 675	6, 666, 933	5.00
7.00 00700 OPERATION OF PLANT	385, 014	1, 429, 334	1, 814, 348	-678, 959	1, 135, 389	7.00
7. 01 00701 UTI LI TI ES	0	0	0	360, 291	360, 291	7.01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0 179, 224	62, 677 143, 759		0 -76, 890	62, 677 246, 093	8.00 9.00
10. 00 01000 DI ETARY	204, 522	165, 878		-241, 958	128, 442	10.00
11. 00 01100 CAFETERIA	0	0		161, 371	161, 371	11.00
13.00 01300 NURSING ADMINISTRATION	659, 598	858, 550		-243, 151	1, 274, 997	13.00
13. 01 01301 HOUSE SUPERVI SORS	410, 672	94, 609		-63, 758	441, 523	
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	0 228, 707	43, 801 1, 619, 401	43, 801 1, 848, 108	293, 490 -1, 361, 576	337, 291 486, 532	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LI BRARY	228, 707	13, 810		-1, 301, 570	480, 552	
17. 00 01700 SOCIAL SERVICE	Ö	0		0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	342, 377	79, 046	421, 423	-43, 625	377, 798	19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0/5 0/7		1 525 022	404 250	1 020 5/2	20.00
30. 00  03000   ADULTS & PEDI ATRI CS 31. 00  03100   INTENSI VE CARE UNI T	965, 867	559, 955	1, 525, 822	-486, 259	1, 039, 563	30.00 31.00
43. 00 04300 NURSERY	163, 956	22, 597	186, 553	-107, 992	78, 561	43.00
ANCILLARY SERVICE COST CENTERS		,				
50.00 05000 OPERATING ROOM	445, 008	342, 895		-265, 435	522, 468	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	56, 130	0	,	165, 418	221, 548	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	811, 926 0	1, 085, 361 1, 258, 909		-627, 079 -1, 589	1, 270, 208 1, 257, 320	54.00 60.00
64. 00 06400 I NTRAVENOUS THERAPY	68, 870	37, 906		-23, 878	82, 898	64.00
65. 00 06500 RESPI RATORY THERAPY	327, 980	130, 741		-81, 570	377, 151	65.00
66. 00 06600 PHYSI CAL THERAPY	568, 332	323, 577	891, 909	-390, 838	501, 071	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	100, 365	100, 365	67.00
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20, 623 49, 320	20, 623 49, 320	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	49, 320 3, 531	49, 320 3, 531	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	0	0	1, 296, 108	1, 296, 108	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74.00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 07501 CARDI AC REHAB	0	0	0	0	0	75.00 75.01
76. 97 07697 CARDI AC REHABILI TATI ON	267	3, 815	4, 082	-3, 794	288	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 32, 305	0 26, 713	0 59, 018	0 -1, 303	0 57, 715	89.00 90.00
90. 01 09001 VISITING SPECIALTY CLINIC	32, 305	20, 713	0	-1, 303	57, 715	90.00
91. 00 09100 EMERGENCY	1, 228, 265	1, 504, 158	2, 732, 423	-394, 809	2, 337, 614	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REI MBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES 101. 00 10100 HOME HEALTH AGENCY	0	0		0	0	95.00 101.00
SPECIAL PURPOSE COST CENTERS	Q	0		0	0	101.00
113.00 11300 INTEREST EXPENSE		0	0	0		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 519, 809	16, 374, 867	23, 894, 676	14, 227	23, 908, 903	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190. 01 19000 VISITING SPECIALTY CLINIC	9, 051	174, 606	-	-4, 963	178, 694	
190. 02 19002 OUTREACH	0	3, 241	3, 241	-282		190.02
190. 03 19003 FOUNDATI ON	O	51	51	0	51	190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	0	6,825		-2, 224		190.05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH		6, 758 0	6, 758 0	-6, 758 0		190. 06 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	0	0	0		192.00
193.00 19300 NONPALD WORKERS	О	0	0	0		193.00
200.00   TOTAL (SUM OF LINES 118 through 199)	7, 528, 860	16, 566, 348	24, 095, 208	0	24, 095, 208	200. 00

ECLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IU HEALTH PAOL F EXPENSES	Provider CC	I: 15-1306	Peri od:	u of Form CMS-2552 Worksheet A
					From 01/01/2018 To 12/31/2018	Date/Time Prepare
	Cost Center Description		Net Expenses or Allocation		_ <u> </u>	5/28/2019 12: 19
		6.00	7.00			
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	105 214	252 470			1
. 00 . 00	00200 CAP REL COSTS-BLDG & FIXT	-195, 214	352, 678			1
. 00	00300 OTHER CAP REL COSTS	-129, 414 0	741, 574 0			3
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-	-			
. 00	00500 ADMINISTRATIVE & GENERAL	-45, 240 -931, 035	1,539,334			4
00	00700 OPERATION OF PLANT		5, 735, 898 1, 112, 501			7
00	00701 UTILITIES	-22, 888 0	360, 291			7
. 00	00800 LAUNDRY & LINEN SERVICE	0	62, 677			8
. 00	00900 HOUSEKEEPING	0	246, 093			9
. 00 D. 00	01000 DI ETARY	0	128, 442			10
1.00	01100 CAFETERI A	-47, 331	128, 442			11
	01300 NURSI NG ADMI NI STRATI ON	-226, 984	1, 048, 013			13
3.00	01301 HOUSE SUPERVI SORS	-220, 984	441, 523			13
	01400 CENTRAL SERVICES & SUPPLY	0	337, 291			13
5.00	01500 PHARMACY	-15, 627	470, 905			15
	01600 MEDICAL RECORDS & LIBRARY	-2, 506	7, 254			16
	01700 SOCIAL SERVICE	-2, 500	7, 234			17
	01900 NONPHYSICIAN ANESTHETISTS	-96, 222	281, 576			19
9.00	INPATIENT ROUTINE SERVICE COST CENTERS	- 90, 222	201, 570			
0. 00	03000 ADULTS & PEDIATRICS	-2,645	1,036,918			30
	03100 I NTENSI VE CARE UNI T	-2,045	1,030,710			31
	04300 NURSERY	0	78, 561			43
3.00	ANCI LLARY SERVICE COST CENTERS	0	76, 501			43
0. 00	05000 OPERATI NG ROOM	0	522, 468			50
	05200 DELIVERY ROOM & LABOR ROOM	0	221, 548			52
4.00	05400 RADI OLOGY-DI AGNOSTI C	-31	1, 270, 177			54
	06000 LABORATORY	0	1, 257, 320			60
4.00	06400 I NTRAVENOUS THERAPY	0	82, 898			64
5.00	06500 RESPI RATORY THERAPY	0	377, 151			65
6.00	06600 PHYSI CAL THERAPY	-22,050	479, 021			66
7.00	06700 OCCUPATI ONAL THERAPY	22,000	100, 365			67
	06800 SPEECH PATHOLOGY	0	20, 623			68
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49, 320			71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 531			72
	07300 DRUGS CHARGED TO PATIENTS	1,003	1, 297, 111			73
	07301 DRUGS CHARGED TO PATIENTS	0	0			73
	07400 RENAL DI ALYSI S	0	0			74
	07500 ASC (NON-DI STINCT PART)	0	0			75
	07501 CARDI AC REHAB	0	0			75
	07697 CARDI AC REHABI LI TATI ON	0	288			76
	OUTPATIENT SERVICE COST CENTERS					
8. 00	08800 RURAL HEALTH CLINIC	0	0			88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89
	09000 CLINIC	18, 645	76, 360			90
	09001 VISITING SPECIALTY CLINIC	0	0			90
	09100 EMERGENCY	-160, 376	2, 177, 238			91
	09200 OBSERVATION BEDS (NON-DISTINCT PART					92
	OTHER REIMBURSABLE COST CENTERS					
5.00	09500 AMBULANCE SERVI CES	0	0			95
	10100 HOME HEALTH AGENCY	0	0			101
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE	0	0			113
18. OC	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 877, 915	22, 030, 988			118
	NONREIMBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190
	19001 VISITING SPECIALTY CLINIC	0	178, 694			190
	19002 OUTREACH	0	2, 959			190
	19003 FOUNDATI ON	0	51			190
	19004 SPRING VALLEY FAMILY PRACTICE	0	0			190
	19005 PAOLI FAMILY PRACTICE	0	4, 601			190
90.06	19006 OTHER PROPERTY	О	0			190
	19100 RESEARCH	0	0			191
	19200 PHYSICIANS' PRIVATE OFFICES	0	0			192
92.00	17200 THISICIANS TRIVATE OFFICES					
	19300 NONPALD WORKERS	О	0			193

	Financial Systems		IU HEALTH PAOI	<u>I HOSPITAL</u> Provider CCN: 15-13		u of Form CMS-2552-10 Worksheet A-6
REULAS	STFICATIONS			Provider CCN: 15-13	From 01/01/2018 To 12/31/2018	
	Cost Center 2.00	I ncreases Li ne # 3.00	Salary 4.00	0ther 5.00		<u>- 572072017 12. 17 pm</u>
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	A - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT OUTREACH	4.00 190.02 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		1, 395, 821 64 0 0 0 0 0 0 0 0 0 0 0 0 0		1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
1.00 2.00	B - BILLABLE DRUGS DRUGS CHARGED TO PATIENTS 	73.00 0.00	0	1, 296, 108 0_ 1, 296, 108		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	C - BILLABLE SUPPLIES MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		49, 320 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 23.00 24.00	D - CAPITAL RELATED COSTS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 0 E - IMPLANT SUPPLIES IMPL. DEV. CHARGED TO PATIENTS	1.00           2.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00           0.00		378, 312 870, 988 0 0 0 0 0 0 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 1.00
2.00 3.00 1.00	F - LEASE EXPENSE	0.00		0 0 <u>3, 531</u> <u>169, 580</u> 169, 580		2. 00 3. 00 1. 00

	Financial Systems		IU HEALTH PAOL						MS-2552-10
CLASS	SIFICATIONS			Provider CCN	l: 15-1306	Period: From 01/01/		rksheet	A-6
						To 12/31/	2018 Da		Prepared:
		Increases					57.	28/2019	12:19 pm
	Cost Center	Line #	Salary	Other					
	2.00	3.00	4.00	5.00					
	G – NON-BILLABLE DRUGS								
00	PHARMACY	15.00	0	28, 150					1.00
00		0.00	0	0					2.00
00		0.00	0	0					3.00
00 00		0. 00 0. 00	0	0					4.00 5.00
00		0.00	0	0					6. 00
00		0.00	0	0					7.00
00		0.00	0	0					8.00
00		0.00	0	0					9.00
0. 00		0.00	О	0					10.00
	0		0	28, 150					
	H - NON-BILLABE MED SUPPLIES								
00	ADMINISTRATIVE & GENERAL	5.00	0	113					1.00
00	OPERATION OF PLANT	7.00	0	267					2.00
00	NURSING ADMINISTRATION	13.00	0	61					3.00
00	CENTRAL SERVICES & SUPPLY	14.00	0	296, 412					4.00
00 00	CARDIAC REHABILITATION	76. 97 0. 00	0	2					5.00
00		0.00	0	0					7.00
00		0.00	0	0					8.00
00		0.00	0	0					9.00
0. 00		0.00	0	0					10.00
. 00		0.00	ō	0					11.00
2.00		0.00	0	0					12.00
8.00		0.00	О	0					13.00
. 00		0.00	0	0					14.00
6.00		0.00	0	0					15.00
. 00	<u> </u>	0.00	0	0					16.00
	0		0	296, 855					
~~		5 00	150.000	a					
00	ADMI NI STRATI VE & GENERAL	5.00	<u>158, 039</u> 158, 039	<u>0</u>					1.00
	J - UTILITIES		156, 039	0					
00	UTILITIES	7.01	0	360, 291					1.00
00			0	360, 291					1.00
	L - OBSTETRI CS	I		000,271					
00	NURSERY	43.00	0	9, 466					1.00
00	DELIVERY ROOM & LABOR ROOM	52.00	137, 991	27, 427					2.00
	0		137, 991	36, 893					
	M – CAFETERIA								
00	CAFETERI A	<u>11.</u> 00	113, 880	47,491					1.00
			113, 880	47, 491					
~~	N - OT AND ST	(7.00	01 (07	0.(/0					1.00
00 00		67.00	91, 697	8, 668					1.00
00	SPEECH PATHOLOGY		1 <u>8, 842</u> 110, 539	<u>1, 781</u> 10, 449					2.00
	Grand Total: Increases		520, 449	4, 943, 853					500.00

## IU HEALTH PAOLI HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1306

 Period:
 Worksheet A-6

 From 01/01/2018
 Bate/Time Prepared:

 To
 12/31/2018
 Date/Time Prepared:

						5/28/2019 1	<u>2:19 pm</u>
		Decreases					
	Cost Center	Line #	Salary		Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	5.00	0	43, 783	0		1.00
2.00	OPERATION OF PLANT	7.00	0		0		2.00
3.00	HOUSEKEEPING	9.00	0	73, 447	0		3.00
4.00	DI ETARY	10.00	0	72, 620	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	83, 251	0		5.00
6.00	HOUSE SUPERVI SORS	13.01	0	63, 758	0		6.00
7.00	PHARMACY	15.00	0	48, 142	0		7.00
8.00	NONPHYSICIAN ANESTHETISTS	19.00	0	22, 307	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	303, 151	0		9.00
10.00	OPERATING ROOM	50.00	0	98, 723	0		10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00 64.00	0	115, 849	0		11.00
12.00 13.00	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	65.00	0	14, 521 46, 362	0		12.00 13.00
14.00	PHYSICAL THERAPY	66.00	0	111, 032	0		14.00
15.00	CARDI AC REHABI LI TATI ON	76.97	0	11	0		15.00
16.00	CLINIC	90.00	0	1, 303	0		16.00
17.00	EMERGENCY	91.00	0	225, 871	0		17.00
18.00	VISITING SPECIALTY CLINIC	190.01	0	1, 194	0		18.00
	0		0	1, 395, 885			
	B - BILLABLE DRUGS						
1.00	PHARMACY	15.00	0		0		1.00
2.00	RADI OLOGY-DI AGNOSTIC	54.00	0	11, 177	0		2.00
			0	1, 296, 108			_
1 00	C - BILLABLE SUPPLIES CENTRAL SERVICES & SUPPLY	14.00	0	249	0		1 00
1.00 2.00	NONPHYSICIAN ANESTHETISTS	14.00	0		0		1.00 2.00
3.00	ADULTS & PEDIATRICS	30.00	0	649	0		3.00
4.00	NURSERY	43.00	0	21	0		4.00
5.00	OPERATING ROOM	50.00	0	41, 286	0		5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 919	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	285	0		7.00
8.00	EMERGENCY	91.00	0	4, 268	0		8.00
9.00	VISITING SPECIALTY CLINIC	<u> </u>	0		0		9.00
	0		0	49, 320			_
	D - CAPITAL RELATED COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0		9 9		1.00
2.00 3.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	96, 464 248, 375	9		2.00 3.00
4.00	HOUSEKEEPI NG	9.00	0	248, 375	0		4.00
5.00	DI ETARY	10.00	0	7, 664	0		5.00
6.00	NURSI NG ADMI NI STRATI ON	13.00	0	1, 922	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 608	0		7.00
8.00	PHARMACY	15.00	0	33, 366	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	4, 045	0		9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	18, 897	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	60, 958	0		11.00
	NURSERY	43.00	0	_,	0		12.00
13.00	OPERATING ROOM	50.00	0		0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	450, 684	0		14.00
15.00	LABORATORY I NTRAVENOUS THERAPY	60.00 64.00	0	1, 563 1, 605	0		15.00 16.00
16. 00 17. 00	RESPIRATORY THERAPY	65.00	0	26, 867	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	151, 981	0		18.00
19.00	CARDI AC REHABI LI TATI ON	76.97	0	3, 785	0		19.00
20.00	EMERGENCY	91.00	0	46, 763	0		20.00
21.00	VISITING SPECIALTY CLINIC	190.01	0	542	0		21.00
22.00	OUTREACH	190. 02	0	308	0		22.00
23.00	PAOLI FAMILY PRACTICE	190.05	0	2, 224	0		23.00
24.00	OTHER PROPERTY	190.06	0	<u> </u>	0		24.00
	0		0	1, 249, 300			_
	E - IMPLANT SUPPLIES				_		
1.00	PHARMACY	15.00	0	285	0		1.00
2.00	OPERATING ROOM	50.00	0	3, 078	0		2.00
3.00	EMERGENCY	91.00	0		<u>0</u>		3.00
	U F - LEASE EXPENSE		0	3, 531			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	169, 580	10		1.00
1.00		<u> </u>	<u> </u>				1.00
	G - NON-BILLABLE DRUGS	I I		,			
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	65	0		1.00
2.00	NONPHYSI CI AN ANESTHETI STS	19.00	0	37	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2, 829	0		3.00
4.00	NURSERY	43.00	0	168	0		4.00

RECLAS	Financial Systems SIFICATIONS		IU HEALTH PAOL	Provider (	CCN: 15-1306	Peri od:	u of Form CMS-2552 Worksheet A-6
						From 01/01/2018 To 12/31/2018	Date/Time Prepare 5/28/2019 12:19 p
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .	
	6. 00	7.00	8.00	9.00	10.00		
5.00	OPERATING ROOM	50.00	0	1, 810		0	5.
b. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	15, 787	r	0	6.
. 00	INTRAVENOUS THERAPY	64.00	0	578		0	7.
8.00	RESPI RATORY THERAPY	65.00	0	18		0	8.
. 00	PHYSI CAL THERAPY	66.00	0	59		0	9.
0.00	EMERGENCY	91.00	0	6, 799		0	10.
	0		0	28, 150	)	1	
	H - NON-BILLABE MED SUPPLIES	· · ·				·	
. 00	HOUSEKEEPI NG	9.00	0	3, 283		0	1.
. 00	DI ETARY	10.00	0	303	8	0	2.
. 00	PHARMACY	15.00	0	23, 002		0	3.
. 00	MEDICAL RECORDS & LIBRARY	16.00	0	5		0	4.
. 00	NONPHYSI CLAN ANESTHETI STS	19.00	0	2, 122		0	5.
. 00	ADULTS & PEDIATRICS	30.00	0	38, 908		0	6.
. 00	NURSERY	43.00	0	20, 144		0	7.
. 00	OPERATING ROOM	50.00	0	41, 585		0	8.
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	31, 663		0	9
0.00	LABORATORY	60,00	0	26		0	10.
1.00	INTRAVENOUS THERAPY	64.00	0	7, 174		0	11.
2.00	RESPI RATORY THERAPY	65.00	0	8, 323		0	12.
3.00	PHYSI CAL THERAPY	66.00	0	6, 493		0	13.
4.00	EMERGENCY	91.00	0	110, 940		0	14.
5.00	VI SI TI NG SPECIALTY CLINIC	190.01	0	2, 846		0	15.
6.00	OUTREACH	190.02	0	2, 040		0	16.
0.00		190.02	0	296, 855		9	10.
	U - COO/CNO		0	290, 000	,		
. 00	NURSI NG ADMI NI STRATI ON	13.00	158, 039	0		0	1.
. 00			158, 039 158, 039	0		4	1.
	J - UTILITIES		156, 039	U			
. 00	OPERATION OF PLANT	7.00	0	360, 291	1	0	1.
. 00			0	<u>360, 291</u> 360, 291		<u><u>u</u></u>	1.
			U	360, 291			
00	L - OBSTETRI CS	20.00	42.071	26.002	, I	0	1
. 00	ADULTS & PEDIATRICS	30.00	42, 871	36, 893			1.
. 00	NURSERY	<u>43.00</u>	95, 120		<u> </u>	Ō	2.
	0		137, 991	36, 893	j		
00	M - CAFETERIA	10.00	110.000	47.404	1		
. 00	DI ETARY	<u>10.00</u>	113, 880	47, 491		Ō	1.
			113, 880	47, 491	L		
	N - OT AND ST						
. 00	PHYSI CAL THERAPY	66.00	110, 539	10, 449		0	1.
. 00			0	0	<u> </u>	Ō	2.
	TOTALS		110, 539	10, 449		_	
00.00	Grand Total: Decreases		520, 449	4, 943, 853	8		500.

Heal th	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ILLIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-1306		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part I	pared:
				Acquisition			
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES				•	
1.00	Land	148,000	0		0 0	0	1.00
2.00	Land Improvements	438, 464	0		0 0	0	2.00
3.00	Buildings and Fixtures	4, 741, 722	0		0 0	0	3.00
4.00	Building Improvements	1, 416, 127	369, 994		0 369, 994	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	10, 649, 460	393, 070		0 393, 070	1, 164, 990	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17, 393, 773	763, 064		0 763, 064	1, 164, 990	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	17, 393, 773	763, 064		0 763, 064	1, 164, 990	10.00
		Ending Balance	Fully				
		Ũ	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	148, 000	0				1.00
2.00	Land Improvements	438, 464	0				2.00
3.00	Buildings and Fixtures	4, 741, 722	0				3.00
4.00	Building Improvements	1, 786, 121	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9, 877, 540	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	16, 991, 847	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	16, 991, 847	0				10.00

Heal th	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1306	Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018		norod.
					To 12/31/2018	Date/Time Pre 5/28/2019 12:	19 nm
			SI	UMMARY OF CAP	I TAL	0/20/2017 12.	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
	<b>T</b>	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	C		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	C		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	C	)	0 0	0	3.00
		SUMMARY O	F CAPITAL				
				_			
	Cost Center Description		Total (1) (sum	ו			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions) 14.00	15.00	-			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			und 2			
1 00		SHEET A, CULUM	IN Z, LINES I à				1 00
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0					1.00 2.00
2.00	Total (sum of lines 1-2)	0					2.00
3.00	Total (sum of Tries 1-2)	1 0		4			J 3.00

Health Financial Systems	IU HEALTH PAO	LI 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		
	COMF	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPI TAL	
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 CE	-					
1.00 CAP REL COSTS-BLDG & FIXT	7, 114, 307	0			0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	9, 877, 539	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	2.00
3.00 Total (sum of lines 1-2)	16, 991, 846	0	16, 991, 84		0	3.00
	ALLOCAT	TION OF OTHER O	CAPITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 519, 085		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 741, 574	0	2.00
3.00 Total (sum of lines 1-2)	0	0		0 1, 260, 659	-166, 407	3.00
		SL	IMMARY 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 CE	-		L			
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	352, 678	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0	741, 574	2.00
3.00  Total (sum of lines 1-2)	0	0		0 0	1, 094, 252	3.00

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1306	Period:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 12:	
				Expense Classification o		572672019 12.	
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	<u>Wkst. A-7 Ref.</u> 5.00	
1.00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		o	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
	(chapter 2)		0			-	
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10. 00	Provider-based physician adjustment	A-8-2	-2, 141, 504			0	10.00
11. 00	Sale of scrap, waste, etc.		О		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	3, 116, 931			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16. 00	Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and		0		0.00	0	18.00
19.00	abstracts Nursing and allied health		О		0.00	0	19.00
	education (tuition, fees, books, etc.)						
	Vending machines		0		0.00	0	
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
22.00	overpayments and borrowings to		U		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
	(chapter 21)						
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
	therapy costs in excess of		Ŭ				
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of		0				
32.00	limitation (chapter 14) CAH HIT Adjustment for	A	-140, 773	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
22 00	Depreciation and Interest MISCELLANEOUS INCOME	В	-8 617	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Health Financial Systems		IU HEALTH PAO	LI HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Period:	Worksheet A-8	
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/28/2019 12:	
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description Ba	asis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 MI SCELLANEOUS I NCOME	В	-47, 331	CAFETERIA	11.00	0	33.01
33. 02 MI SCELLANEOUS I NCOME	В	-1, 527	NURSING ADMINISTRATION	13.00	0	33.02
33. 03 MI SCELLANEOUS I NCOME	В	-2,506	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33. 04 MI SCELLANEOUS I NCOME	В	-31	RADI OLOGY-DI AGNOSTI C	54.00	0	33.04
33. 05 MI SCELLANEOUS I NCOME	В	-22,050	PHYSICAL THERAPY	66.00	0	33.05
33.06 MI SCELLANEOUS I NCOME	В	1,003	DRUGS CHARGED TO PATIENTS	73.00	0	33.06
33.07 MI SCELLANEOUS I NCOME	В	-120	CLINIC	90.00	0	33.07
33.08 MI SCELLANEOUS I NCOME	В	-2,500	EMERGENCY	91.00	0	33.08
33.09 UNWONTED SITUATIONS	В	-100	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33. 10 HAF	A	-724, 331	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 ACCRUED PTO	А	-12, 817	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	33. 11
33. 12 BENEFITS	А	-1, 397, 901	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	33.12
33. 13 CRNA	А	-96, 222	NONPHYSI CI AN ANESTHETI STS	19.00	0	33.13
33.14 MARKETING	А	-2,645	ADULTS & PEDIATRICS	30.00	0	33.14
33. 15 RECRUI TI NG EXPENSE	А	-58, 857	ADMINISTRATIVE & GENERAL	5.00	0	33.15
50.00 TOTAL (sum of lines 1 thru 49)		-1, 877, 915				50.00
(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.

Heal th	Financial Systems	IU HEALTH PA	OLI HOSPITAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1306	Period: From 01/01/2018	Worksheet A-8	8-1
OFFICE	COSTS				Date/Time Pre	pared:
					5/28/2019 12:	19 pm
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00			1.00	5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAIMED	
1.00	HOME OFFICE COSTS:	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	140, 773	0	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1, 425, 841	0	2.00
2.00		ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	3, 642, 297	3, 516, 395	2.00
3.00		ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	432,004	3, 310, 393	3.00
3.01			RELATED PARTY	432,004	0	3.01
3.02		EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	66, 916	127, 279	3.02
3.03			RELATED PARTY	807, 048	878, 620	3.03
3.04			RELATED PARTY	007,048	22, 888	3.04
3.05			RELATED PARTY	476, 621	702,078	
3.00			RELATED PARTY	194, 121	209, 748	
3.08			RELATED PARTY	41, 694	207, 740	3.08
3.09			SIP ER ALLOCATION	2, 353, 756	995, 562	3.00
3.10			SHARED EMPLOYEES	1, 591	1, 591	3, 10
3.11			SHARED EMPLOYEES	156, 328	156, 328	3. 11
3.12			SHARED EMPLOYEES	1, 344	1, 344	3. 12
3.13			SHARED EMPLOYEES	4, 163	4, 163	3.13
3.14	54.00	RADI OLOGY-DI AGNOSTI C	SHARED EMPLOYEES	67, 340		3.14
3.15	60.00	LABORATORY	SHARED EMPLOYEES	1, 228, 002		
3.16			SHARED EMPLOYEES	21, 311	21, 311	3.16
4.00	190.01	VISITING SPECIALTY CLINIC	SHARED EMPLOYEES	166, 070		4.00
5.00	TOTALS (sum of lines 1-4).			11, 238, 579	8, 121, 648	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which

nas not	been posted to worksneet A,	corumns r and/or 2, 1	rne amoun	t allowable sh	ould be indicated in cold	mn 4 of this part.	
					Related Organization(s)	and/or Home Office	
					<u>j</u>		
	Symbol (1)	Name		Percentage of	Name	Percentage of	
				Ownershi p		Ownershi p	
	1.00	2.00		3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELAT	FED_ORGANIZATION(S) A	ND/OR HON	IE OFFLCE:			

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

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

6.00	В	0.00 I U HEALTH BLOOM 0.0	6.00
7.00	В	0.00 I U HEALTH 100.0	7.00
8.00	С	0.00 UH SIP 0.0	8.00
9.00		0.00 0.0	9.00
10.00		0.00 0.0	0 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.

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

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

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

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELA OFFICE COSTS	ATED ORGANIZATIONS AND HOME		From 01/01/2018	Worksheet A-8-1 Date/Time Prepared:

					5/28/2019 12:	<u>19 pm</u>
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTMI	ENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	140, 773	9				1.00
2.00	1, 425, 841	0				2.00
3.00	125, 902	0				3.00
3.01	432,004	0				3. 01
3.02	11, 359	9				3. 02
3.03	-60, 363	0				3.03
3.04	-71, 572	0				3.04
3.05	-22,888					3.05
3.06	-225, 457	0				3.06
3.07	-15, 627					3.07
3.08	18, 765					3.08
3.09	1, 358, 194					3.09
3.10	0	0				3.10
3.11	0	0				3. 11
3.12	0	0				3.12
3.13	0	0				3.13
3.14	0	0				3.14
3.15	0	0				3.15
3.16	0	o o				3, 16
4.00	0	o o				4.00
5.00	3, 116, 931					5.00
-				the second the state of the West	kabaat A column 6 linea ac	

* 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.

nas not	Deen posteu to worksneet A,	corumns r and/or z, the amount arrowable should be rhu cated rh corumn 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	Type of business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

rerinbur	Sement under title Aviii.		
6.00	HOSPI TAL		6.00
7.00	HOME OFFICE		7.00
8.00	PHYSICIAN GROUP		8.00
9.00			9.00
10.00		1	10.00
100.00		10	00.00
(1) 1160	the following symbols to inc	licata interrelationchin to related organizations:	

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	IU HEALTH PA	OLI HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (		Period:	Worksheet A-8	3-2
						From 01/01/2018 To 12/31/2018		narod
						10 12/31/2010	5/28/2019 12:	19 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der		Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMINISTRATIVE & GENERAL	625, 434					1.00
2.00		EMERGENCY	2, 181, 979	1, 516, 070			-	2.00
3.00	0.00		0	0	(		-	3.00
4.00	0.00		0	-			0	4.00
5.00	0.00		0	0	· · · · · · · · · · · · · · · · · · ·	-	0	5.00
6.00	0.00		0	0	(	0	0	6.00
7.00	0.00		0	0		0	0	7.00
8.00	0.00		0	0		0	0	8.00
9.00	0.00		0	0			0	9.00
10.00	0.00		0			0	0	10.00
200.00	What Alipa #	Cost Costos (Dhusi si on	2, 807, 413				0 Dhuci ci ch Cast	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of Memberships &		Physician Cost of Malpractice	
		rdentifier		Limit	Continuing	Share of col.	Insurance	
					Education	12	Thou ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	0.00					1.00
2.00		EMERGENCY	0					2.00
3.00	0.00		0			0	0	3.00
4.00	0.00		0			0	0	4.00
5.00	0.00		0	0	) (	o o	0	5.00
6.00	0.00		0	0	) (	0 0	0	6.00
7.00	0.00		0	0	) (	0 0	0	7.00
8.00	0.00		0	0	) (	0 0	0	8.00
9.00	0.00		0	0	) (	0 0	0	9.00
10.00	0.00		0	0	) (	0 0	0	10.00
200.00			0	0	) (	0 0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16.00	17.00	10.00		
1 00	1.00	ADMI NI STRATI VE & GENERAL	15.00			18.00		1.00
1.00 2.00		EMERGENCY	0	-				2.00
2.00	0.00	EWERGENCT	0					2.00
4.00	0.00		0	0		-		4.00
4.00 5.00	0.00		0					4.00 5.00
5.00 6.00	0.00		0	0		-		6.00
7.00	0.00		0			-		7.00
8.00	0.00		0					8.00
9.00	0.00		0			-		9.00
10.00	0.00		0					10.00
200.00	0.00		0					200.00
	I	1	۱ ^۷ ۱		1	, , 00 .	I	

Health Financial Systems COST ALLOCATION - GENERAL SERVICE CO:		IEALTH PAO	LI HOSPITAL Provider CO	N: 15 1206 D	In Lie	u of Form CMS-2 Worksheet B	2552-10
COST ALLOCATION - GENERAL SERVICE CO.	515		Provider CC		rom 01/01/2018	Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/28/2019 12:	
		_					
Cost Center Description	fo Al I (fro	Expenses or Cost ocation m Wkst A ol. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS	т	352, 678	352, 678		I		1.00
2.00 00200 CAP REL COSTS-BLDG & FTX		741, 574	332,070	741, 574			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPART		1, 539, 334	6, 294		1, 559, 690		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	1	5, 735, 898	21, 015		121, 617	5, 925, 481	5.00
7.00 00700 OPERATION OF PLANT		1, 112, 501	26, 671	59, 589 0	79, 895	1, 278, 656	7.00
7.01 00701 UTILITIES 8.00 00800 LAUNDRY & LINEN SERVICE		360, 291 62, 677	0 1, 839	, s	0	360, 291 68, 624	7.01 8.00
9. 00 00900 HOUSEKEEPI NG		246, 093	5, 749		37, 191	301, 876	9.00
10. 00 01000 DI ETARY		128, 442	10, 002		18, 809	179, 599	
11.00 01100 CAFETERIA		114,040	6, 159		23, 632	157, 592	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 13. 01 01301 HOUSE SUPERVI SORS		1,048,013 441,523	8, 923	19, 936 0	104, 080 85, 220	1, 180, 952 526, 743	13.00 13.01
14.00 01400 CENTRAL SERVICES & SUPPL	Y	337, 291	12, 802	28, 603	03, 220	378, 696	
15.00 01500 PHARMACY		470, 905	7, 164	16, 006	47, 460	541, 535	
16.00 01600 MEDICAL RECORDS & LIBRAR	Y	7, 254	4, 768		0	22, 675	
17.00 01700 SOCIAL SERVICE 19.00 01900 NONPHYSICIAN ANESTHETIST	s	0 281, 576	0	0	0 71, 048	0 352, 624	17.00 19.00
INPATIENT ROUTINE SERVICE COST		201, 370	0	0	71,040	552, 024	17.00
30. 00 03000 ADULTS & PEDI ATRI CS		1, 036, 918	47, 483	106, 087	191, 534	1, 382, 022	30.00
31.00 03100 INTENSIVE CARE UNIT		0	0	0	0	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS		78, 561	1, 532	3, 423	14, 284	97, 800	43.00
50. 00 05000 OPERATI NG ROOM		522, 468	36, 937	82, 523	92, 345	734, 273	50.00
52.00 05200 DELIVERY ROOM & LABOR RO		221, 548	1, 373		40, 283	266, 271	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		1, 270, 177	35, 441	79, 182	168, 485	1, 553, 285	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY		1, 257, 320 82, 898	11, 252 2, 758		0 14, 291	1, 293, 711 106, 109	60.00 64.00
65. 00 06500 RESPI RATORY THERAPY		377, 151	1, 740		68, 060	450, 840	
66.00 06600 PHYSI CAL THERAPY		479, 021	27, 609	61, 684	94, 998	663, 312	66.00
67.00 06700 OCCUPATIONAL THERAPY		100, 365	5, 528		19, 028	137, 271	67.00
68. 00 06800 SPEECH PATHOLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED		20, 623 49, 320	1, 134 0	2, 533 0	3, 910	28, 200 49, 320	
72.00 07200 I MPL. DEV. CHARGED TO PA		3, 531	0	0	0	3, 531	72.00
73.00 07300 DRUGS CHARGED TO PATIENT		1, 297, 111	0	0	0	1, 297, 111	
73. 01 07301 DRUGS CHARGED TO PATIENT	S	0	0	0	0	0	73.01
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)		0	0	0	0	0	74.00 75.00
75. 01 07501 CARDI AC REHAB		0	0		0	0	•
76. 97 07697 CARDI AC REHABI LI TATI ON		288	0	0	55	343	76.97
0UTPATIENT SERVICE COST CENTER 88.00 08800 RURAL HEALTH CLINIC	S	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEAL	TH CENTER	0	0	0	0	0	
90. 00 09000 CLINIC		76, 360	251	561	6, 704	83, 876	•
90. 01 09001 VI SI TI NG SPECIALTY CLI NI		0	0	0	0	0	90.01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI		2, 177, 238	24, 686	55, 153	254, 883	2, 511, 960 0	
OTHER REIMBURSABLE COST CENTER					I	0	72.00
95.00 09500 AMBULANCE SERVICES		0	0	0	0	0	
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		0	0	0	0	0	101.00
113. 00 11300 I NTEREST EXPENSE							113.00
118.00 SUBTOTALS (SUM OF LINES	1 through 117) 2	2, 030, 988	309, 110	690, 611	1, 557, 812	21, 934, 579	
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SH0 190.01 19001 VISITING SPECIALTY CLINI	P & CANTEEN	0 178, 694	0 22, 774	0 50, 881	0 1, 878	0 254, 227	190.00
190. 02 19002 OUTREACH		2, 959	22, 774		1, 878		190.01
190. 03 19003 FOUNDATI ON		51	37	82	0		190.03
190.04 19004 SPRING VALLEY FAMILY PRA	CTICE	0	0	0	0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE		4, 601	723		0		190.05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH		0	17, 356 0	0 0		17, 356 0	190.06
192. 00 19200 PHYSI CLANS' PRI VATE OFFI	CES	0	0	0	0	0	192.00
193.00 19300 NONPALD WORKERS		О	0	0	О		193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers			0	_	~		200. 00 201. 00
202.00 TOTAL (sum lines 118 thr	ough 201) 2	2, 217, 293	352, 678	741, 574	1, 559, 690	22, 217, 293	
	5 / 1 -					,_;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;	

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	IU HEALTH PAOL	HOSPITAL Provider CCI		eri od:	u of Form CMS-2 Worksheet B	2552-10
					rom 01/01/2018 o 12/31/2018	Part I Date/Time Pre 5/28/2019 12:	pared: 19 pm
	Cost Center Description	ADMI NI STRATI VE ( & GENERAL	OPERATION OF PLANT	UTI LI TI ES	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.00	7.00	7.01	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	5, 925, 481					5.00
7.00	00700 OPERATION OF PLANT	465, 059	1, 743, 715				7.00
7.01 8.00	00701 UTI LI TI ES 00800 LAUNDRY & LI NEN SERVI CE	131, 041 24, 959	0 14 424	491, 332 3, 059			7.01
8.00 9.00	00900 HOUSEKEEPING	109, 795	14, 434 45, 129	3, 039 9, 565		466, 365	
10.00	01000 DI ETARY	65, 322	78, 518	16, 641		20, 255	
11.00	01100 CAFETERI A	57, 318	48, 352	10, 248	0	12, 473	
13.00	01300 NURSING ADMINISTRATION	429, 523	70, 051	14, 847	0	18, 070	
13.01	01301 HOUSE SUPERVI SORS	191, 581	0	0	-	0	
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	137, 735	100, 505	21, 302		0	
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	196, 961 8, 247	56, 243 37, 431	11, 920 7, 933		9, 656	
17.00	01700 SOCIAL SERVICE	0, 247	0	,, ,35		0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	128, 253	0	0		0	
	INPATIENT ROUTINE SERVICE COST CENTERS				1		1
30.00	03000 ADULTS & PEDI ATRI CS	502,654	372, 769	79, 008		96, 159	
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	12 020	0	-	0 3, 103	
43.00	ANCI LLARY SERVICE COST CENTERS	35, 571	12, 028	2, 549	0	3, 103	43.00
50.00	05000 OPERATI NG ROOM	267,062	289, 970	61, 457	5, 806	74, 801	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	96, 845	10, 777	2, 284		2, 780	
54.00	05400 RADI OLOGY-DI AGNOSTI C	564, 944	278, 230	58, 969	15, 693	71, 772	54.00
60.00	06000 LABORATORY	470, 534	88, 333	18, 722		22, 786	
64.00	06400 I NTRAVENOUS THERAPY	38, 593	21, 650	4, 589		5, 585	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	163, 975 241, 253	13, 664 7, 698	2, 896 45, 937		3, 525 55, 911	
67.00	06700 OCCUPATI ONAL THERAPY	49, 927	1, 540	9, 198		11, 195	
68.00	06800 SPEECH PATHOLOGY	10, 257	337	1, 886		2, 296	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 938	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 284	0	0	0	0	
73.00 73.01	07300 DRUGS CHARGED TO PATIENTS 07301 DRUGS CHARGED TO PATIENTS	471, 771	0	0	0	0	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	
75.00	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	
75.01	07501 CARDI AC REHAB	0	0	0	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	125	0	0	0	0	76.97
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0 0		0	
90.00		30, 506	1, 973	418			90.00
90.01	09001 VISITING SPECIALTY CLINIC	0	0	0		0	1
91.00	09100 EMERGENCY	913, 622	193, 794	41, 073	49, 148	49, 991	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES		0		0	0	
	10100 HOME HEALTH AGENCY	0	0	0 0		0	95.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		0	0	0	101.00
113.00	11300 I NTEREST EXPENSE						113.00
118.00		5, 822, 655	1, 743, 426	424, 501	109, 112	460, 867	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC	0 92, 465	0	0 37, 892	0 1, 964		190. 00 190. 01
	19001 VISITING SPECIALIY CLINIC 19002 OUTREACH	92, 465 2, 050		37, 892 N	1, 904 N		190.01
	19003 FOUNDATI ON	62	289	61	0		190.02
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190.04
190 05	19005 PAOLI FAMILY PRACTICE	1, 936	О	0	0		190. 05
		6, 313	0	28, 878	0		190.06
190.06	19006 OTHER PROPERTY	0, 515	-1				
190. 06 191. 00	19100 RESEARCH	0	0	0	0		191.00
190.06 191.00 192.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		0	192.00
190.06 191.00 192.00	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0 0 0	0 0 0	0 0 0	0	
190.06 191.00 192.00 193.00	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS Cross Foot Adjustments Negative Cost Centers	0, 313 0 0 0 0 0 0 5, 925, 481	0 0 0 1, 743, 715	0 0 0 491, 332	0 0 0 111, 076	0	192.00 193.00 200.00 201.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: com 01/01/2018 0 12/31/2018	Worksheet B Part I Date/Time Pre	narodi
Cost Costor Description					5/28/2019 12:	19 pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	HOUSE SUPERVI SORS	CENTRAL SERVI CES & SUPPLY	
	10.00	11.00	13.00	13.01	14.00	
1.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 7. 01 00701 UTI LI TI ES						5.00 7.00 7.01
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	360, 335					9.00 10.00
11. 00 01100 CAFETERI A	300, 335	285, 983				11.00
13.00 01300 NURSING ADMINISTRATION	0	20, 110				13.00
13. 01 01301 HOUSE SUPERVI SORS	0	14, 404		732, 728		13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	0 10, 885	0	0	638, 238 41, 716	14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	10, 885	1	0	41,710	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSI CI AN ANESTHETI STS	0	5, 672	0	0	3, 820	19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	240.225	44 502	((0.17)	202 041	70 700	20.00
30. 00  03000  ADULTS & PEDI ATRI CS 31. 00  03100  I NTENSI VE CARE UNI T	360, 335 0	44, 593	669, 172 0	282, 841 0	70, 788 0	30.00 31.00
43. 00 04300 NURSERY	0	2, 365	-	15, 893	35, 715	43.00
ANCI LLARY SERVICE COST CENTERS	-					
50. 00 05000 OPERATI NG ROOM	0	17, 239		92, 975	88, 347	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 667		44,831	0 57 053	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	31, 618 34, 741		1, 598 0	57, 053 46	54.00 60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	2, 418		16, 258	12, 954	64.00
65. 00 06500 RESPI RATORY THERAPY	0	15, 185	0	0	14, 828	65.00
66. 00 06600 PHYSI CAL THERAPY	0	17, 907		0	9, 327	66.00
67. 00  06700  0CCUPATI 0NAL THERAPY 68. 00  06800  SPEECH PATHOLOGY	0	3, 587 737		0	1, 968 404	67.00 68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	/3/		0	86, 349	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6, 180	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0 0	0	0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
74. 00  07400  RENAL DIALYSI S 75. 00  07500  ASC (NON-DI STINCT PART)	0	U		0	0	74.00 75.00
75. 01 07501 CARDI AC REHAB	0	0	0	0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	12	194	82	0	76.97
OUTPATIENT SERVICE COST CENTERS			-1			
88. 00  08800  RURAL HEALTH CLINIC 89. 00  08900  FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	88.00 89.00
90. 00 09000 CLINIC	0	714	0	0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	C	0 0	0	0	90.01
91. 00 09100 EMERGENCY	0	56, 840	656, 991	277, 693	203, 036	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	C	0	0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	C		0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0 ( 0 . 0 . 0 .	0.05 / 0.4	4 700 00/	700 474	(00 E 10	113.00
118.00       SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN	360, 335	285, 694		732, 171	632, 540	118.00 190.00
190. 01 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 289		557		190.00
190. 02 19002 OUTREACH	0	237	0	0		190.02
190. 03 19003 FOUNDATI ON	О	C	0	0	0	190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190.04
190. 05 19005 PAOLI FAMILY PRACTICE 190. 06 19006 OTHER PROPERTY	0	0	0	0		190. 05 190. 06
190. 00 19000 0 THER PROPERTY 191. 00 19100 RESEARCH	0	0	0	0		190.08
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	Ő	C	0	o		192.00
193. 00 19300 NONPAI D WORKERS	0	C	0	0		193.00
200.00 Cross Foot Adjustments		~		-		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 360, 335	0 285, 983	0 1, 733, 553	0 732, 728	0 638, 238	201.00
202.00 TITL (Sum TITLES TTO THE OUGH 201)	300, 330	200, 900	η i, /35, 505	132,120	030, 230	202.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-1306	Period: From 01/01/2018	Worksheet B	
				To 12/31/2018	Date/Time Pre	epared:
Cost Contor Description	PHARMACY	MEDI CAL		CE NONPHYSI CI AN	5/28/2019 12: Subtotal	19 pm
Cost Center Description	PHARMACY	RECORDS &	SUCIAL SERVIC	ANESTHETISTS	Subtotal	
		LIBRARY				
	15.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
7. 01 00701 UTI LI TI ES 8. 00 00800 LAUNDRY & LI NEN SERVI CE						7.01
9. 00 00900 HOUSEKEEPING						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
13. 01 01301 HOUSE SUPERVI SORS 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13.01
15. 00 01500 PHARMACY	859, 260					14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	007,200	85, 951				16.00
17.00 01700 SOCIAL SERVICE	0	0		0		17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	24	0		0 490, 393		19.00
INPATIENT ROUTINE SERVICE COST CENTERS	4 00/	0.000			0.000.010	
30. 00  03000  ADULTS & PEDI ATRI CS 31. 00  03100  I NTENSI VE CARE UNI T	1,836	8, 029 0		0 0 0 0	3, 900, 019 0	
43. 00 04300 NURSERY	109	432		0 0	243, 166	
ANCI LLARY SERVICE COST CENTERS	10,1	102			210/100	101.00
50. 00 05000 OPERATI NG ROOM	1, 174	6, 789		0 490, 393	2, 350, 255	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 890		0 0	540, 848	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	10, 244	14, 480		0 0	2, 661, 666	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0 375	7, 475 2, 309			1, 936, 348 249, 305	
65. 00 06500 RESPI RATORY THERAPY	12	1,837		0 0	666, 762	
66. 00 06600 PHYSI CAL THERAPY	31	2, 188		0 0	1, 048, 565	66.00
67.00 06700 OCCUPATI ONAL THERAPY	6	395		0 0	216, 092	
68. 00 06800 SPEECH PATHOLOGY	1	55		0 0	44, 380	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	352 120		0 0	153, 959 11, 115	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	841,036	11, 070		0 0	2, 620, 988	
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	1
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	
75. 01 07501 CARDI AC REHAB 76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0 756	
OUTPATIENT SERVICE COST CENTERS	9	0		0 0	/30	/0. //
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	63		0 0	118, 059	
90.01 09001 VISITING SPECIALTY CLINIC 91.00 09100 EMERGENCY	0	0		0 0	0 4, 987, 027	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 412	28, 467		0 0	4, 907, 027	91.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					72.00
95.00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	1					1110 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	859, 260	85, 951		0 490, 393	21, 749, 310	113.00
NONREIMBURSABLE COST CENTERS	039,200	05, 751		490, 393	21, 749, 310	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	0	0		0 0	394, 082	
190. 02 19002 OUTREACH	0	0		0 0		190. 02
190. 03 19003 FOUNDATION	0	0		0 0		190.03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 05 19005 PAOLI FAMILY PRACTICE	0	0				190. 04 190. 05
190. 06 19006 OTHER PROPERTY	0	0		0 0		190.05
191. 00 19100 RESEARCH	o o	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers		0		0 0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	859, 260	85, <b>9</b> 51		0 490, 393		
	007,200	55, 751	I	.,0,070	,,,,,,,,,	

	Financial Systems	IU HEALTH PAOLI			Form CMS-2552-10
CUST	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-130	From 01/01/2018 Part To 12/31/2018 Date	e/Time Prepared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	5728	8/2019 12:19 pm
		25.00	26.00		
1 00	GENERAL SERVICE COST CENTERS	T T			1.00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
7.01	00701 UTI LI TI ES				7.01
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY				9.00
11.00	01100 CAFETERIA				10.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
13.01	01301 HOUSE SUPERVI SORS				13.01
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY				16.00
17.00	01700 SOCIAL SERVICE				17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS				19.00
30.00	03000 ADULTS & PEDIATRICS	0	3, 900, 019		30.00
31.00		0	0		31.00
43.00		0	243, 166		43.00
	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	2, 350, 255		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	540, 848		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2,661,666		54.00
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	1, 936, 348 249, 305		60. 00 64. 00
65.00	06500 RESPI RATORY THERAPY	0	666, 762		65.00
66.00	06600 PHYSI CAL THERAPY	0	1,048,565		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	216, 092		67.00
68.00	06800 SPEECH PATHOLOGY	0	44, 380		68.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	153, 959		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	11, 115		72.00
73.00 73.01	07301 DRUGS CHARGED TO PATIENTS	0	2, 620, 988 0		73.00
74.00		0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	o		75.00
75.01	07501 CARDI AC REHAB	0	О		75.01
76.97		0	756		76. 97
	OUTPATIENT SERVICE COST CENTERS	-	-1		
88.00	08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 118, 059		89.00 90.00
90.01	09001 VISITING SPECIALTY CLINIC	0	0		90.01
91.00		0	4, 987, 027		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
	OTHER REIMBURSABLE COST CENTERS	1 1	1		
95.00		0	0		95.00
101.0	10100 HOME HEALTH AGENCY	0	0		101.00
113 0	SPECIAL PURPOSE COST CENTERS				113.00
118.0		0	21, 749, 310		118.00
	NONREI MBURSABLE COST CENTERS	· -			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190 0	1 19001 VISITING SPECIALTY CLINIC	0	394, 082		190. 01
	2 19002 OUTREACH	0	13, 438		190.02
190.0		0	656 0		190. 03 190. 04
190. 0 190. 0	19003 FOUNDATION		C III		1190.04
190. 0 190. 0 190. 0	4 19004 SPRING VALLEY FAMILY PRACTICE	0	-		190 05
190. 0 190. 0 190. 0 190. 0		000000000000000000000000000000000000000	7, 260 52, 547		190. 05 190. 06
190. 0 190. 0 190. 0 190. 0 190. 0	4 19004 SPRING VALLEY FAMILY PRACTICE 5 19005 PAOLI FAMILY PRACTICE	0 0 0 0	7, 260		
190. 0 190. 0 190. 0 190. 0 190. 0 191. 0 192. 0	4 19004 SPRING VALLEY FAMILY PRACTICE 5 19005 PAOLI FAMILY PRACTICE 6 19006 OTHER PROPERTY 0 19100 RESEARCH 0 19200 PHYSICIANS' PRIVATE OFFICES	0 0 0 0 0	7, 260 52, 547		190. 06 191. 00 192. 00
190.0. 190.0. 190.0. 190.0. 190.0. 190.0. 191.0. 192.0. 193.0.	4 19004 SPRING VALLEY FAMILY PRACTICE 5 19005 PAOLI FAMILY PRACTICE 6 19006 OTHER PROPERTY 0 19100 RESEARCH 0 19200 PHYSICIANS' PRIVATE OFFICES 0 19300 NONPAID WORKERS	0 0 0 0 0 0	7, 260 52, 547 0 0 0		190. 06 191. 00 192. 00 193. 00
190. 0. 190. 0. 190. 0. 190. 0. 190. 0. 191. 0. 192. 0. 193. 0. 200. 0.	4 19004 SPRING VALLEY FAMILY PRACTICE 5 19005 PAOLI FAMILY PRACTICE 5 19006 OTHER PROPERTY 1 9100 RESEARCH 1 9200 PHYSICIANS' PRIVATE OFFICES 1 9300 NONPAID WORKERS 0 Cross Foot Adjustments		7, 260 52, 547 0 0 0 0		190. 06 191. 00 192. 00 193. 00 200. 00
190.0. 190.0. 190.0. 190.0. 190.0. 190.0. 191.0. 192.0. 193.0.	4 19004 SPRING VALLEY FAMILY PRACTICE 5 19005 PAOLI FAMILY PRACTICE 5 19006 OTHER PROPERTY 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 0 Cross Foot Adjustments Negative Cost Centers		7, 260 52, 547 0 0 0		190. 06 191. 00 192. 00 193. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH PAO	LI HOSPITAL Provider CC	N. 1E 1204	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
ALLUCA	HON OF CAPITAL RELATED COSTS		Provider CC	F	rom 01/01/2018 o 12/31/2018	Part II Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/28/2019 12:	19 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS	1					1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 294	14, 062		20, 356	•
5.00	00500 ADMI NI STRATI VE & GENERAL	0	21,015	46, 951		1, 587	•
7.00 7.01	00700 OPERATION OF PLANT 00701 UTILITIES	0	26, 671 0	59, 589 0		1, 043 0	•
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 839	4, 108	-	0	
9.00	00900 HOUSEKEEPI NG	0	5, 749	12, 843		485	•
10.00		0	10, 002	22, 346		245	•
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	6, 159 8, 923	13, 761 19, 936		308 1, 358	1
13.01	01301 HOUSE SUPERVI SORS	0	0, 720	C		1, 112	•
14.00	01400 CENTRAL SERVICES & SUPPLY	0	12, 802	28, 603		0	
15.00		0	7, 164	16,006		619	•
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	4, 768 0	10, 653 0	15, 421 0	0	
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C		927	•
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	47, 483	106, 087 0		2, 499 0	
43.00	04300 NURSERY	0	1, 532	3, 423	-	186	•
	ANCI LLARY SERVI CE COST CENTERS	-	.,	-,			
50.00	05000 OPERATING ROOM	0	36, 937	82, 523		1, 205	•
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	1, 373 35, 441	3, 067 79, 182		526 2, 199	
60. 00	06000 LABORATORY	0	11, 252	25, 139		2, 199	•
64.00	06400 I NTRAVENOUS THERAPY	0	2, 758	6, 162		186	•
65.00	06500 RESPI RATORY THERAPY	0	1, 740	3, 889		888	•
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	27, 609 5, 528	61, 684 12, 350		1, 240 248	•
68.00	06800 SPEECH PATHOLOGY	0	1, 134	2, 533		51	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
74.00	07400 RENAL DIALYSIS	0	0	C	0	0	1
75.00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	
	07501 CARDI AC REHAB	0	0	C		0	
/6.9/	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	0	C	0	1	76.97
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		0	
90. 00 90. 01	09000 CLINIC 09001 VISITING SPECIALTY CLINIC	0	251	561	812	87 0	90.00 90.01
90.01 91.00	09100 EMERGENCY	0	24, 686	55, 153	79, 839	3, 331	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART		,	,	0	-,	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	0	C		0	95.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	9		ч Ч	0	101.00
	11300 INTEREST EXPENSE						113.00
118.00		0	309, 110	690, 611	999, 721	20, 331	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
	19001 VISITING SPECIALTY CLINIC	0	22, 774	50, 881			190.01
	19002 OUTREACH	0	2, 678	C	2, 678		190. 02
		0	37	82			190.03
	19004 SPRING VALLEY FAMILY PRACTICE 19005 PAOLI FAMILY PRACTICE	0	0 723	C	0 723		190. 04 190. 05
	19006 OTHER PROPERTY	0	17, 356	C	17, 356		190.05
191.00	19100 RESEARCH	0	0	C	0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192.00
193.00	19300 NONPAID WORKERS	0	0	C	0	0	193.00 200.00
200 00							
200. 00 201. 00			0	C	0		200.00 201.00 202.00

ALLOCATION OF CARTAL RELATED COSTS         Provider COL 15-1306         Perfort         Backheet B           Cost Center Description         Add Statute         Provider COL 15-1306         Provi	Health Financial Systems	IU HEALTH PAOL	_I HOSPITAL		In Lie	u of Form CMS-:	2552-10
International activity at the prepared of the provided activity at the provided activity at the prepared of the provided activity at the					eri od:	Worksheet B	
Desking         Desking <thdesking< th=""> <thdesking< th=""> <thd< td=""><td></td><td></td><td></td><td></td><td></td><td>Date/Time Pre</td><td>pared:</td></thd<></thdesking<></thdesking<>						Date/Time Pre	pared:
A GENERAL         PLANT         LIMEN SERVICE           100         GONDAL SEGNICE COST CENTERS         5.00         7.00         8.00         9.00           100         GONDAL SEGNICE COST CENTERS         5.00         7.00         8.00         9.00           100         GONDAL PELCOST-SELUCIS FITT         5.00         7.00         8.00         4.00           100         GONDAL PELCOST-SELUCIS FITT         5.00         7.00         8.00         4.00           10000         GONDAL PELCOST-SELUCIS FITT         5.00         7.01         8.00         7.01         8.00           10000         GONDAL PELCOST-SELUCIS FITT         5.04         7.01         8.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	UTILITIES	LAUNDRY &		19 pm
ENERGY SERVICE COST CONTENT         1           0.0         00100 CAP REL COST-SHUELE EXAMPLE         0         2.00           0.00         0000 CAP REL COST-SHUELE EXAMPLE         0         2.00           0.00         0000 CAP REL COST-SHUELE EXAMPLE         0         2.00           0.00         0000 CAP REL COST-SHUELE EXAMPLE         0         2.00           0.00         00000 CAP REL COST-SHUELE EXAMPLE         0         2.00           0.00         00000 CAP REL COST-SHUELE EXAMPLE         0         2.00           0.00         00000 CAPRENT CARANTSTART TO RESERVE         2.90         1.538         0         2.00         0         2.00         0         2.00         0         2.00         0         0         2.00         0         0         2.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	oust center bescription	& GENERAL	PLANT				
1000         D0100         CAP NIL COSTS MURG & LIXT         1.00           00000         D0200         DPRIL COSTS MURG F 2014         60           00000         D0200         DPRIL COSTS MURG F 2014         60           00000         D0200         DPRIL COSTS MURG F 2014         60           00000         DPRIL COSTS MURG F 2014         50         55           000000         DURGE F 2014         DPRIL COSTS MURG F 2014         7.00           000000         DURGE F 2014         DPRIL COSTS MURG F 2014         7.00           000000         DURGE F 2014         DPRIL COSTS MURG F 2014         7.00           000000         DURGE F 2014         DPRIL COSTS MURG F 2014         7.00           11.00         DURGE F 2014         DPRIL COSTS MURG F 2014         7.00           11.00         DURGE F 2014         DPRIL COSTS MURG F 2014         0.00         0.00           11.00         DURGE F 2014         DPRIL COSTS MURG F 2014         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0		5.00	7.00	7.01	8.00	9.00	
2-00         DOXID CAP ENT COSTS JUNIE FOURP         2.00         DOXID CAP ENT COSTS JUNIE FOURP         60         COST         COSTO         COSTO <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>1.00</td></td<>							1.00
6. 00         00500 AMU NI STRATI VE & GENERAL         69, 553	2.00 00200 CAP REL COSTS-MVBLE EQUIP						
1         00         00700         OPERATION OF FLANT         5.499         9.2.762         7.00           00         00000         LAURERY & LINEN SERVICE         293         7.60         8.00         00000         2.2.701         8.00         9.2.752         8.00         9.2.752         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         8.00         9.2.701         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00		(0.552					
2. 01         00/201         UTILLITES         1,538         0         5,80         7,01         7,01         7,01         8,00           0. 00/200         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201         00/201 <td< td=""><td></td><td></td><td>92, 762</td><td></td><td></td><td></td><td></td></td<>			92, 762				
9.00         09000 HOUSERKEPING         1,289         2,401         30         0         22,797         9,00           11 00         01100 (CALTERIA         6,73         2,572         32         0         611         10           11 00         01100 (CALTERIA         6,73         2,572         32         0         610         11.00           11 00         01400 (CALTERIA         5,944         6,77         2,572         32         0         0.01         10         0         10         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	7. 01 00701 UTI LI TI ES						
10.00         01000         DITARY         762         4,177         52         990         10.00           13.00         01300         NURSI NG ZAFTERI A         673         2,572         40         0         888         13.00           13.00         01300         NURSI SNG ZAPERIN SORS         2,249         0         0         0         14         00         14         00         14         00         14         00         14         00         14         00         14         00         14         00         14         00         14         00         14         00         14         00         14         00         14         00         14         00         17         00         0         0         0         17         00         00         00         00         00         00         00         00         17         00         10         10         00         00         00         00         00         17         00         10         0         00         10         10         10         10         10         10         10         10         10         10         10         10         10         10						00 707	
11.00       01100 CATETRIA       673       2.572       32       0       010       010         13.01       01301 HRUSE MANNISTRATION       5.041       3.727       46       0       683       13.01         13.01       01301 HRUSE MANNISTRATION       2.249       0       0       0       15.00         15.00       01500 FRARLSERVICES & LIBRAY       2.312       2.992       37       0       15.00         16.00       01500 FRARUACY       2.312       2.992       37       0       0       16.00         16.00       01500 FRARUACY       2.312       2.992       37       0       0       16.00         17.00       01900 KNOMPHSICIAN ANESTHEITST       1.505       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
13. 00       13.00       HOUSE SUPERVISORS       2.249       0       0       0       13.00       14.00         14. 00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       17.00       0.00       0       0       0       17.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00       10.00							
14.00       01400 CENTRAL SERVICES & LIBRARY       1, 617       5, 347       or       0       16.00         15.00       01500 MEDICAL, RECORDS & LIBRARY       97       1, 991       225       0       472       16.00         17.00       017000 MORPHARMACY       97       1, 991       225       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0							
15. 00         01500 (PHARMACY         2, 312         2, 992         37         0         0         15. 00           16. 00         01500 (BELCAL, RECORDS & LIBRARY         97         1, 91         25         0         0         17. 00         0         0         0         0         0         17. 00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td></td><td></td><td>-</td><td></td><td>0</td><td></td><td></td></t<>			-		0		
17.00       01700 SQCIAL SERVICE       0       0       0       17.00       0       0       0       17.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0					0		
19:00         01900 NONPEYSICIAN AMESTERITISTS         1,505         0         0         0         0         19:00           30:00         03000 ADULTS & PEDIATIN CSS CENTERS         5:900         19:830         247         1.884         4.701         30:00           10:00         01500 ADULTS & PEDIATIN CSS CENTERS         0         0         0         152         43:00         0         0.00         0         0         0         152         43:00         0         0.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0							
INPATI ENT BOUTI NE SERVICE COST CENTERS		-	-				
00:0000       00:000       ADULTS & PEDIATRICS       5.900       19.830       247       1.884       4.701       30.00       31.00       00:00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td< td=""><td></td><td>1, 505</td><td>0</td><td>0</td><td>0</td><td>0</td><td>19.00</td></td<>		1, 505	0	0	0	0	19.00
43.00         04300 NURSERY         418         640         8         0         152         43.00           ANCLULARY SERVICE COST CENTERS	30. 00 03000 ADULTS & PEDI ATRI CS	5, 900	19, 830			4, 701	
ANCILLARY SERVICE COST CENTERS			-				
90.00         05000         0PERATING ROOM         3.135         15, 426         192         367         3.666         50.00           52.00         05200         DELIVERY ROM & LABOR ROOM         1,137         753         7154         136         52.00           54.00         05400         RADIOLOGV-DIAGNATING         6.631         14.969         59         0         1.114         60.00           66.00         06400         INTRAFENDUS THERAPY         1.925         727         9         0         172         65.00           65.00         06500         DESPIR ATORY THERAPY         2.832         410         144         316         2.733         66.00           66.00         OCCUPATIONAL THERAPY         586         82         2.9         63         547         67.00         071.00         071.00         071.00         071.00         071.00         071.00         071.00         071.00         0.0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td< td=""><td></td><td>418</td><td>640</td><td>8</td><td>0</td><td>152</td><td>43.00</td></td<>		418	640	8	0	152	43.00
54.00         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]         [64.00]	50. 00 05000 OPERATI NG ROOM	3, 135				3, 656	50.00
60.00         0cool (LABORATORY         5, 523         4, 699         59         0         1, 114         60.00           64.00         0cool (INTRAVENOUS THERAPY         453         1, 152         14         0         273         64.00           65.00         0cool (INTRAVENOUS THERAPY         1, 225         727         9         0         772         65.00           66.00         0cool (INTRAVENOUS THERAPY         2, 832         410         144         316         2, 733         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00							
64.00       064001       INTRAVENOUS THERAPY       1.453       1.152       14       0       273       64.00         65.00       066000       RESPIRATORY THERAPY       1.925       727       9       0       772       65.00         66.00       06000       RESPIRATORY THERAPY       2.832       410       144       316       2.733       66.00         67.00       06000       OCCUPATIONAL THERAPY       586       82       29       63       547       67.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       120       18       6       13       111.2       68.00       0       0       0       73.00       73.00       0       0       0       0       73.00       73.00       73.00       73.00       73.00       73.00       0       0       0       0       0       0       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01							
66.00       06600       PHYSICAL THERAPY       2,832       410       144       316       2,733       66.00         67.00       06000       COUCUPATIONAL THERAPY       586       82       29       63       547       67.00         70.00       0700       MOD OCUPATIONAL THERAPY       586       82       29       63       547       67.00         70.00       700       0700       MOD MEDICAL SUPPLIES CHARGED TO PATIENTS       15       0       0       0       71.00         71.00       07301       DRUSS CHARGED TO PATIENTS       5.537       0       0       0       0       73.01       73.01       73.01       73.01       73.01       73.01       73.01       73.01       73.01       73.01       74.00       0       0       0       0       0       74.00       76.72       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97							
67.00       06700       0CCUPATI ONAL THERAPY       586       82       29       63       547       67.00         68.00       66000       66000       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6600       6700       6700       6700       6700       6700       6700       6700       6700       72.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00       74.00       74.00       74.00       74.00       76.70       75.70       75.70       75.70       75.70       75.70       75.70       75.70       75.70       75.70       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97       76.97				-	-		
68.00         06800         SPEECH PATHOLOGY         120         18         6         13         112         68.00           71.00         OTOOD MEDICAL SUPPLIES CHARGED TO PATIENTS         211         0         0         0         0         71.00           72.00         OT200 IMPL. DEV. CHARGED TO PATIENTS         5,537         0         0         0         0         73.00           73.01         OT301 DRUGS CHARGED TO PATIENTS         5,537         0         0         0         0         73.00           74.00         OT400 RENAL DIALYSIS         0         0         0         0         74.00           75.00         OT500 CABOLAC REHAB         0         0         0         0         0         75.01           76.00         OT500 CABOLAC REHABILITATION         1         0         0         0         0         76.97           0UTPATIENT SERVICE COST CENTERS         0         0         0         0         0         88.00         89.00           80.00         088000 RUPAL HEALTH CLINIC         358         105         1         0         2.444         91.00           90.00         09000 CLINIC         358         105         1         0         2.444							
72.00         07200         IMPL         DEV         CHARGED TO PATIENTS         15         0         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         5,537         0         0         0         0         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.01         75.00         75.00         75.00         75.00         75.00         75.							
73.00         07300         DRUGS CHARGED TO PATIENTS         5,537         0         0         0         73.00           73.01         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         73.01           74.00         07400         RENAL DI ALYSIS         0         0         0         0         74.00         0         0         0         73.01           74.00         07400         RENAL DI ALYSIS         0         0         0         0         74.00         0         0         74.00         0         0         75.01         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00         75.00			-		-		
73.01       07301       DRUGS       CHARGED TO PATLENTS       0       0       0       0       0       73.01         74.00       O7400       RENAL DI ALYSIS       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<			-		-		
74.00       07400       RENAL DI ALYSIS       0       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			0	0	=		
75. 01       07501       CARDIAC REHAB       0       0       0       0       0       0       0       0       75. 01         76. 97       CARDIAC REHABILITATION       1       0       0       0       0       0       0       0       76. 97         88. 00       08800 RURAL HEALTH CLINIC       0       0       0       0       0       88. 00         90. 00       09000 FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       89. 00         90. 01       09001 VISITING SPECIALTY CLINIC       0       0       0       0       0       90. 01         91. 00       09000 FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       0       0       90. 01         92. 00       09000 VISITING SPECIALTY CLINIC       0       0       0       0       0       92. 00       9200 OBSERVATION BEDS (NON-DISTINCT PART       10. 724       10. 309       129       3. 106       2. 444       92. 00         92. 00       09200 ABBULANCE SERVICES       0       0       0       0       0       0       10. 00       101. 00         101.00       IDTORE MELMBURSABLE COST CENTERS       10. 300       0       0       0<	74.00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
76. 97       07697       CARDIA C. REHABILITATION       1       0       0       76. 97         OUTPATIENT SERVICE COST CENTERS		Ű	0	-	-		
OUTPATIENT SERVICE COST CENTERS         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O <t< td=""><td></td><td>1</td><td>-</td><td></td><td></td><td></td><td></td></t<>		1	-				
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		· ·					/0///
90.00         09000         CLINIC         358         105         1         0         25         90.00           90.01         09001         VISITING SPECIALTY CLINIC         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0							
90.01         09001         VISITING SPECIALTY CLINIC         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0					0		
92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       92.00         0THER REIMBURSABLE COST CENTERS       95.00       0       0       0       0       0       95.00       9500       AMBULANCE SERVI CES       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       101.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       <	90.01 09001 VISITING SPECIALTY CLINIC				0		
OTHER         REI MBURSABLE         COST         CENTERS           95.00         09500         AMBULANCE         SERVI CES         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td></td><td>10, 724</td><td>10, 309</td><td>129</td><td>3, 106</td><td>2, 444</td><td></td></t<>		10, 724	10, 309	129	3, 106	2, 444	
95.00         09500         AMBULANCE SERVICES         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>92.00</td>							92.00
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           113.00         INTEREST EXPENSE           SUBTOTALS (SUM OF LINES 1 through 117)         68,346           92.01         900.00           GIFT, FLOWER, COFFEE SHOP & CANTEEN         0           190.00         19000           GIFT, FLOWER, COFFEE SHOP & CANTEEN         0           190.02         19002           019000         GIFT, FLOWER, COFFEE SHOP & CANTEEN           190.02         19002           1900.03         FOUNDATI ON           190.04         19003           1900.05         FOUNDATI ON           190.06         19004           1900.07         FOUNDATI ON           190.06         19004           1900.07         FOUNDATI ON           190.06         19004           1900.07         19004           1900.06         O           0         0           0         0           190.06         19004           19005         19005           19006         OTHER PROPERTY           74         0           0         0           0         0 <tr< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>95.00</td></tr<>		0	0	0	0	0	95.00
113.00       INTEREST EXPENSE       113.00       INTEREST EXPENSE       113.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       68,346       92,747       1,329       6,894       22,528       118.00         NONREL MBURSABLE COST CENTERS         190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         190.01       19010       VISITING SPECIALTY CLINIC       1,085       0       119       124       0       190.01         190.02       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       265       190.02         190.02       UNTRACH       24       0       0       0       265       190.02         190.03       FOUNDATION       1       15       0       0       4       190.03         190.04       19004       SPRING VALLEY FAMILY PRACTICE       0       0       0       0       190.04         190.05       19005       PAOLI FAMILY PRACTICE       23       0       0       0       190.06         191.00       19100       RESEARCH       0       0       0       0       190.06         192.00       19000		0	0	0	0	0	101. 00
I18.00         SUBTOTALS (SUM OF LINES 1 through 117)         68,346         92,747         1,329         6,894         22,528         118.00           NONREI MBURSABLE COST CENTERS         Image: Cost Centers							112 00
NONRE         MBURSABLE         COST         CENTERS           190.00         19000         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN         0         0         0         0         190.00           190.01         19001         VI SI TI NG         SPECIALTY         CLI NI C         1,085         0         119         124         0         190.01           190.02         19002         OUTRACH         24         0         0         0         265         190.02           190.03         FOUNDATI ON         1         15         0         0         4         190.03           190.04         19005         PAOLI         FAMI LY         PRACTI CE         0         0         0         0         190.05           190.05         19005         PAOLI         FAMI LY         PRACTI CE         23         0         0         0         190.05           190.06         19006         OTHER         PROPERTY         74         0         90         0         190.06           191.00         19100         RESARCH         0         0         0         0         192.00           192.00         PHYSI CI ANS'         PRI VATE OF		68, 346	92, 747	1, 329	6, 894	22, 528	
190.01       VISITING SPECIALTY CLINIC       1,085       0       119       124       0       190.01         190.02       19002       OUTREACH       24       0       0       265       190.02         190.03       19003       FOUNDATION       1       15       0       0       4       190.03         190.04       19004       SPRING VALLEY FAMILY PRACTICE       0       0       0       0       190.04         190.05       19005       PAOLI FAMILY PRACTICE       0       0       0       0       190.05         190.06       19006       OTHER PROPERTY       74       0       90       0       190.06         191.00       19100       RESEARCH       0       0       0       191.00       192.00         192.00       192.00       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       192.00       193.00       200.00       200.00         201.00       Negative Cost Centers       0       0       0       0       201.00	NONREI MBURSABLE COST CENTERS				· · · ·		
190.02       19002       OUTREACH       24       0       0       265       190.02         190.03       19003       FOUNDATION       1       15       0       0       4       190.03         190.04       19004       SPRING VALLEY FAMILY PRACTICE       0       0       0       0       190.04         190.05       19005       PAOLI       FAMILY PRACTICE       0       0       0       190.05         190.06       19006       OTHER PROPERTY       74       0       90       0       190.06         191.00       19100       RESEARCH       0       0       0       191.00       192.00         192.00       192.00       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       193.00       200.00       200.00       200.00       200.00       200.00       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00							
190.03       FOUNDATION       1       15       0       4       190.03         190.04       SPRING VALLEY FAMILY PRACTICE       0       0       0       0       190.04         190.05       19005       PAOLI FAMILY PRACTICE       0       0       0       0       190.04         190.05       19005       PAOLI FAMILY PRACTICE       23       0       0       0       190.05         190.06       19006       OTHER PROPERTY       74       0       90       0       190.06         191.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adjustments       200.00       0       0       0       201.00			0				
190.05       19005       PAOLI FAMILY PRACTICE       23       0       0       0       190.05         190.06       19006       OTHER PROPERTY       74       0       90       0       190.06         191.00       19100       RESEARCH       0       0       0       0       191.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adj ustments	190. 03 19003 FOUNDATI ON		15		0	4	190. 03
190.06       19006       OTHER PROPERTY       74       0       90       0       190.06         191.00       19100       RESEARCH       0       0       0       0       191.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       193.00       200.00         200.00       Cross Foot Adjustments       0       0       0       0       201.00			0		-		
191.00       19100       RESEARCH       0       0       0       191.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00			0				
192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0	191. 00 19100 RESEARCH		0	0	0		
200.00         Cross Foot Adjustments         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00	192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
201.00         Negative Cost Centers         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td>		0	0	0	0	0	
		0	0	0	о	0	201.00
		69, 553	92, 762	1, 538	7, 018		

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eri od:	Worksheet B	
			To	rom 01/01/2018 0 12/31/2018	Part II Date/Time Pre	pared:
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	HOUSE	5/28/2019 12: CENTRAL	19 pm
cost center bescription	DILIARI	CALLIENTA	ADMI NI STRATI ON		SERVICES &	
	10.00		10.00	10.01	SUPPLY	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	13.01	14.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
7. 01 00701 UTILITIES						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	38, 579	24, 115				10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	1, 696				13.00
13. 01 01301 HOUSE SUPERVI SORS	0	1, 215		4, 576		13.01
14.00 01400 CENTRAL SERVICES & SUPPLY	0	C		0	48, 436	14.00
15. 00 01500 PHARMACY	0	918		0	3, 166	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	0		0	1	16.00 17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	478		0	290	
INPATIENT ROUTINE SERVICE COST CENTERS			1 -1			
30. 00 03000 ADULTS & PEDI ATRI CS	38, 579	3, 760		1, 766	5, 372	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0	0	0	0	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	199	903	99	2, 710	43.00
50. 00 05000 OPERATI NG ROOM	0	1, 454	5, 280	581	6, 705	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	562		280	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 666		10	4, 330	54.00
60. 00  06000  LABORATORY 64. 00  06400  I NTRAVENOUS_THERAPY	0	2, 929 204		0 102	3 983	60.00 64.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 280		0	1, 125	
66.00 06600 PHYSI CAL THERAPY	0	1, 510		0	708	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	302		0	149	67.00
68. 00 06800 SPEECH PATHOLOGY	0	62		0	31	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6, 553 469	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	407	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	C	0	0	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	75.00
75. 01 07501 CARDI AC REHAB 76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0 0	0	0	75.01 76.97
OUTPATIENT SERVICE COST CENTERS	<u> </u>			•1		
88.00 08800 RURAL HEALTH CLINIC	0	C		0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00 09000 CLINIC 90.01 09001 VISITING SPECIALTY CLINIC	0	60		0	0	90. 00 90. 01
91. 00 09100 EMERGENCY	0	4, 795	15, 770	1, 734	15, 408	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	0	0		0	0	95.00 101.00
SPECIAL PURPOSE COST CENTERS	0		<u>/                                    </u>	<u> </u>	0	101.00
113.00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	38, 579	24, 091	41, 578	4, 573	48, 003	118.00
NONREI MBURSABLE COST CENTERS						100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 VISITING SPECIALTY CLINIC	0	0 24		0 3		190. 00 190. 01
190. 02 19002 OUTREACH	0	24		0		190.01
190. 03 19003 FOUNDATI ON	0	C	0	0		190.03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	C	0	0		190.04
190. 05 19005 PAOLI FAMILY PRACTICE	0	0	0	0		190.05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH	0	0	0	0		190. 06 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191.00
193. 00 19300 NONPALD WORKERS	0	C	0	0		193.00
200.00 Cross Foot Adjustments		-		_	-	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	20 570	0 21 115		0 1 574	0 48, 436	201.00
202.00   TOTAL (sum lines 118 through 201)	38, 579	24, 115	41, 610	4, 576	48, 430	1202. UU

Heal th	Financial Systems	IU HEALTH PAO	_I HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	<u>5/28/2019 12:</u> Subtotal	19 pm
		15.00	16.00	17.00	19.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
7.00	00700 UTILITIES						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
	01301 HOUSE SUPERVI SORS						13.01
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	33, 214					14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	33, 214	18, 007				16.00
	01700 SOCIAL SERVICE	0	10,007	0			17.00
	01900 NONPHYSI CLAN ANESTHETI STS	1	0	0	3, 201		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	71	1, 683	0		255, 922	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300 NURSERY	4	90	0		10, 364	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	45	1, 423	0		158, 929	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	43	396	0		10, 757	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	396	3, 036	0		153, 467	54.00
60.00	06000 LABORATORY	0	1, 567	0		52, 285	
64.00	06400 INTRAVENOUS THERAPY	14	484	0		13, 708	64.00
65.00	06500 RESPI RATORY THERAPY	0	385	0		12, 140	65.00
66.00	06600 PHYSI CAL THERAPY	1	459	0		99, 646	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	83	0		19, 967	67.00
68.00	06800 SPEECH PATHOLOGY	0	12	0		4, 092	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	74 25	0		6, 838 509	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	32, 511	2, 321	0		40, 369	
73.01	07301 DRUGS CHARGED TO PATIENTS	02,011	0	0		0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0		0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0		0	75.00
	07501 CARDI AC REHAB	0	0	0		0	75.01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0		9	76.97
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0		0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	
	09000 CLI NI C	0	13	0			90.00
	09001 VISITING SPECIALTY CLINIC	0	0	0		0	
	09100 EMERGENCY	171	5, 956	0		153, 716	
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	0	0	0		0	95.00
	10100 HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS	<u>_</u>					
	11300 INTEREST EXPENSE						113.00
118.00		33, 214	18, 007	0	0	994, 179	118.00
100.00	NONREIMBURSABLE COST CENTERS	0	0	0		0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC	0	0	0		75, 475	
	19002 OUTREACH	0	0	0			190.02
	19003 FOUNDATI ON	0	0	0			190.03
190.04	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0		0	190. 04
	19005 PAOLI FAMILY PRACTICE	0	0	0			190. 05
	19006 OTHER PROPERTY	0	0	0			190. 06
	19100 RESEARCH	0	0	0			191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.00
193.00 200.00	19300 NONPAID WORKERS Cross Foot Adjustments	0	0	0	3, 201		193.00 200.00
200.00		0	0	0	3, 201		200.00
201.00		33, 214	18, 007		3, 201	1, 094, 252	

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lieu of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1306	Period: Worksheet B From 01/01/2018 Part II	
			To 12/31/2018 Date/Time Pr 5/28/2019 12	epared:
Cost Center Description	Intern &	Total	5/26/2019 12	
	Residents Cost & Post			
	Stepdown			
	Adjustments			
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL				4.00 5.00
7.00 00700 OPERATION OF PLANT				7.00
7. 01 00701 UTI LI TI ES				7.01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				9.00 10.00
11. 00 01100 CAFETERIA				11.00
13.00 01300 NURSI NG ADMI NI STRATI ON				13.00
13. 01  01301 HOUSE_SUPERVI SORS 14. 00  01400 CENTRAL_SERVI CES_& SUPPLY				13.01 14.00
15. 00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
17.00 01700 SOCIAL SERVICE				17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS				19.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	255, 922		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		31.00
43.00 04300 NURSERY	0	10, 364		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	158, 929		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	10, 757		52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	153, 467		54.00
60. 00 06000 LABORATORY	0	52, 285		60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	13, 708 12, 140		64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	99, 646		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	19, 967		67.00
68. 00 06800 SPEECH PATHOLOGY	0	4, 092		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	6, 838 509		71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	40, 369		73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00 75.00
75. 00  07500  ASC (NON-DI STI NCT PART) 75. 01  07501  CARDI AC REHAB	0	0		75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	9		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		88.00 89.00
90. 00 099001 EDERALET GOALTTED HEALTH CENTER	0	1, 461		90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0		90.01
91.00 09100 EMERGENCY	0	153, 716		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	0			92.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	994, 179		118.00
NONREI MBURSABLE COST CENTERS		· 1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190. 01 19001 VI SI TI NG SPECI ALTY CLI NI C 190. 02 19002 OUTREACH	0	75, 475 2, 992		190. 01 190. 02
190. 03 19003 FOUNDATI ON	0	139		190.02
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	0	746		190.05
190. 06 19006 OTHER PROPERTY 191. 00 19100 RESEARCH	0	17, 520 0		190. 06 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	o		192.00
193. 00 19300 NONPAI D WORKERS	0	0		193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	3, 201		200. 00 201. 00
201.00   Negative cost centers 202.00   TOTAL (sum lines 118 through 201)	0	1, 094, 252		201.00
		•		

Health Financial Systems COST ALLOCATION - STATIS		IU HEALTH PAO	LI HOSPITAL Provider CO	CN: 15-1306 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2018 o 12/31/2018		
		CAPI TAL REL	ATED COSTS			5/28/2019 12:	19 pm
Cost Center	Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARIES) 4.00	5A	5.00	
GENERAL SERVICE C					1		
1.00         00100         CAP         REL         COS*           2.00         00200         CAP         REL         COS*           4.00         00400         EMPLOYEE         BEI           5.00         00500         ADMI NI STRATI           7.00         00700         OPERATI ON OI           7.01         00701         UTI LI TI ES           8.00         00800         LAUNDRY & LI	FS-MVBLE EQUIP NEFITS DEPARTMENT VE & GENERAL F PLANT	57, 547 1, 027 3, 429 4, 352 0 300	54, 160 1, 027 3, 429 4, 352 0 300	7, 516, 099 586, 067 385, 014 0 0	-5, 925, 481 0	16, 291, 812 1, 278, 656 360, 291 68, 624	7.00 7.01
9.00 00900 HOUSEKEEPI NO 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI 13.01 01301 HOUSE SUPER 14.00 01400 CENTRAL SER 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECO 17.00 01700 SOCI AL SERV	NI STRATI ON /I SORS /I CES & SUPPLY DRDS & LI BRARY CE	938 1, 632 1, 005 1, 456 0 2, 089 1, 169 778 0	938 1, 632 1, 005 1, 456 0 2, 089 1, 169 778 0	179, 224 90, 642 113, 880 501, 559 410, 672 0 228, 707 0 0	0 0 0 0 0 0 0 0	157, 592 1, 180, 952 526, 743 378, 696 541, 535 22, 675 0	10.00 11.00 13.00 13.01 14.00 15.00 16.00 17.00
19.00 01900 NONPHYSICIAI	N ANESTHETISTS SERVICE COST CENTERS	0	0	342, 377	0	352, 624	19.00
30.00         03000         ADULTS & PEI           31.00         03100         I NTENSI VE C/           43.00         04300         NURSERY	DI ATRI CS ARE UNI T	7, 748 0 250	7, 748 0 250	922, 996 0 68, 836	0	0	31.00
72.00         07200         I MPL.         DEV.         0           73.00         07300         DRUGS         CHARGI           73.01         07301         DRUGS         CHARGI           74.00         07400         RENAL         DI ALY           75.00         07500         ASC         (NON-DI S)           75.01         07501         CARDI AC         REH           76.97         07697         CARDI AC         REH/           0UTPATI ENT         SERVIC         0         0	DOM M & LABOR ROOM AGNOSTIC THERAPY THERAPY ERAPY _ THERAPY DLOGY PLIES CHARGED TO PATIENTS ENARGED TO PATIENTS ED TO PATIENTS ED TO PATIENTS SIS STINCT PART) AB BAILITATION E COST CENTERS	6, 027 224 5, 783 1, 836 450 284 4, 505 902 185 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 027 224 5, 783 1, 836 450 284 4, 505 902 185 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	445,008 194,121 811,926 0 68,870 327,980 457,793 91,697 18,842 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		266, 271 1, 553, 285 1, 293, 711 106, 109 450, 840 663, 312 137, 271 28, 200 49, 320 3, 531 1, 297, 111 0 0 0 0 0 343	52.00 54.00 60.00 64.00 65.00 67.00 68.00 71.00 72.00 73.01 74.00 75.01 75.01 76.97
90.00         09000         CLINIC           90.01         09001         VISITING SPI           91.00         09100         EMERGENCY           92.00         09200         OBSERVATION	JALIFIED HEALTH CENTER ECIALTY CLINIC BEDS (NON-DISTINCT PART	0 0 41 0 4, 028	0 0 41 0 4, 028	0 0 32, 305 0 1, 228, 265	0	0 83, 876 0	90. 00 90. 01
95. 00 09500 AMBULANCE SI	ERVI CES	0	0	0			
101.00 10100 HOME HEALTH SPECIAL PURPOSE C		0	0	0	0	0	101.00
113.00 11300 INTEREST EXI		50, 438	50, 438	7, 507, 048	-5, 925, 481	16, 009, 098	113. 00 118. 00
NONREI MBURSABLE C 190. 00 19000 GI FT, FLOWEI 190. 01 19001 VI SI TI NG SPI 190. 02 19002 OUTREACH 190. 03 19003 FOUNDATI ON 190. 04 19004 SPRI NG VALLI	OST CENTERS R, COFFEE SHOP & CANTEEN ECIALTY CLINIC	0 3, 716 437 6 0	0 3, 716 0 6 0	9, 051 0 0 0	0	0 254, 227 5, 637 170	190. 00
190. 05         19005         PAOLI         FAMIL'           190. 06         19006         OTHER         PROPEI           191. 00         19100         RESEARCH           192. 00         19200         PHYSI CLANS'           193. 00         19300         NONPAI D WORI           200. 00         Cross Foot A	Y PRACTICE RTY PRIVATE OFFICES KERS Adjustments	118 2, 832 0 0 0	0 0 0 0 0		0	5, 324 17, 356 0 0	190. 05
201.00         Negative Cost           202.00         Cost to be a           Part I)	at Centers allocated (per Wkst. B,	352, 678	741, 574	1, 559, 690		5, 925, 481	
	ultiplier (Wkst. B, Part I)	6. 128521	13. 692282	0. 207513		0. 363709	203.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2018 To 12/31/2018		
	CAPI TAL REL	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS	Reconciliation	ADMI NI STRATI VE & GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
204.00 Cost to be allocated (per Wkst. B, Part II)			20, 35	6	69, 553	204. 00
205.00 Unit cost multiplier (Wkst. B, Part			0.00270	В	0.004269	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH PAC		CN: 15-1306 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-10
			F	rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/28/2019 12:	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY	
	7.00	7.01	LAUNDRY) 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						1.00
1.00         O0100         CAP         REL         COSTS-BLDG         & FIXT           2.00         O0200         CAP         REL         COSTS-MVBLE         EQUI P           4.00         O0400         EMPLOYEE         BENEFI TS         DEPARTMENT           5.00         O0500         ADMI NI STRATI VE & GENERAL         00700         OPERATION OF         PLANT	36, 243					1.00 2.00 4.00 5.00 7.00
7. 01 00701 UTI LI TI ES 8. 00 00800 LAUNDRY & LI NEN SERVI CE	0 300	300	14, 482			7.01 8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	938				4, 345	9.00 10.00
11. 00 01100 CAFETERI A	1,032				4, 345	11.00
13.00 01300 NURSING ADMINISTRATION	1, 456			1, 456	0	13.00
13. 01 01301 HOUSE SUPERVI SORS	0	-	-	0	0	13.01
14. 00 01400 CENTRAL SERVICES & SUPPLY	2,089			0	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 169 778			778	0	15.00 16.00
17. 00 01700 SOCIAL SERVICE	0			0,70	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7,748			7, 748	4, 345	
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0		0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	250	250	0	250	0	43.00
50. 00 05000 OPERATING ROOM	6,027	6, 027	757	6, 027	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	224				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 783				0	54.00
60. 00 06000 LABORATORY	1, 836			1, 836	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	450				0	64.00
65. 00 06500 RESPI RATORY THERAPY	284				0	65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	160 32				0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	7	185		185	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0			0	0	73.01 74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0			0	0	75.00
75. 01 07501 CARDI AC REHAB	0	0	0	0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1	1	1	I		
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC	41	41		0 41	0	89.00 90.00
90.01 09001 VISITING SPECIALTY CLINIC	41	41	0	41	0	90.00
91.00 09100 EMERGENCY	4, 028	4, 028	6, 408	4, 028	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	-	-	-		-	
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	0					95.00 101.00
SPECIAL PURPOSE COST CENTERS	0		ν <u>ι</u> υ	0	0	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	36, 237	41, 630	14, 226	37, 134	4, 345	118.00
NONREI MBURSABLE COST CENTERS	1	1	i	1		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190.00
190. 01 19001 VESETING SPECEALTY CLENEC 190. 02 19002 OUTREACH	0	3, 716	256	0 437		190. 01 190. 02
190. 03 19003 FOUNDATI ON	6	6		437		190.02
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190.04
190.05 19005 PAOLI FAMILY PRACTICE	0	0	0	0	0	190. 05
190.06 19006 OTHER PROPERTY	0	2, 832	0	0		190.06
191. 00 19100 RESEARCH	0		0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			0		192.00 193.00
193.00 19300 NONPALD WORKERS 200.00 Cross Foot Adjustments	0		, 0	0	0	200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	1, 743, 715	491, 332	111, 076	466, 365	360, 335	
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	48. 111773				82.930955	
204.00 Cost to be allocated (per Wkst. B, Part II)	92, 762	1, 538	7, 018	22, 797	38, 579	204.00
	1	I	1	I I		I

Health Fi	nancial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS					Period: From 01/01/2018	Worksheet B-1	
					To 12/31/2018		
	Cost Center Description	OPERATION OF	UTI LI TI ES	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT	(SQUARE FEET)	LINEN SERVICI	E (SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)		(POUNDS OF			
				LAUNDRY)			
		7.00	7.01	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part	2. 559446	0. 031919	0. 48460	2 0. 606674	8. 878941	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH PAC	DLI HOSPITAL Provider CO		eriod:	u of Form CMS-: Worksheet B-1	
				rom 01/01/2018 o 12/31/2018	Date/Time Pre	
Cost Center Description	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	(DIRECT NRSING	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	5/28/2019 12: PHARMACY (COSTED REQUI S. )	<u>19 pm</u>
	11.00	13.00	13.01	14.00	15.00	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         CAP         REL         COSTS-BLDG & FIXT           2.00         00200         CAP         REL         COSTS-BLDG & FIXT           2.00         00200         CAP         REL         COSTS-BLDG & FIXT           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL         7.00           7.01         00701         UTI LI TI ES           8.00         00800         LAUNDRY & LINEN SERVICE           9.00         009000         HOUSEKEEPI NG           10.00         01000         DI TARY           11.00         01100         CAFETERI A           13.00         01300         NURSI NG ADMI NI STRATI ON           13.01         01301         HOUSE SUPERVI SORS           14.00         01400         CENTRAL SERVI CES & SUPPLY           15.00         01500         PHARMACY           16.00         01600         MEDI CAL           17.00         01700         SOCI AL           19.00         01900         NONPHYSI CI AN ANESTHETI STS           INPATI ENT         R	210, 656 14, 813 10, 610 0 8, 018 0 0 4, 178	80, 267 0 0 0 0 0 0	80, 267 0 0 0 0 0 0	364, 541 23, 827 5 0	1, 324, 194 0 0 37	16. 00 17. 00
30. 00 03000 ADULTS & PEDI ATRI CS	32, 847	30, 984	30, 984	40, 432	2, 829	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0 1, 742	-	0 1, 741	0 20, 399	0 168	31.00 43.00
50. 00         05000         OPERATI NG ROOM           52. 00         05200         DELI VERY ROOM & LABOR ROOM           54. 00         05400         RADI OLOGY-DI AGNOSTI C           60. 00         06000         LABORATORY           64. 00         06400         INTRAVENOUS THERAPY           65. 00         06500         RESPI RATORY THERAPY           66. 00         06600         PHYSI CAL THERAPY           67. 00         06700         OCCUPATI ONAL THERAPY           68. 00         06800         SPEECH PATHOLOGY           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS           73. 00         07300         DRUGS CHARGED TO PATI ENTS           73. 01         07301         DRUGS CHARGED TO PATI ENTS           73. 00         07400         RENAL DI ALYSI S           75. 00         07500         ASC (NON-DI STI NCT PART)           75. 01         07501         CARDI AC REHAB           76. 97         07697         CARDI AC REHAB           76. 97         07697         CARDI AC REHABI LI TATI ON	12, 698 4, 911 23, 290 25, 590 1, 781 11, 185 13, 190 2, 642 543 0 0 0 0 0 0 0 0 0 9	4, 911 175 0 1, 781 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4,911 175 0 1,781 0 0 0 0 0 0 0 0 0 0 0 0 0 9 9	0 32, 587 26 7, 399 8, 469 5, 327 1, 124 231 49, 320 3, 530 0 0 0 0 0 0 0 0 0 0 0	1, 810 0 15, 787 578 18 48 10 2 0 0 0 1, 296, 108 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52.00 54.00 60.00 64.00 65.00 66.00 67.00 68.00 71.00 72.00 73.01 74.00 75.01 75.01
88. 00         08800         RURAL HEALTH CLINIC           89. 00         08900         FEDERALLY QUALIFIED HEALTH CENTER           90. 00         09000         CLINIC           90. 01         09001         VISITING SPECIALTY CLINIC           91. 00         09100         EMERGENCY           92. 00         092200         OBSERVATION BEDS (NON-DISTINCT PART           OTHER REIMBURSABLE COST CENTERS         OTHER	0 0 526 0 41, 870	0 0 0	0 0 0	0 0 0	0 0 0 6, 799	88.00 89.00 90.00 90.01 91.00 92.00
95. 00 09500 AMBULANCE SERVICES 101. 00 10100 HOME HEALTH AGENCY	C				0	95.00 101.00
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           118.00         SUBTOTALS (SUM OF LINES 1 through 117)           NONREI MBURSABLE COST CENTERS	210, 443	80, 206	80, 206	361, 286	1, 324, 194	113. 00 118. 00
190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN         190.01       19001       VISITING SPECIALTY CLINIC         190.02       19002       OUTREACH         190.03       19003       FOUNDATION         190.04       19004       SPRING VALLEY FAMILY PRACTICE         190.05       19005       PAOLI FAMILY PRACTICE         190.06       19006       OTHER PROPERTY         191.00       19100       RESEARCH         192.00       19200       PHYSICIANS' PRIVATE OFFICES         193.00       00       Cross Foot Adjustments	0 213 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61	0 61 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 191. 00 192. 00 193. 00 200. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I)	285, 983	1, 733, 553	732, 728	638, 238	859, 260	201.00
203.00 204.00 Part I) 204.10 Part II)	1. 357583 24, 115				0. 648893 33, 214	203. 00 204. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2018	Worksheet B-1	
		_		To 12/31/2018		
Cost Center Description	CAFETERI A	NURSI NG	HOUSE	CENTRAL	PHARMACY	
	(MAN HOURS)	ADMI NI STRATI ON	SUPERVI SORS	SERVICES &	(COSTED	
			(DIRECT NRSIN	G SUPPLY	REQUIS.)	
		(DIRECT NRSING	HRS)	(COSTED		
		HRS)		REQUIS.)		
	11.00	13.00	13.01	14.00	15.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 114476	0. 518395	0. 05701	0 0. 132868	0. 025082	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	inancial Systems	IU HEALTH PAO				u of Form CMS	
COST ALL	LOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2018	Worksheet B-	
					To 12/31/2018	Date/Time Pr 5/28/2019 12	
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS			
		LIBRARY	(TIME SPENT)	(ASSI GNED			
		(GROSS CHARGES)		TIME)			
		16.00	17.00	19.00			
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00 0	0700 OPERATION OF PLANT						7.00
	0701 UTILITIES 0800 LAUNDRY & LINEN SERVICE						7.01 8.00
9.00 0	0900 HOUSEKEEPI NG						9.00
	1000 DI ETARY 1100 CAFETERI A						10.00
13.00 0	1300 NURSING ADMINISTRATION						13.00
	1301 HOUSE SUPERVI SORS 1400 CENTRAL SERVI CES & SUPPLY						13.01 14.00
15.00 0	1500 PHARMACY						15.00
	1600 MEDICAL RECORDS & LIBRARY 1700 SOCIAL SERVICE	58, 524, 629 0	о				16.00 17.00
	1900 NONPHYSICIAN ANESTHETISTS	0	0	10	ο		19.00
	NPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS	5, 465, 689	0		0		30.00
	3100 I NTENSI VE CARE UNI T	5, 405, 089	0		0		31.00
	4300 NURSERY NCI LLARY SERVI CE COST CENTERS	293, 795	0		0		43.00
	5000 OPERATING ROOM	4, 621, 537	0	10	0		50.00
	5200 DELIVERY ROOM & LABOR ROOM	1, 286, 310	0		0		52.00 54.00
1	5400 RADI OLOGY-DI AGNOSTI C 6000 LABORATORY	9, 857, 002 5, 088, 451	0		0		60.00
1	6400 I NTRAVENOUS THERAPY	1, 571, 985	0		0		64.00
1	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	1, 250, 702 1, 489, 629	0		0		65.00 66.00
	6700 OCCUPATI ONAL THERAPY	268, 769	0		0		67.00
	6800 SPEECH PATHOLOGY 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 409 239, 701	0		0		68.00 71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	81, 564	0		0		72.00
	7300 DRUGS CHARGED TO PATIENTS 7301 DRUGS CHARGED TO PATIENTS	7, 535, 759 0	0		0		73.00 73.01
74.00 0	7400 RENAL DI ALYSI S	0	0		0		74.00
	7500 ASC (NON-DI STI NCT PART) 7501 CARDI AC REHAB	0	0		0		75.00 75.01
76.97 0	7697 CARDI AC REHABI LI TATI ON	0	0		0		76. 97
	UTPATIENT SERVICE COST CENTERS 8800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 0	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö		0		89.00
	9000 CLINIC 9001 VISITING SPECIALTY CLINIC	42, 753 0	0		0		90.00 90.01
91.00 0	9100 EMERGENCY	19, 393, 574	0		0		91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART THER REIMBURSABLE COST CENTERS						92.00
95.00 0	9500 AMBULANCE SERVICES	0	0		0		95.00
	0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	0	0		0		101.00
113.001	1300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	58, 524, 629	0	10	0		118.00
190.001	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	9001 VISITING SPECIALTY CLINIC 9002 OUTREACH	0	0		0		190. 01 190. 02
	9003 FOUNDATI ON	0	0		0		190.02
	9004 SPRING VALLEY FAMILY PRACTICE	0	0		0		190.04
	9005 PAOLI FAMILY PRACTICE 9006 OTHER PROPERTY	0	0		0		190. 05 190. 06
	9100 RESEARCH	0	0		0		191.00
	9200 PHYSICIANS' PRIVATE OFFICES 9300 NONPAID WORKERS	0	0		0		192.00 193.00
200.00	Cross Foot Adjustments						200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	85, 951	О	490, 39	3		201.00 202.00
	Part I)						
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 001469 18, 007	0. 000000 0	4, 903. 93000 3, 20			203.00 204.00
	Part II)		-				

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS				Period: Worksheet E From 01/01/2018		
		_		To 12/31/2018	Date/Time Pre 5/28/2019 12:	
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN			
	RECORDS &		ANESTHETI STS			
	LI BRARY	(TIME SPENT)	(ASSI GNED			
	(GROSS		TIME)			
	CHARGES)					
	16.00	17.00	19.00			
205.00 Unit cost multiplier (Wkst. B, Part	0. 000308	0. 000000	32.01000	0		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Fina	ncial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1306	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/28/2019 12:	
			Title	× XVIII	Hospi tal	Cost	•
					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	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	0 ADULTS & PEDIATRICS	3, 900, 019		3, 900, 01	19 0	0	30.00
	O INTENSIVE CARE UNIT	0			0 0	0	31.00
	0 NURSERY	243, 166		243, 16	6 0	0	43.00
ANCI	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	2, 350, 255		2, 350, 25	55 0	0	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	540, 848		540, 84	18 0	0	52.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	2, 661, 666		2, 661, 66	6 0	0	54.00
60.00 0600	0 LABORATORY	1, 936, 348		1, 936, 34	18 0	0	60.00
64.00 0640	O I NTRAVENOUS THERAPY	249, 305		249, 30	05 0	0	64.00
65.00 0650	0 RESPI RATORY THERAPY	666, 762	0	666, 76	52 0	0	65.00
66.00 0660	0 PHYSI CAL THERAPY	1, 048, 565	0	1, 048, 56	55 0	0	66.00
67.00 0670	0 OCCUPATI ONAL THERAPY	216, 092	0	216, 09	92 0	0	67.00
68.00 0680	O SPEECH PATHOLOGY	44, 380	0	44, 38	30 0	0	68.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	153, 959		153, 95	59 0	0	71.00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	11, 115		11, 1	15 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	2, 620, 988		2, 620, 98	38 0	0	73.00
73.01 0730	1 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.01
74.00 0740	O RENAL DIALYSIS	0			0 0	0	74.00
75.00 0750	O ASC (NON-DISTINCT PART)	0			0 0	0	75.00
75.01 0750	1 CARDI AC REHAB	0			0 0	0	75.01
76.97 0769	7 CARDI AC REHABI LI TATI ON	756		75	56 0	0	76.97
OUTP	ATIENT SERVICE COST CENTERS						
88.00 0880	O RURAL HEALTH CLINIC	0			0 0	0	88.00
89.00 0890	O FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90.00 0900		118, 059		118, 05	59 0	0	90.00
90.01 0900	1 VISITING SPECIALTY CLINIC	0			0 0	0	90.01
91.00 0910	0 EMERGENCY	4, 987, 027		4, 987, 02	27 0	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	1, 976, 227		1, 976, 22	27	0	92.00
OTHE	R REIMBURSABLE COST CENTERS		•	•			
	0 AMBULANCE SERVI CES	0			0 0	0	95.00
101.00 1010	O HOME HEALTH AGENCY	0			0	0	101.00
	AL PURPOSE COST CENTERS						1
	O I NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	23, 725, 537	0	23, 725, 53	37 0	0	200.00
201.00	Less Observation Beds	1, 976, 227		1, 976, 22	27	0	201.00
202.00	Total (see instructions)	21, 749, 310	0	21, 749, 31	0 0	0	202.00

Heal th	Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-3	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-1306	Peri od:	Worksheet C	
					From 01/01/2018	Part I	
					To 12/31/2018	Date/Time Pre 5/28/2019 12:	pared:
			Title	XV/111	Hospi tal	Cost	19 pili
	· · · · · · · · · · · · · · · · · · ·		Charges	AVIII	поѕргта	CUST	
	Cost Center Description	Inpatient		Total (col	6 Cost or Other	TEFRA	
	cost center bescription	Inpatrent	outpatrent	+ col. 7)	Ratio	Inpatient	
				+ cor. 7)	Ratio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	1100	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	
	03000 ADULTS & PEDIATRI CS	1, 373, 721		1, 373, 72	1		30.00
	03100 I NTENSI VE CARE UNI T	0			0		31.00
	04300 NURSERY	293, 795		293, 79	5		43.00
	ANCI LLARY SERVICE COST CENTERS				-		1
	05000 OPERATING ROOM	795, 264	3, 826, 273	4, 621, 53	7 0. 508544	0. 000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	910, 994	375, 316	1, 286, 31		0. 000000	•
	05400 RADI OLOGY-DI AGNOSTI C	98, 265	9, 758, 737	9,857,00		0. 000000	•
	06000 LABORATORY	252, 267	4, 836, 184	5, 088, 45		0. 000000	
	06400 INTRAVENOUS THERAPY	0	1, 571, 985	1, 571, 98		0.000000	
	06500 RESPI RATORY THERAPY	127, 321	1, 123, 381	1, 250, 70		0.000000	•
	06600 PHYSI CAL THERAPY	68, 896	1, 420, 733	1, 489, 62		0.000000	•
	06700 OCCUPATI ONAL THERAPY	23, 984	244, 785	268, 76		0.000000	•
	06800 SPEECH PATHOLOGY	0	37, 409	37, 40		0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 245	199, 456	239, 70		0.000000	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	81, 564	81, 56		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	575, 484	6, 960, 275	7, 535, 75		0.000000	•
	07301 DRUGS CHARGED TO PATIENTS	0	0	, , .	0 0.000000	0.000000	•
	07400 RENAL DIALYSIS	0	0		0 0.000000	0.000000	
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0.000000	0.000000	
	07501 CARDI AC REHAB	0	0		0 0.000000	0.000000	75.01
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90.00	09000 CLINIC	0	42, 753	42, 75	3 2.761420	0.000000	90.00
90.01	09001 VISITING SPECIALTY CLINIC	0	0		0 0.000000	0.000000	90.01
91.00	09100 EMERGENCY	165, 208	19, 228, 366	19, 393, 57	4 0. 257148	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	27, 750	4,064,218	4, 091, 96	8 0. 482953	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES	0	0		0 0.000000	0.00000	95.00
101.00	10100 HOME HEALTH AGENCY	0	0		0		101.00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	4, 753, 194	53, 771, 435	58, 524, 62	9		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	4, 753, 194	53, 771, 435	58, 524, 62	9		202.00
	•						•

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-1306         Period: From 01/01/2018         Period: Part I Date/Time, Part I Date/Time, Part I Date/Time, PPS Inpatient         Period: Title XVIII         Period: Part I Date/Time, Part I Date/Time, Part I Date/Time, PS/28/2019         Period: Part I Date/Time, Part I Date/Time, Part I Date/Time, PS/28/2019         Period: Part I Date/Time, Part I Date/Time, Part I Date/Time, Part I Date/Time, PS/28/2019         Period: Part I Date/Time, Part I Date/Time, P	5-2552-10
Cost Center Description         PPS Inpatient Ratio           1.00         11.00           1.00         03000 ADULTS & PEDIATRICS           31.00         03100 INTENSIVE CARE UNIT           43.00         04300 NURSERY           ANCILLARY SERVICE COST CENTERS           50.00         05000 OPERATING ROOM           60.000         05000 OPERATING ROOM           61.000         05000 OPERATING ROOM           62.00         05000 OPERATING ROOM           62.00         05000 OPERATING ROOM           60.00         06000 LABORATORY           0.000000         0.000000           64.00         064000 INTRAVENOUS THERAPY           0.000000         0.000000           65.00         065000 RESPI RATORY THERAPY           0.000000         0.000000           65.00         066000 SPEECH PATHOLOGY           0.000000         0.000000           67.00         0CUPATI INAL THERAPY           0.000000         0.000000           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS           0.000000         0.000000           73.00         07300 DRUGS CHARGED TO PATIENTS           0.000000         0.000000           73.00         07300 DRUGS CHARGED TO PA	repared: 2:19 pm
Ratio           30.00         03000         ADULTS & PEDI ATRI CS           31.00         03100         INTENSI VE CARE UNI T           32.00         03000         ANTELLARY SERVI CE COST CENTERS           ANCILLARY SERVI CE COST CENTERS	
11.00           INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000 ADULTS & PEDIATRICS           31.00         03100 INTENSIVE CARE UNIT           43.00         04300 NURSERY           ANCILLARY SERVICE COST CENTERS           50.00         05000 DPENTING ROOM           0.000000         0.000000           52.00         05200 DELIVERY ROOM & LABOR ROOM           0.000000         0.000000           54.00         05400 RADIOLOGY-DI AGNOSTIC           0.000000         0.000000           64.00         064001 INTRAVENOUS THERAPY           0.000000         0.000000           65.00         06500 RESPIRATORY THERAPY           0.000000         0.000000           65.00         06500 PESPI RATORY THERAPY           0.000000         0.000000           67.00         06700 OCCUPATIONAL THERAPY           0.000000         0.000000           68.00         08000 SPEECH PATHOLOGY           0.000000         0.010000           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS           0.000000         0.010000           73.01         0.025 CHARGED TO PATIENTS           0.000000         0.0100000           73.01	
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS           31.00         03100         INTENSIVE CARE UNIT           43.00         04300         NURSERY           ANCILLARY SERVICE COST CENTERS	
30.00       O3000       ADULTS & PEDIATRICS         31.00       O3100       INTENSIVE CARE UNIT         43.00       O4300       INTENSIVE CARE UNIT         43.00       O5000       OPERATING ROM       0.000000         52.00       DELIVERY ROM & LABOR ROM       0.000000         54.00       O5400       RADIOLOGY - DIAGNOSTI C       0.000000         64.00       O6400       INTRAVENOUS THERAPY       0.000000         65.00       O6500       RESPI RATORY THERAPY       0.000000         66.00       O6600       PHYSI CAL THERAPY       0.000000         67.00       O6700       OCUPATI ONAL THERAPY       0.000000         68.00       O6800       SPECH PATHOLOGY       0.000000         71.00       OT100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000         72.00       O7200 I MPL. DEV. CHARGED TO PATIENTS       0.000000         73.01       O7300 DRUGS CHARGED TO PATIENTS       0.000000         74.00       O7400 RENAL DI ALYSIS       0.000000         75.01       ORDI AC REHAB<	
31.00       03100       INTENSIVE CARE UNIT         43.00       04300       NURSERY         ANCILLARY SERVICE COST CENTERS         50.00       05000       DERATING ROOM       0.000000         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.000000         54.00       05400       RADIOLOGY-DI AGNOSTIC       0.000000         64.00       06400       INTRAVENOUS THERAPY       0.000000         65.00       06500       RESPI RATORY THERAPY       0.000000         66.00       PHYSI CAL THERAPY       0.000000         66.00       PHYSI CAL THERAPY       0.000000         66.00       O6700       OCCUPATI ONAL THERAPY       0.000000         67.00       06700       DCUPATI ONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       07100       MEUS CHARGED TO PATI ENTS       0.000000         73.00       ORUGS CHARGED TO PATI ENTS       0.000000         73.00       ORUGS CHARGED TO PATI ENTS       0.000000         73.01       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       DRUGS CHARGED TO PATI ENTS       0.000000         75.00       07500       ASC (NON-DI STINCT P	
43. 00       NURSERY       0         ANCI LLARY SERVICE COST CENTERS       0.000000         52. 00       OS200       DELI VERY ROOM & LABOR ROOM       0.000000         54. 00       05400       RADI OLGCY-DI AGNOSTI C       0.000000         60. 00       CAG00       LABORATORY       0.000000         64. 00       OK400       INTRAVENOUS THERAPY       0.000000         65. 00       06500       RESPI RATORY THERAPY       0.000000         66. 00       06600       PHYSI CAL THERAPY       0.000000         66. 00       06600       SPECH PATHOLOGY       0.000000         67. 00       06700       0CCUPATI ONAL THERAPY       0.000000         68. 00       06800       SPEECH PATHOLOGY       0.000000         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.000000         73. 01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         74. 00       O7400       RENAL DI ALYSI S       0.000000         75. 01       O7501       CARDI AC REHAB       0.000000         75. 01       07501       CARDI AC REHAB       0.000000         75. 01	30.00
ANCI LLARY SERVI CE COST CENTERS           50. 00         O5000 (PERATI NG ROOM)         0.000000           52. 00         05200 DELI VERY ROOM & LABOR ROOM         0.000000           54. 00         05400 RAD LOLGY - DI AGNOSTI C         0.000000           60. 00         06000 LABORATORY         0.000000           64. 00         06400 I NTRAVENOUS THERAPY         0.000000           65. 00         06500 RESPI RATORY THERAPY         0.000000           66. 00         06600 PHYSI CAL THERAPY         0.000000           67. 00         06700 OCCUPATI ONAL THERAPY         0.000000           68. 00         06800 SPEECH PATHOLOGY         0.000000           71. 00         OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000           72. 00         07200 I MPL. DEV. CHARGED TO PATI ENTS         0.000000           73. 01         07300 DRUGS CHARGED TO PATI ENTS         0.000000           73. 01         07301 DRUGS CHARGED TO PATI ENTS         0.000000           75. 00         07500 ASC (NON-DI STI NCT PART)         0.000000           75. 01         07501 CARDI AC REHAB         0.000000           75. 01         07501 CARDI AC REHAB         0.000000           75. 01         07501 CARDI AC REHAB         0.0000000           76. 97	31.00
50.00       05000       0PERATI NG ROOM       0.000000         52.00       05200       DELI VERY ROOM & LABOR ROOM       0.000000         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000         60.00       06400       INTRAVENOUS THERAPY       0.000000         64.00       06400       INTRAVENOUS THERAPY       0.000000         65.00       06500       RESPI RATORY THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       06700       OCCUPATI ONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.01       07500       ASC (NON-DI STI NCT PART)       0.000000         75.01       07501       CARDI AC REHAB       0.000000         75.01       07507       CARDI AC REHAB       0.000000         76.97       CARDI AC REHAB	43.00
52.00       05200       DELI VERY ROOM & LABOR ROOM       0.000000         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000         60.00       06000       LABORATORY       0.000000         64.00       06400       INTRAVENOUS THERAPY       0.000000         65.00       06500       RESPI RATORY THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       06700       OCCUPATI ONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         74.00       7400       RENAL DI ALYSI S       0.000000         75.01       07501       CARDI AC REHAB       0.000000 <td></td>	
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000         60.00       06000       LABORATORY       0.000000         64.00       06400       INTRAVENOUS THERAPY       0.000000         65.00       06500       RESPI RATORY THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       0C700       OCUPATI ONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       07302       RENAL DI ALYSI S       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.01       07500       ASC (NON-DI STI NCT PART)       0.000000         75.01       07500       ASC (NON-DI STI NCT PART)       0.000000         76.77       CARDI AC REHAB       0.000000         76.79       CARDI AC REHAB       0.000000         76.97       CARDI AC REHABILI TATI ON       0.0000000         78.00	50.00
60.00       06000       LABORATORY       0.000000         64.00       06400       INTRAVENOUS THERAPY       0.000000         65.00       06500       RESPI RATORY THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       06700       0CCUPATI IONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.01       07501       CARDI AC REHAB       0.000000         76.77       CARDI AC REHAB       0.000000         76.97       CARDI AC REHABILITATI ON       0.000000         76.97       CARDI AC REHABILITATI ON       0.000000         00TPATI ENT	52.00
64.00       06400       INTRAVENOUS THERAPY       0.000000         65.00       06500       RESPI RATORY THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       0CCUPATI ONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       OTIO       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000         73.01       07300       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         75.00       07500       ASC (NON-DI STI NCT PART)       0.000000         75.01       07501       CARDI AC REHAB       0.000000         76.97       CARDI AC REHAB       0.000000         76.97       CARDI AC REHAB LI TATI ON       0.000000         0UTPATI ENT SERVICE COST CENTERS       0.000000         88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER	54.00
65.00       06500       RESPI RATORY THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       06700       0CCUPATI ONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.00       07500       ASC (NON-DI STI NCT PART)       0.000000         75.01       07500       ASC (NON-DI STI NCT PART)       0.000000         76.97       CARDI AC REHAB       0.000000         00TPATI ENT SERVICE COST CENTERS       0.000000         00TPATI ENT SERVICE COST CENTERS       0.000000         00TPATI ENT SERVICE COST CENTERS       0.000000         88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER	60.00
65.00       06500       RESPI RATORY THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       06700       0CCUPATI ONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.00       07500       ASC (NON-DI STI NCT PART)       0.000000         75.01       07500       ASC (NON-DI STI NCT PART)       0.000000         76.97       CARDI AC REHAB       0.000000         00TPATI ENT SERVICE COST CENTERS       0.000000         00TPATI ENT SERVICE COST CENTERS       0.000000         00TPATI ENT SERVICE COST CENTERS       0.000000         88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER	64.00
66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       06700       OCCUPATI ONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.000000         73.01       07300       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.01       07500       ASC (NON-DI STI NCT PART)       0.000000         75.01       07501       CARDI AC REHAB       0.000000         76.97       CARDI AC REHAB LI TATI ON       0.000000         0UTPATI ENT SERVICE COST CENTERS       0.000000         88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER	65.00
67.00       06700       OCCUPATIONAL THERAPY       0.000000         68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       OT100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATIENTS       0.000000         74.00       07400       RENAL DIALYSIS       0.000000         75.00       07500       ASC (NON-DISTINCT PART)       0.000000         75.01       07501       CARDIAC REHAB       0.000000         76.97       CARDIAC REHAB LITATION       0.000000         00TPATIENT SERVICE COST CENTERS       0.000000         88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER	66.00
68.00       06800       SPEECH PATHOLOGY       0.000000         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       07300       DRUGS CHARGED TO PATI ENTS       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.01       07500       ASC (NON-DI STINCT PART)       0.000000         75.01       07501       CARDI AC REHAB       0.000000         76.97       CARDI AC REHAB       0.000000         76.97       CARDI AC REHABI LI TATI ON       0.000000         00TPATI ENT SERVICE COST CENTERS       88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       Image: Content of the c	67.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.01       07500       ASC (NON-DI STI NCT PART)       0.000000         75.01       07501       CARDI AC REHAB       0.000000         76.97       CARDI AC REHAB       0.000000         76.97       CARDI AC REHABI LI TATI ON       0.000000         0UTPATI ENT SERVICE COST CENTERS       88.00       08800       RURAL HEALTH CLI NI C         89.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       Image: Content of the content of	68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATIENTS       0.000000         74.00       07400       RENAL DIALYSIS       0.000000         75.01       07500       ASC (NON-DI STINCT PART)       0.000000         75.01       07501       CARDIAC REHAB       0.000000         76.97       CARDIAC REHABILITATION       0.000000         0UTPATIENT SERVICE COST CENTERS       0.000000         88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER	71.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000         73.01       07301       DRUGS CHARGED TO PATIENTS       0.000000         74.00       07400       RENAL DIALYSIS       0.000000         75.01       07500       ASC (NON-DI STINCT PART)       0.000000         75.01       07501       CARDIAC REHAB       0.000000         76.77       CARDIAC REHABILITATION       0.000000         0017401       ENT SERVICE COST CENTERS         88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER	72.00
73.01       07301       DRUGS CHARGED TO PATIENTS       0.000000         74.00       07400       RENAL DI ALYSI S       0.000000         75.00       07500       ASC (NON-DI STINCT PART)       0.000000         75.01       07501       CARDI AC REHAB       0.000000         76.97       OZARDI AC REHABILITATION       0.000000         0UTPATIENT SERVICE COST CENTERS       0.000000         88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER	73.00
74.00       07400       RENAL DI ALYSI S       0.000000         75.00       07500       ASC (NON-DI STI NCT PART)       0.000000         75.01       07501       CARDI AC REHAB       0.000000         76.97       07697       CARDI AC REHABILITATI ON       0.000000         0UTPATI ENT SERVICE COST CENTERS       0.000000       0.000000         88.00       08800       RURAL HEALTH CLINIC       89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER	73.00
75. 00       07500       ASC (NON-DI STINCT PART)       0.000000         75. 01       07501       CARDI AC REHAB       0.000000         76. 97       07697       CARDI AC REHABI LI TATI ON       0.000000         OUTPATI ENT SERVICE COST CENTERS         88. 00       08800       RURAL HEALTH CLINIC         89. 00       08900       FEDERALLY QUALIFIED HEALTH CENTER	74.00
75. 01       07501       CARDI AC REHAB       0.000000         76. 97       07697       CARDI AC REHABI LI TATI ON       0.000000         OUTPATI ENT SERVICE COST CENTERS         88. 00       08800       RURAL HEALTH CLINIC         89. 00       08900       FEDERALLY QUALI FI ED HEALTH CENTER	
76. 97         07697         CARDI AC_REHABI LI TATI ON         0.000000           OUTPATI ENT_SERVICE_COST_CENTERS         08800         RURAL HEALTH CLINIC           89. 00         08900         FEDERALLY_QUALI FI ED_HEALTH_CENTER         0	75.00
OUTPATI ENT SERVICE COST CENTERS         88.00       08800         RURAL HEALTH CLINIC         89.00       08900         FEDERALLY QUALIFIED HEALTH CENTER	75.01
88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER	76.97
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER	
	88.00
	89.00
90. 00 09000 CLINIC 0. 000000	90.00
90. 01 09001 VISITING SPECIALTY CLINIC 0. 000000	90. 01
91. 00 09100 EMERGENCY 0. 000000	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVICES 0. 000000	95.00
101.00 10100 HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS	
113.00 I 1300 I NTEREST EXPENSE	113.00
200.00 Subtotal (see instructions)	200.00
201.00 Less Observation Beds	201.00
202.00 Total (see instructions)	202.00

Health Fina	ncial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/28/2019 12:	pared: 19 pm
			Titl	e XIX	Hospi tal	PPS	
					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	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDI ATRI CS	3, 900, 019		3, 900, 01	9 0	3, 900, 019	30.00
	O INTENSIVE CARE UNIT	0			0 0	0	31.00
	0 NURSERY	243, 166		243, 16	06 0	243, 166	43.00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	2, 350, 255		2, 350, 25	5 0	2, 350, 255	50.00
	O DELIVERY ROOM & LABOR ROOM	540, 848		540, 84	8 0	540, 848	52.00
	O RADI OLOGY-DI AGNOSTI C	2, 661, 666		2, 661, 66		2, 661, 666	
60.00 0600	O LABORATORY	1, 936, 348		1, 936, 34	8 0	1, 936, 348	60.00
64.00 0640	O I NTRAVENOUS THERAPY	249, 305		249, 30	05 0	249, 305	64.00
65.00 0650	O RESPI RATORY THERAPY	666, 762				666, 762	65.00
66.00 0660	O PHYSI CAL THERAPY	1, 048, 565	0	1, 048, 56	5 0	1, 048, 565	66.00
	O OCCUPATI ONAL THERAPY	216, 092		216, 09	02 0	216, 092	67.00
68.00 0680	O SPEECH PATHOLOGY	44, 380		44, 38	0 0	44, 380	
	OMEDICAL SUPPLIES CHARGED TO PATIENTS	153, 959		153, 95	9 0	153, 959	
	OIMPL. DEV. CHARGED TO PATIENTS	11, 115		11, 11		11, 115	
	O DRUGS CHARGED TO PATIENTS	2, 620, 988		2, 620, 98	8 0	2, 620, 988	
	1 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.01
	O RENAL DI ALYSI S	0			0 0	0	74.00
	O ASC (NON-DI STINCT PART)	0			0 0	0	75.00
	1 CARDI AC REHAB	0			0 0	0	75.01
	7 CARDIAC REHABILITATION	756		75	6 0	756	76.97
	ATIENT SERVICE COST CENTERS						
	O RURAL HEALTH CLINIC	0			0 0	0	88.00
	O FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
		118, 059		118, 05	9 0	118, 059	
	1 VISITING SPECIALTY CLINIC	0			0 0	0	
		4, 987, 027		4, 987, 02		4, 987, 027	
	O OBSERVATION BEDS (NON-DISTINCT PART	1, 976, 227		1, 976, 22	27	1, 976, 227	92.00
	R REIMBURSABLE COST CENTERS	I	1	T			
	O AMBULANCE SERVI CES	0			0 0	0	
	O HOME HEALTH AGENCY	0			0	0	101.00
	I AL PURPOSE COST CENTERS	T	1	1			
	0 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	23, 725, 537				23, 725, 537	
201.00	Less Observation Beds	1, 976, 227		1, 976, 22		1, 976, 227	
202.00	Total (see instructions)	21, 749, 310	0	21, 749, 31	0 0	21, 749, 310	202.00

Health Fir	nancial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-1306	Peri od:	Worksheet C	
					From 01/01/2018	Part I	
					To 12/31/2018	Date/Time Pre 5/28/2019 12:	epared:
				e XIX	Hospi tal	PPS	
			Charges		nospi tai	113	
	Cost Center Description	Inpatient		Total (col	6 Cost or Other	TEFRA	
	Cost conter beschiption	Inpatront	outpatront	+ col. 7)	Ratio	Inpatient	
				1 001. 7)	hatro	Ratio	
		6.00	7.00	8.00	9,00	10.00	
INP	PATIENT ROUTINE SERVICE COST CENTERS	1					
	DOO ADULTS & PEDIATRICS	1, 373, 721		1, 373, 72	21		30.00
	IOO I NTENSI VE CARE UNI T	0		, ,	0		31.00
	BOO NURSERY	293, 795		293, 79	5		43.00
	CILLARY SERVICE COST CENTERS				-		1
	DOO OPERATING ROOM	795, 264	3, 826, 273	4, 621, 53	0. 508544	0. 000000	50.00
	200 DELIVERY ROOM & LABOR ROOM	910, 994	375, 316	1, 286, 31		0. 000000	
	100 RADI OLOGY-DI AGNOSTI C	98, 265	9, 758, 737	9, 857, 00		0. 000000	
	DOO LABORATORY	252, 267	4, 836, 184	5, 088, 45		0. 000000	
	100 INTRAVENOUS THERAPY	0	1, 571, 985	1, 571, 98		0. 000000	
	500 RESPI RATORY THERAPY	127, 321	1, 123, 381	1, 250, 70		0. 000000	
	500 PHYSI CAL THERAPY	68, 896	1, 420, 733	1, 489, 62		0. 000000	
	700 OCCUPATIONAL THERAPY	23, 984	244, 785	268, 76		0. 000000	
	300 SPEECH PATHOLOGY	20,701	37, 409	37,40		0. 000000	
	IOO MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 245	199, 456	239, 70		0. 000000	
	200 IMPL. DEV. CHARGED TO PATIENTS	0	81, 564	81, 56		0. 000000	
	BOO DRUGS CHARGED TO PATIENTS	575, 484	6,960,275	7, 535, 75		0. 000000	
	BOT DRUGS CHARGED TO PATIENTS	0	0	.,	0 0.000000	0. 000000	
	100 RENAL DIALYSIS	0	0		0 0.000000	0. 000000	
	500 ASC (NON-DISTINCT PART)	0	0		0 0.000000	0. 000000	
75.01 075	501 CARDI AC REHAB	0	o		0 0.000000	0. 000000	
	597 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0. 000000	
	PATIENT SERVICE COST CENTERS		-1				
	BOO RURAL HEALTH CLINIC	0	0		0 0.000000	0. 000000	88.00
	POO FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0. 000000	
		0	42, 753	42, 75		0.000000	
	DO1 VISITING SPECIALTY CLINIC	0	0	//0	0 0.000000	0. 000000	
	IOO EMERGENCY	165, 208	19, 228, 366	19, 393, 57		0. 000000	
	200 OBSERVATION BEDS (NON-DISTINCT PART	27, 750	4,064,218	4, 091, 96		0. 000000	
	IER REI MBURSABLE COST CENTERS	2,,,,,,,,,	1,001,210	1,0,1,70	01 102,000	0.00000	12.00
	500 AMBULANCE SERVICES	0	0		0 0.000000	0. 000000	95.00
	100 HOME HEALTH AGENCY	0	o		0	0.000000	101.00
	CIAL PURPOSE COST CENTERS						1
	BOO INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	4, 753, 194	53, 771, 435	58, 524, 62	9		200.00
201.00	Less Observation Beds						201.00
201.00							

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1306	Period: From 01/01/2018 To 12/31/2018	5/28/2019 12:1	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 508544				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 420465				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 270028				54.00
60. 00 06000 LABORATORY	0. 380538				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 158592				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 533110				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 703910				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 804006				67.00
68. 00 06800 SPEECH PATHOLOGY	1. 186346				68.00
					71.00
	0. 136273				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 347807				73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0. 000000				73.01
74.00 07400 RENAL DI ALYSI S	0. 000000				74.00
75.00 07500 ASC (NON-DI STINCT PART)	0. 000000				75.00
75. 01 07501 CARDI AC REHAB	0. 000000				75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0. 000000				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90. 00 09000 CLINIC	2. 761420				90.00
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000				90.01
91.00 09100 EMERGENCY	0. 257148				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 482953				92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					201.00
	i i			I.	202.00

ealth Financial Systems ALCULATION OF OUTPATIENT SERV	/ICE COST TO CHARGE RA	ATIOS NET OF	Provider C	CN: 15-1306	Period:	u of Form CMS- Worksheet C	
EDUCTIONS FOR MEDICAID ONLY					From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	naroo
					10 12/31/2018	5/28/2019 12:	19 pm
			Titl	e XIX	Hospi tal	PPS	
Cost Center Descri	iption	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST	CENTERS			1	-		
D. 00 05000 OPERATING ROOM		2, 350, 255				0	1
2.00 05200 DELIVERY ROOM & Li		540, 848				0	
4. 00 05400 RADI OLOGY-DI AGNOS	TIC	2, 661, 666				0	1
D. 00 06000 LABORATORY		1, 936, 348	52, 285	1, 884, 0	63 0	0	60.
4. 00 06400 INTRAVENOUS THERA		249, 305		235, 5	97 0	0	1
5. 00 06500 RESPI RATORY THERA	PY	666, 762	12, 140	654, 6	22 0	0	65.
6.00 06600 PHYSI CAL THERAPY		1, 048, 565	99, 646	948, 9	19 0	0	66.
7.00 06700 OCCUPATIONAL THER	APY	216, 092	19, 967	196, 12	25 0	0	67.
B. 00 06800 SPEECH PATHOLOGY		44, 380	4, 092	40, 2	88 0	0	68.
1.00 07100 MEDICAL SUPPLIES (	CHARGED TO PATIENTS	153, 959	6, 838	3 147, 12	21 0	0	71.
2.00 07200 IMPL. DEV. CHARGE	D TO PATIENTS	11, 115	509	10, 60	0 0	0	72.
3.00 07300 DRUGS CHARGED TO I	PATIENTS	2, 620, 988	40, 369	2, 580, 6	19 0	0	73.
3.01 07301 DRUGS CHARGED TO I	PATIENTS	0	(		0 0	0	73.
4.00 07400 RENAL DIALYSIS		0	0		0 0	0	74.
5.00 07500 ASC (NON-DISTINCT	PART)	0	0		0 0	0	75.
5. 01 07501 CARDI AC REHAB	,	0	0		0 0	0	75.
6. 97 07697 CARDI AC REHABILITA	ATI ON	756	ç	7	47 0	0	76.
OUTPATIENT SERVICE COST	CENTERS						
8.00 08800 RURAL HEALTH CLIN	IC	0	(		0 0	0	88.
9.00 08900 FEDERALLY QUALIFII	ED HEALTH CENTER	0	0		0 0	0	89.
D. 00 09000 CLINIC		118,059	1, 461	116, 59	98 0	0	90.
0.01 09001 VISITING SPECIALT	Y CLINIC	0			0 0	0	90.
1.00 09100 EMERGENCY		4, 987, 027	153, 716	4, 833, 3	11 0	0	91.
2.00 09200 OBSERVATION BEDS	(NON-DISTINCT PART	1, 976, 227				0	92.
OTHER REIMBURSABLE COST							
5. 00 09500 AMBULANCE SERVICE		0	(		0 0	0	95.
01.00 10100 HOME HEALTH AGENC		0			0 0	0	101.
SPECIAL PURPOSE COST CE							1
13.00 11300 INTEREST EXPENSE							113.
00.00 Subtotal (sum of	lines 50 thru 199)	19, 582, 352	857, 575	18, 724, 7	77 0	0	200.
01.00 Less Observation I		1, 976, 227					201.
02.00 Total (line 200 m		17, 606, 125					202.

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Li	eu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C	CN: 15-1306	Period: From 01/01/201 To 12/31/201	Worksheet C 8 Part II 8 Date/Time Prepared: 5/28/2019 12:19 pm
			e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,			
	Operating Cost			6	
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS	-				
50.00 05000 OPERATI NG ROOM	2, 350, 255				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	540, 848				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 661, 666				54.00
60. 00 06000 LABORATORY	1, 936, 348				60.00
64. 00 06400 I NTRAVENOUS THERAPY	249, 305				64.00
65. 00 06500 RESPI RATORY THERAPY	666, 762				65.00
66. 00 06600 PHYSI CAL THERAPY	1, 048, 565	1, 489, 629			66.00
67.00 06700 OCCUPATI ONAL THERAPY	216, 092				67.00
68.00 06800 SPEECH PATHOLOGY	44, 380				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	153, 959	239, 701			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 115	81, 564	0. 1362	73	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 620, 988	7, 535, 759	0. 3478	07	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.0000	00	73.01
74.00 07400 RENAL DIALYSIS	0	0	0. 0000	00	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 0000	00	75.00
75. 01 07501 CARDI AC REHAB	0	0	0. 0000	00	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	756	0	0. 0000	00	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	C	0. 0000	00	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 0000	00	89.00
90. 00 09000 CLINIC	118, 059	42, 753	2. 7614	20	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0	0. 0000	00	90.01
91.00 09100 EMERGENCY	4, 987, 027	19, 393, 574	0. 2571	48	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 976, 227	4, 091, 968	0. 4829	53	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0	C			95.00
101.00 10100 HOME HEALTH AGENCY	0	0	0. 0000	00	101.00
SPECIAL PURPOSE COST CENTERS			•	· ·	
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (sum of lines 50 thru 199)	19, 582, 352	56, 857, 113	8		200.00
201.00 Less Observation Beds	1, 976, 227				201.00
202.00 Total (line 200 minus line 201)	17, 606, 125	56, 857, 113	3		202.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2018	Worksheet D Part II	
				To 12/31/2018		pared:
					5/28/2019 12:	19 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	150.000			0 05 433		
50.00 O5000 OPERATING ROOM	158, 929					
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 757					52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	153, 467					54.00
60. 00 06000 LABORATORY	52, 285					60.00
64.00 06400 I NTRAVENOUS THERAPY	13, 708				-	64.00
65.00 06500 RESPI RATORY THERAPY	12, 140					65.00
66. 00 06600 PHYSI CAL THERAPY	99, 646					
67.00 06700 OCCUPATI ONAL THERAPY	19, 967					67.00
68.00 06800 SPEECH PATHOLOGY	4, 092				0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 838					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	509				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	40, 369	7, 535, 759				73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.00000		0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0.00000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75.00
75. 01 07501 CARDI AC REHAB	0	0	0.00000		0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	9	0	0.00000	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1		r	-		
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000		-	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89.00
90. 00 09000 CLINIC	1, 461	42, 753			0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0	0.00000		0	90.01
91. 00 09100 EMERGENCY	153, 716					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	129, 682	4, 091, 968	0. 03169	2 7, 270	230	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)	857, 575	56, 857, 113		325, 078	4, 431	200. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS			Period: From 01/01/2018 To 12/31/2018		
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	490, 393	C		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0 0	0	54.00
60. 00 06000 LABORATORY	0	C	)	0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	C	)	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C	)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C	)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.01
74.00 07400 RENAL DI ALYSI S	0	c c		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	c c		0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0	c c		0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	c c		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC	0	C	)	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	c c		0 0	0	89.00
90. 00 09000 CLINIC	0	c c		0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	C C		0 0	0	90.01
91.00 09100 EMERGENCY	0	C C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS		·				
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	490, 393	C		0 0	0	200. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2018	Date/Time Pre	pared:
					5/28/2019 12:	19 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3, and 4)	8)	7)	
	4.00	5.00	6, 00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		0100	0100	1100	0.00	
50. 00 05000 OPERATI NG ROOM	0	490, 393		0 4, 621, 537	0. 106110	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 286, 310	0.000000	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 9, 857, 002	0.000000	54.00
60. 00 06000 LABORATORY	0	0		0 5, 088, 451	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 1, 571, 985	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 250, 702	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 489, 629	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 268, 769	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 37, 409	0.00000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 239, 701	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 81, 564	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 535, 759	0.00000	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0 0	0.000000	73.01
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.00000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.00000	75.00
75. 01 07501 CARDI AC REHAB	0	0		0 0	0.000000	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS		1			1	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		•
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	•
90. 00 09000 CLINIC	0	0		0 42, 753		
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0 0	0. 000000	•
91.00 09100 EMERGENCY	0	0		0 19, 393, 574		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0		0 4, 091, 968	0.000000	92.00
OTHER REI MBURSABLE COST CENTERS	1	1	1		1	
95. 00 09500 AMBULANCE SERVICES		400.000				95.00
200.00  Total (lines 50 through 199)	0	490, 393	I	0 56, 857, 113	1	200.00

APPORTI OWENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS         Provider CON: 15-1306         Period: To 12/31/2018         Period: To 12/31/2018         Period: To 12/31/2018         Worksheet D Period: To 12/31/2018                  Cost Center Description               Outpatient Ratio of Cost Cost Center Description               Outpatient Ratio of Cost Cost Center Description               Outpatient Program Charges Cost Center Description               Outpatient Program Charges               Outpatient Program	Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Li	eu of Form CMS-	2552-10
Antiodal 00010         To         12/31/2018         Date/Time Prepared: 5/28/2019 12: 19 pm           Cost Center Description         Outpatient Ratio of Cost (col. 6 + col. 7)         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Charges         Outpatient Program Charges           50:00         05000         OPERATING R00M         0:000000         25: 177         2: 672         0         0         50: 00           50:00         05000         DEACTINERS         0:000000         0         0:00000         0         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:00000         0:000000         <		RVICE OTHER PASS	Provider C	CN: 15-1306			
Cost Center Description         Outpatient Ratio of Cost to Charges (col. 6 + col. 7)         Inpatient Program Charges (col. 6 + col. 7)         Unpatient Program Charges (col. 6 + col. 7)         Outpatient Program Charges (col. 6 + col. 7)         Outpatient Program Charges (col. 6 + col. 7)         Outpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges           50.00         05000         000000         25,177         2,672         0         0         50.00           50.00         05000         000000         4,425         0         0         0         50.00           50.00         05000         000000         23,030         0         0         0         50.00           50.00         05000         000000         23,030         0         0         0         50.00           50.00         05000         000000         11.00         12.00         13.00         0         64.00           60.00         06000         100.00         11.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	THROUGH COSTS						narod:
Cost Center Description         Utpatient Ratio of Cost (col. 6 + col. 7)         Inpatient Program (Charges)         Hospital Program (Charges)         Hospital Program (Charges)         Cost Program (Charges)           ANCI LLARY SERVICE COST CENTERS         0.00000         10.00         11.00         12.00         13.00           50.00         05000 (DPERATING ROOM 00 (ADD RADO (ADD ROOM)         0.000000         25,177         2,672         0         0         0         52.00           50.00         05000 (DPERATING ROOM 00 (ADD RADO (ADD ROOM)         0.000000         25,177         2,672         0         0         0         52.00           50.00         05000 (ADD ROOM CADD ROOM)         0.000000         23,030         0         0         0         52.00           64.00         CAON (ADD ROLOC)         0.000000         23,030         0         0         0         66.00           65.00         06500 (BRBATORY         0.000000         58.047         0         0         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         66.00         67.00         66.00         67.00         0         66.00         67.00					10 12/31/2010	5/28/2019 12:	19 pm
Ratio of Cost to Charges         Program Charges         Program Pass-Through Costs (col. 8 x col. 10)         Program Charges         Program Costs (col. 9           ANCILLARY SERVICE COST CENTERS         0         10.00         11.00         12.00         30.0         0         55.00           54.00         05000         0PERATI NG ROM         0.000000         23.030         0         0         54.00           60.00         06000 LABORATIORY         0.000000         36.437         0         0         66.00         66.00           65.00         06500 RESPI RATORY THERAPY         0.000000         55.647         0         0         67.00         66.00           66.00         06600 SPEECH PATHOLOGY         0.000000         0         0         0         71.00           72.00         0700 IMPL DEV. CHARGED TO PATI ENTS         0.000000         0			Title	XVIII	Hospi tal		
to         to         Charges (col.         Charges (col.         Charges (col.         Charges (col.         Pass-Through (costs (col.         Pass-Through (costol.         Passc.Through	Cost Center Description		Inpati ent	I npati ent	Outpati ent	Outpati ent	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$							
T)         x col. 10)         x col. 12)           ANCI LLARY SERVI CE COST CENTERS         9.00         10.00         11.00         12.00         13.00           S0.00         05000         DPERATI NG ROOM         0.000000         25,177         2,672         0         0         50.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         23,030         0         0         54.00           64.00         06400         INTRAVENUS THERAPY         0.000000         36,437         0         0         0         66.00           65.00         06500         RESPI RATORY THERAPY         0.000000         58,047         0         0         0         66.00           66.00         06500         CUL THERAPY         0.000000         15,604         0         0         66.00           67.00         06700         CCUPATI ONAL THERAPY         0.000000         526         0         0         67.00           68.00         06800         SPECH PATHOLOGY         0.000000         17.30         0         0         71.00           73.00         07300         DRUS CHARGED TO PATI ENTS         0.000000         0         0         73.00           73.01			Charges				
ANCILLARY SERVICE COST CENTERS         9.00         10.00         11.00         12.00         13.00           ANCILLARY SERVICE COST CENTERS         0         0.000000         25,177         2,672         0         0         50.00           52.00         05200         DELIVERY ROM & LABOR ROM         0.000000         4,425         0         0         0         52.00           54.00         05400         RADIOLOGY-DIAGNOSTIC         0.000000         23,030         0         0         54.00           66.00         06400         INTRAVENOUS THERAPY         0.000000         36,437         0         0         66.00           65.00         06500         RSPIRATORY THERAPY         0.000000         0         0         0         64.00           66.00         06600         PHYSICAL THERAPY         0.000000         15,604         0         0         0         65.00           66.00         06600         SPECH PATHORY THERAPY         0.000000         1,173         0         0         71.00           71.00         07300         IMPL.         DEV. CHARGED TO PATIENTS         0.000000         0         0         72.00           73.00         07300         IMPL.         DEV. CHARGED TO PATIENT					8		
ANCI LLARY SERVICE COST CENTERS         0         0           50.00         05000         0PERATI NG ROOM         0.000000         25, 177         2, 672         0         0         50.00           52.00         05200         0DELVERY ROOM & LABOR ROOM         0.000000         24, 255         0         0         0         52.00           54.00         05400 RADI OLCGY-DI AGNOSTI C         0.000000         23, 030         0         0         54.00           60.00         06400 I NTRAVENOUS THERAPY         0.000000         0         0         0         64.00         0         64.00         0         64.00         0         64.00         0         65.00         0         65.00         0         65.00         0         65.00         0         65.00         0         65.00         0         65.00         0         66.00         0         66.00         0         66.00         0         66.00         0         66.00         0         66.00         0         66.00         0         66.00         0         0         67.00         67.00         67.00         67.00         67.00         67.00         67.00         68.00         71.00         0         71.00         0         71.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
50.00       05000       0PERATING ROOM       0.000000       25, 177       2, 672       0       0       0       52.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.000000       4, 425       0       0       0       52.00         64.00       06400       LABORATORY       0.000000       36, 437       0       0       0       64.00         64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       64.00         65.00       06500       RESPIRATORY THERAPY       0.000000       58,047       0       0       65.00         66.00       06600       DEGODO CUPATI INAL THERAPY       0.000000       526       0       0       66.00         67.00       06700 OCUPATI INAL THERAPY       0.000000       0       0       66.00       67.00       0       66.00       66.00       66.00       66.00       67.00       0       67.00       0       68.00       0       67.00       0       68.00       0       0       68.00       0       71.00       0       67.00       0       67.00       0       67.00       0       67.00       0       71.00       0       71.00       0		9.00	10.00	11.00	12.00	13.00	
52.00       05200       DELIVERY ROOM & LABOR ROOM       0.000000       4,425       0       0       0       52.00         54.00       05400       RADIOLOGY-DIAGNOSTI C       0.000000       23.030       0       0       0       54.00         60.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       0       64.00         64.00       05500       RESPI RATORY THERAPY       0.000000       58.047       0       0       0       66.00         65.00       0500       RESPI RATORY THERAPY       0.000000       526       0       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.000000       526       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       67.00         71.00       07100       MEDL AL SUPPLIE S CHARGED TO PATIENTS       0.000000       0       0       0       72.00         73.01       07300       DRUGS CHARGED TO PATIENTS       0.000000       0       0       0       73.01         74.00       OT400       RENAL DI ALSISPE       0.000000       0       0       0       73.01		1 1				-	
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       23,030       0       0       0       64.00         60.00       06000       LABORATORY       0.000000       36,437       0       0       60.00         64.00       INTRAVENOUS THERAPY       0.000000       36,437       0       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       58,047       0       0       66.00         67.00       0500       RESPI RATORY THERAPY       0.000000       526       0       0       66.00         67.00       0500       SPEECH PATHOLOGY       0.000000       526       0       0       67.00       68.00         68.00       06400       SPEECH PATHOLOGY       0.000000       0       0       0       67.00       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       72.00       0       72.00       0       72.00       0       72.00       72.00       0       73.00       73.00							
60.00       06000       LABORATORY       0.000000       36, 437       0       0       60.00         64.00       06400       INTRAVENUUS THERAPY       0.000000       0       0       0       64.00         65.00       06500       RESPIRATORY THERAPY       0.000000       58,047       0       0       66.00         66.00       06600       PHYSI CAL THERAPY       0.000000       15,604       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       526       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         71.00       07100       MEICAL SUPPLIES CHARGED TO PATIENTS       0.000000       0       0       71.00       0       71.00       0       71.00       0       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.01       07300       RENAL DIALYSIS       0.000000       0       0       0       74.00       0       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.01       0					0 0	-	•
64.00       06400       INTRAVENOUS THERAPY       0.000000       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.000000       58,047       0       0       65.00         66.00       06500       RESPI RATORY THERAPY       0.000000       15,604       0       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.000000       526       0       0       67.00         68.00       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         71.00       OTION       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       0       0       0       71.00         72.00       O7200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       0       0       0       73.00       73.00       73.00       73.00       0       0       0       73.00       73.00       73.01       73.01       73.01       73.01       73.01       73.01       74.00       0       0       0       0       0       74.00       75.00       0       0       75.00       0       75.01       75.01       75.01       75.01       75.01       75.01       75.01       75.01       <					0 0	0 0	
65.00       06500       RESPI RATORY THERAPY       0.000000       58,047       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       15,604       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       526       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.000000       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       0       0       0       73.00         73.00       07300       RUGS CHARGED TO PATIENTS       0.000000       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       75.00       75.00         75.01       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       75.00         76.97       CARDI AC REHAB LLITATION       0.000000       0       0       0       75.01         70.597       CARDI AC REHABILLITATI	60. 00 06000 LABORATORY		36, 437		0 0	0 0	60.00
66.00       06000       PHYSI CAL THERAPY       0.000000       15,604       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       526       0       0       0       67.00         68.00       05800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       0       0       0       72.00         73.00       07301       DRUGS CHARGED TO PATI ENTS       0.000000       0       0       0       73.01         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.00         75.01       07501       CARDI AC REHAB       0.000000       0       0       0       75.00         76.97       CARDI AC REHAB       0.000000       0       0       0       76.97         76.97       CARDI AC REHAB LI TATI ON       0.000000       0       0       0       76.97         76.97       CARDI AC REHAB LI TATI ON       0.000			0		0 0	0 0	
67.00       06700       0CCUPATI ONAL THERAPY       0.000000       526       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       1,173       0       0       0       71.00         72.00       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       128,117       0       0       73.00       73.00       0       0       73.00       0       0       73.00       73.00       0       0       73.00       73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000       0       0       0       73.01       73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000       0       0       0       73.00       73.01         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       75.00       75.01       75.01       75.00       75.01       75.01       75.00       75.01       75.01       75.01       76.97       76.97       76.97       76.97       76.97       76.97       76.97       97.00       0       0       0       88.00       89.00       8	65. 00 06500 RESPI RATORY THERAPY	0.000000	58, 047		0 0	0 0	65.00
68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       0       68.00         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       1,173       0       0       0       71.00         72.00       O7200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       0       0       0       72.00       0       0       0       73.00       73.00       0       0       73.00       0       0       73.00       0       0       73.00       0       0       73.00       0       0       73.00       0       73.00       0       0       0       73.00       0       0       0       73.00       0       0       0       73.00       0       73.00       0       0       0       0       0       0       73.00       73.00       0       0       0       0       73.00       0       0       0       0       73.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	66. 00 06600 PHYSI CAL THERAPY	0.000000	15, 604		0 0	0 0	66.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       1,173       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       0       0       0       72.00         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000       0       0       0       73.00         73.01       07301       DRUGS CHARGED TO PATI ENTS       0.000000       0       0       0       73.01         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.00         75.01       07501       CARDI AC REHAB       0.000000       0       0       0       75.00         75.01       07501       CARDI AC REHAB       0.000000       0       0       0       75.00         75.01       07507       CARDI AC REHAB LI TATI ON       0.000000       0       0       0       75.01         76.97       07507       CARDI AC REHAB LI TATI ON       0.000000       0       0       0       88.00         88.00       08800       RUAL HEALTH CLINIC       0.000000       0       0       0       89.00         90.00       09000 <td>67.00 06700 OCCUPATI ONAL THERAPY</td> <td>0.000000</td> <td>526</td> <td></td> <td>0 0</td> <td>0 0</td> <td>67.00</td>	67.00 06700 OCCUPATI ONAL THERAPY	0.000000	526		0 0	0 0	67.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       128,117       0       0       0       73.00         73.01       07301       DRUGS CHARGED TO PATIENTS       0.000000       0       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.00       75.00       75.00       75.00       75.00       0       0       0       0       75.00       75.01       07501       CARDI AC REHAB       0.000000       0       0       0       0       75.00         75.01       07507       CARDI AC REHABILITATION       0.000000       0       0       0       0       75.01         76.97       CARDI AC REHABILITATION       0.000000       0       0       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC       0.000000       0       0       0       89.00       99.00       90.00       0       0       0       90.00         90.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0.0000000       0<	68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0 0	68.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0.00000       128,117       0       0       73.00         73.01       07301       DRUGS CHARGED TO PATIENTS       0.000000       0       0       0       73.01         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       75.00         76.01       07501       CARDI AC REHAB       0.000000       0       0       0       0       75.00         76.97       07697       CARDI AC REHAB LI TATI ON       0.000000       0       0       0       76.97         00TPATIENT SERVICE COST CENTERS       0.000000       0       0       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC       0.000000       0       0       88.00         99.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0.000000       0       0       0       90.00         90.01       09000       CLINIC       0.000000       0       0       0       90.01         91.00       09000       VISITING SPECIALTY CLINIC       0.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 173		0 0	0 0	71.00
73.01       07301       DRUGS CHARGED TO PATIENTS       0.000000       0       0       0       73.01         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       75.00         75.01       07501       CARDI AC REHAB       0.000000       0       0       0       75.01         76.97       07697       CARDI AC REHABILITATION       0.000000       0       0       0       0       75.01         0107501       BRUCE COST CENTERS       0.000000       0       0       0       0       0       0       75.01         010000       08800       RURAL HEALTH CLINIC       0.000000       0       0       0       88.00         88.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0.000000       0       0       0       89.00         90.00       09000       CLINIC       0.000000       0       0       0       90.01       90.01       90.01       90.00       90.00       90.00       90.01       90.01       90.01       90.01       90.01       90.00       90.00       <	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	o o	72.00
74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       75.00         75.01       07501       CARDI AC REHAB       0.000000       0       0       0       0       75.01         76.97       O7697       CARDI AC REHABILI TATI ON       0.000000       0       0       0       0       75.01         76.97       OT697       CARDI AC REHABILI TATI ON       0.000000       0       0       0       0       76.97         0UTPATI ENT SERVICE COST CENTERS         0.000000       0       0       0       88.00         89.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       0.000000       0       0       0       89.00         90.01       09000       CLI NI C       0.000000       0       0       0       90.01         90.01       09000       VI SI TI NG SPECI ALTY CLI NI C       0.000000       0       0       0       90.01         91.00       09100       EMERGENCY       0.000000       0       0       0       90.01       91.00       92.00       00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	128, 117		0 0	o o	73.00
75.00         07500         ASC (NON-DI STINCT PART)         0.000000         0         0         0         75.00           75.01         07501         CARDI AC REHAB         0.000000         0         0         0         0         75.01           76.97         07697         CARDI AC REHABILLITATION         0.000000         0         0         0         0         75.01           76.97         07697         CARDI AC REHABILLITATION         0.000000         0         0         0         0         76.97           0UTPATI ENT SERVICE COST CENTERS         0.000000         0         0         0         0         88.00           88.00         08800         RURAL HEALTH CLINIC         0.000000         0         0         0         89.00           90.00         09000         CLINIC         0.000000         0         0         0         90.01           90.01         09001 VI SI TING SPECIALTY CLINIC         0.000000         0         0         0         90.01           91.00         09100         EMERGENCY         0.000000         25,272         0         0         0         92.00           0         02000         DSERVATI ON BEDS (NON-DI STINCT PART         0.000000 </td <td>73.01 07301 DRUGS CHARGED TO PATIENTS</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0 0</td> <td>o o</td> <td>73.01</td>	73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	o o	73.01
75. 01       07501       CARDI AC REHAB       0.000000       0       0       0       75. 01         76. 97       07697       CARDI AC REHABI LI TATI ON       0.000000       0       0       0       0       76. 97         0UTPATI ENT SERVICE COST CENTERS       0.000000       0       0       0       0       0       88. 00         88. 00       08800       RURAL HEALTH CLINIC       0.000000       0       0       0       88. 00         90. 00       09000       CLINIC       0.000000       0       0       0       89. 00         90. 01       09001       VISITING SPECIALTY CLINIC       0.000000       0       0       0       90. 01         91. 00       09100       EMERGENCY       0.000000       25, 272       0       0       0       92. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0.000000       7, 270       0       0       92. 00         00       09500       AMBULANCE SERVICES       95. 00       95. 00       95. 00       95. 00	74.00 07400 RENAL DI ALYSI S	0.000000	0		0 0	o o	74.00
76.97         07697         CARDI AC REHABILITATION         0.00000         0         0         0         0         76.97           OUTPATI ENT SERVICE COST CENTERS         0.00000         0         0         0         0         0         88.00         88.00         88.00         08000         RURAL HEALTH CLINIC         0.000000         0         0         0         0         88.00         89.00         90.00         0         0         0         0         89.00         89.00         90.00         0         0         0         0         89.00         89.00         90.00         0         0         0         0         89.00         89.00         90.00         90.00         0         0         0         89.00         89.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.	75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0		0 0	o o	75.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0.000000         0         0         0         88.00           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0.000000         0         0         0         88.00           90.00         09000         CLINIC         0.000000         0         0         0         90.00           90.01         09001         VISITING SPECIALTY CLINIC         0.000000         0         0         0         90.01           91.00         09100         EMERGENCY         0.000000         25,272         0         0         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0.000000         7,270         0         0         92.00           0THER REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00	75. 01 07501 CARDI AC REHAB	0.000000	0		0 0	o o	75.01
88.00         08800         RURAL         HEALTH         CLINIC         0.00000         0         0         0         0         88.00           89.00         08900         FEDERALLY QUALIFIED         HEALTH         CENTER         0.000000         0         0         0         0         89.00           90.00         09000         CLINIC         0.000000         0         0         0         0         90.00           90.01         09001         VISITING SPECIALTY CLINIC         0.000000         0         0         0         90.01           91.00         09100         EMERGENCY         0.000000         25,272         0         0         0         91.00           92.00         09200         DBSERVATI ON         BEDS         (NON-DI STINCT PART         0.000000         7,270         0         0         0         92.00           0THER         REI MBURSABLE         COST         CENTERS         95.00         95.00         95.00         95.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	o o	76.97
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0.000000         0         0         0         89.00           90.00         09000         CLINIC         0.000000         0         0         0         90.00           90.01         09000         CLINIC         0.000000         0         0         0         0         90.00           90.01         09100         IVISITING SPECIALTY CLINIC         0.000000         0         0         0         90.01           91.00         09100         EMERGENCY         0.000000         25,272         0         0         0         91.00           92.00         09200         DBSERVATION BEDS (NON-DISTINCT PART         0.000000         7,270         0         0         0         0           0THER REIMBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00	OUTPATIENT SERVICE COST CENTERS	· ·		•			1
90.00         09000         CLINIC         0.00000         0         0         0         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         91.00         91.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00 <td>88.00 08800 RURAL HEALTH CLINIC</td> <td>0.000000</td> <td>0</td> <td></td> <td>0 (</td> <td>0 0</td> <td>88.00</td>	88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 (	0 0	88.00
90.01         09001         VISITING SPECIALTY CLINIC         0.00000         0         0         0         90.01           91.00         09100         EMERGENCY         0.000000         25,272         0         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.000000         7,270         0         0         92.00           0THER         REIMBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0		0 0	o o	89.00
91.00         09100         EMERGENCY         0.00000         25,272         0         0         91.00         91.00         92.00         0         0         92.00         0         0         0         92.00         0         0         0         92.00         0         0         0         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00 <t< td=""><td>90. 00 09000 CLINIC</td><td>0.000000</td><td>0</td><td></td><td>0 0</td><td>o o</td><td>90.00</td></t<>	90. 00 09000 CLINIC	0.000000	0		0 0	o o	90.00
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0.000000         7,270         0         0         0         92. 00           OTHER REI MBURSABLE COST CENTERS         95. 00         09500         AMBULANCE SERVICES         95. 00         950. 00         950. 00         950. 00         950. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95.	90.01 09001 VISITING SPECIALTY CLINIC	0.000000	0		0 0	o o	90.01
OTHER REI MBURSABLE COST CENTERS         95. 00       09500         AMBULANCE SERVI CES       95. 00	91. 00 09100 EMERGENCY	0.000000	25, 272		0 0	o l	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0 0	o o	92.00
	OTHER REIMBURSABLE COST CENTERS	· .			•	·	1
200.00         Total (lines 50 through 199)         325,078         2,672         0         0         200.00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)		325, 078	2,6	72 (	0 0	200.00

Health Financial Systems	IU HEALTH PAC			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2018	Worksheet D Part V	
				To 12/31/2018	Date/Time Pre 5/28/2019 12:	pared: 19 nm
·		Title	XVIII	Hospi tal	Cost	17 pm
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(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	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 508544		1, 264, 12	9 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 420465			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 270028	0	3, 083, 96	9 0	0	54.00
60. 00 06000 LABORATORY	0. 380538	0	1, 619, 64	2 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 158592	0	500, 06	8 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 533110	0	413, 79	5 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 703910	0	478, 35	5 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 804006	0	43, 77	6 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 186346	0	44	5 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 642296	0	32, 97	5 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 136273	0	43, 88	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 347807	0	3, 214, 82	0 3, 483	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.01
74.00 07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0. 000000	0		0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90. 00 09000 CLINIC	2. 761420	0	33, 52	0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 257148	0	5, 378, 56	4 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 482953	0	1, 943, 81		0	92.00
OTHER REIMBURSABLE COST CENTERS		·				
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)	1	0	18, 051, 76	2 3, 483	0	200.00
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	18, 051, 76	2 3, 483	0	202.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1306	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/28/2019 12:	epared: 19 pm
		Titl€	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS		1	1			1
50. 00 05000 OPERATING ROOM	642, 865					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	832, 758					54.00
60. 00 06000 LABORATORY	616, 335					60.00
64.00 06400 INTRAVENOUS THERAPY	79, 307					64.00
65.00 06500 RESPI RATORY THERAPY	220, 598					65.00
66. 00 06600 PHYSI CAL THERAPY	336, 719					66.00
67.00 06700 OCCUPATI ONAL THERAPY	35, 196					67.00
68.00 06800 SPEECH PATHOLOGY	528					68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 180					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 981		1			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 118, 137		1			73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	C				73.01
74.00 07400 RENAL DI ALYSI S	0	C	-			74.00
75.00 07500 ASC (NON-DI STI NCT PART)	0	C				75.00
75. 01 07501 CARDI AC REHAB	0	C				75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C				76.97
OUTPATIENT SERVICE COST CENTERS	-		1			
88.00 08800 RURAL HEALTH CLINIC	0	C	1			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	00 5 ( 0	C				89.00
90.00 09000 CLINIC	92, 563					90.00
90. 01 09001 VISITING SPECIALTY CLINIC	0					90.01
91.00 09100 EMERGENCY	1, 383, 087					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	938, 772	C	1			92.00
OTHER REIMBURSABLE COST CENTERS	-	1				05.00
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	6, 324, 026	1, 211				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	6 224 024	1 011				202 00
202.00   Net Charges (line 200 - line 201)	6, 324, 026	1, 211				202.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period:	Worksheet D	
		Composite (		From 01/01/2018		
		Component (	CCN: 15-Z306	To 12/31/2018	Date/Time Pre 5/28/2019 12:	pared:
		Title	XVIII	Swing Beds - SNF		<u>17 pili</u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 508544	0		0 0	0	1 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 420465	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 270028	0			0	
60. 00 06000 LABORATORY	0. 380538	0			0	1
64. 00 06400 I NTRAVENOUS THERAPY	0. 158592	0			0	1
65. 00 06500 RESPI RATORY THERAPY	0. 533110	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 533110	0		0 0	0	00.00
		0		0 0		
67.00 06700 OCCUPATI ONAL THERAPY	0.804006	0		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	1. 186346	0		0 0	0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 642296	0		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 136273	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 347807	0		0 0	0	
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0. 000000	0		0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000		1		0	89.00
90. 00 09000 CLINIC	2. 761420	0	1	0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 257148	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 482953	0		0 0	0	1
OTHER REIMBURSABLE COST CENTERS	01 102700			<u> </u>		12.00
95. 00 09500 AMBULANCE SERVICES	0, 000000			0		95.00
200.00 Subtotal (see instructions)	0.00000	0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program		0			0	201.00
Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		0		o o	0	202.00
	1 1	0	I	0	0	1202.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-2552	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1306	Peri od:	Worksheet D	
				From 01/01/2018	Part V	
		Component	CCN: 15-Z306	To 12/31/2018	Date/Time Prepare 5/28/2019 12:19 p	
		Title	× XVIII	Swing Beds - SNF		<u></u>
	Cos	sts		Joining Bodd on	0001	
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	-				. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.	. 00
60. 00 06000 LABORATORY	0	0				. 00
64.00 06400 INTRAVENOUS THERAPY	0	0			64.	. 00
65. 00 06500 RESPI RATORY THERAPY	0	0			65.	. 00
66. 00 06600 PHYSI CAL THERAPY	0	0			66.	. 00
67.00 06700 OCCUPATI ONAL THERAPY	0	0			67.	. 00
68.00 06800 SPEECH PATHOLOGY	0	0			68.	. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.	. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.	. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			73.	. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0			73.	. 01
74.00 07400 RENAL DIALYSIS	0	0			74.	. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0			75.	. 00
75. 01 07501 CARDI AC REHAB	0	-				. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			76.	. 97
OUTPATIENT SERVICE COST CENTERS	1		1			
88.00 08800 RURAL HEALTH CLINIC	0					. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				. 00
90. 00 09000 CLI NI C	0	0				. 00
90.01 09001 VISITING SPECIALTY CLINIC	0	0				. 01
91.00 09100 EMERGENCY	0	0				. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.	. 00
OTHER REIMBURSABLE COST CENTERS		I				
95. 00 09500 AMBULANCE SERVI CES	0					. 00
200.00 Subtotal (see instructions)	0	0			200.	
201.00 Less PBP Clinic Lab. Services-Program	0				201.	. 00
Only Charges					000	00
202.00   Net Charges (line 200 - line 201)	0	0	1		202.	. 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/28/2019 12:	pared:
			e XIX	Hospi tal	PPS	19 pili
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,	Aujustillerit	Related Cost			
	Part II, col.		(col, 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 ADULTS & PEDI ATRI CS	255, 922	17, 488	238, 43	4 1, 276	186.86	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	
43.00 NURSERY	10, 364		10, 36	4 207	50.07	43.00
200.00 Total (lines 30 through 199)	266, 286		248, 79	8 1, 483		200.00
Cost Center Description	I npati ent	Inpatient		· · · ·		
·	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 ADULTS & PEDIATRICS	28	5, 232				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
43. 00 NURSERY	31	1, 552				43.00
200.00 Total (lines 30 through 199)	59	6, 784				200.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO	CN: 15-1306	Period:	Worksheet D	
				From 01/01/2018	Part II	
				To 12/31/2018	Date/Time Pre 5/28/2019 12:	
		Titl	e XIX	Hospi tal	972072019 12. PPS	19 pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATI NG ROOM	158, 929					
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 757				429	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	153, 467				185	
60. 00 06000 LABORATORY	52, 285				254	60.00
64.00 06400 INTRAVENOUS THERAPY	13, 708				0	64.00
65. 00 06500 RESPI RATORY THERAPY	12, 140				2	65.00
66. 00 06600 PHYSI CAL THERAPY	99, 646				0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	19, 967				0	67.00
68.00 06800 SPEECH PATHOLOGY	4, 092				0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 838				105	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	509	81, 564			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	40, 369	7, 535, 759			188	
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0.0000	0 00	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 0	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0	0.0000	0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0	0	0.0000	0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	9	0	0.0000	0 00	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0			0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 00	0	
90. 00 09000 CLI NI C	1, 461	42, 753			0	90.00
90. 01 09001 VISITING SPECIALTY CLINIC	0	0	0.0000		0	90.01
91. 00 09100 EMERGENCY	153, 716	19, 393, 574			111	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	129, 682	4, 091, 968	0. 0316	92 2, 170	69	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00   Total (lines 50 through 199)	857, 575	56, 857, 113		186, 760	2, 841	200. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COSTS	Provider CC	-	Period: From 01/01/2018 Fo 12/31/2018	Date/Time Pre 5/28/2019 12:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments 1A	rsing School	Allied Health Post-Stepdown Adjustments 2A	Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	10	1.00	20	2.00	3.00	
30. 00         03000         ADULTS & PEDIATRICS           31. 00         03100         INTENSI VE CARE UNIT           43. 00         04300         NURSERY           200. 00         Total (lines 30 through 199)	0 0 0	0 0 0 0			0 0 0 0	31.00
Cost Center Description	Adjustment (s Amount (see 1 instructions) mi	Fotal Costs sum of cols. through 3, nus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS           30. 00         03000         ADULTS & PEDIATRICS           31. 00         03100         INTENSIVE CARE UNIT           43. 00         04300         NURSERY           200. 00         Total (lines 30 through 199)	0	0 0 0	1, 27 20 1, 48	0.00 7 0.00	0 31	
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS           31.00         03100         INTENSIVE CARE UNIT           43.00         04300         NURSERY           200.00         Total (lines 30 through 199)	0 0 0 0 0					30.00 31.00 43.00 200.00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-1306	Period: From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	•
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		-				
50.00 05000 OPERATING ROOM	490, 393	C	)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 07501 CARDI AC REHAB	0	0		0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0	)	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS					-	1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	490, 393	0	)	0 0	0	200.00
						-

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2018		pared:
					5/28/2019 12:	19 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
	4.00	5.00	and 4) 6,00	7.00	8,00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	490, 393		0 4, 621, 537	0. 106110	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 1, 286, 310		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 9, 857, 002		1
60. 00 06000 LABORATORY	0	0		0 5, 088, 451		
64.00 06400 INTRAVENOUS THERAPY	0	0		0 1, 571, 985		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 250, 702		
66.00 06600 PHYSI CAL THERAPY	0	0		0 1, 489, 629		
67.00 06700 OCCUPATI ONAL THERAPY	0	0	)	0 268, 769		
68.00 06800 SPEECH PATHOLOGY	0	0		0 37, 409	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 239, 701	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 81, 564	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 535, 759	0.000000	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0.000000	73.01
74.00 07400 RENAL DI ALYSI S	0	0		0 0	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	)	0 0	0.000000	75.00
75. 01 07501 CARDI AC REHAB	0	0	)	0 0	0.000000	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS	1					
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000	1
90. 00 09000 CLINIC	0	0		0 42, 753		
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0 0	0. 000000	
91. 00 09100 EMERGENCY	0	0		0 19, 393, 574		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 4, 091, 968	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		1	1		1	
95. 00 09500 AMBULANCE SERVICES		400.000				95.00
200.00  Total (lines 50 through 199)	0	490, 393	1	0 56, 857, 113	1	200.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-1306	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018		nored.
				10 12/31/2010	5/28/2019 12:	19 nm
		Titl	e XIX	Hospi tal	PPS	., bu
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		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	1 1				1	-
50.00 O5000 OPERATI NG ROOM	0. 000000	43, 560	4, 6		-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	51, 317		0 0	-	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	11, 870		0 0	0	
60. 00 06000 LABORATORY	0. 000000	24, 722		0 0	0	
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	242		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0.000000	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0.000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 690		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	35, 146		0 0	0	
73.01 07301 DRUGS CHARGED TO PATIENTS	0.000000	0		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0.000000	0		0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0		0 0	0	
75. 01 07501 CARDI AC REHAB	0.000000	0		0 0	0	75.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 C	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0		0 0	0	
90. 00 09000 CLINIC	0.000000	0		0 0	0	
90.01 09001 VISITING SPECIALTY CLINIC	0.000000	0		0 0	0	
91. 00 09100 EMERGENCY	0.000000	14, 043		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2, 170		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					1	
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00  Total (lines 50 through 199)		186, 760	4, 6	22 C	0	200. 00

MPUT	Financial Systems IU HEALTH PAOL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1306	Period: From 01/01/2018	Worksheet D-1	
		T: 11 - 20/111	To 12/31/2018	Date/Time Prep 5/28/2019 12:	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
00 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			1, 403 1, 276	
00	Private room days (excluding swing-bed and observation bed d		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	bed days)		582	
00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	92	
00	reporting period Total swing-bed SNF type inpatient days (including private r	nom davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5			
00	Total swing-bed NF type inpatient days (including private ro reporting period	om days) through December	- 31 of the cost	35	7
00	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	a swing-bed and	178	9
	newborn days)	<u> </u>			
00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		room days)	92	10
00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private i	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
	through December 31 of the cost reporting period	5 . 51	5 /		
00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
	Medically necessary private room days applicable to the Prog			-	14
00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15
	SWING BED ADJUSTMENT		1		
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31 (	of the cost		17
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	f the cost	129. 14	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of 1	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructio	nc)		3, 900, 019	21
00	Swing-bed cost applicable to SNF type services through Decem		ting period (line	3, 400, 014	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	or 31 of the cost reportio	na period (line 6	0	23
. 00	x line 18)			0	2
00	Swing-bed cost applicable to NF type services through Decemb $7 \times 1$ (ine 19)	er 31 of the cost reporti	ng period (line	4, 520	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			266, 498	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 633, 521	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation bed ch	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)		5.00	0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 m		ctions)	0.00	
	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)	-		0.00 0	35
00	General inpatient routine service cost net of swing-bed cost		fferential (line	3, 633, 521	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (se	e instructions)		2, 847. 59	
	Dreamon general inpatient routing convice cost (line 0 v lin	- 20)		E04 071	39
	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog			506, 871 0	

OMPUTATION OF INPATIENT OPERAT	ING COST		Provider C	CN: 15-1306	Period:	eu of Form CMS- Worksheet D-1	
					From 01/01/2018 To 12/31/2018		
				XVIII	Hospi tal	Cost	-
Cost Center Descrip	tion	Total Inpatient Costlr	Total npatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00 NURSERY (title V & XIX o		0	0				42.
	ient Hospital Units	S		0	0	0	43.
3. 00 INTENSIVE CARE UNIT I. 00 CORONARY CARE UNIT		0	0	0.	0	0	43.
5. 00 BURN INTENSIVE CARE UNIT							45.
5. 00 SURGICAL INTENSIVE CARE							46.
7.00 OTHER SPECIAL CARE (SPEC Cost Center Descrip							47.
						1.00	
.00 Program inpatient ancill						132, 425	
0.00 Total Program inpatient		41 through 48)(s	ee instructio	ns)		639, 296	49.
PASS THROUGH COST ADJUST		natient routine s	ervices (from	Wkst D su	n of Parts I and	0	50.
				WK31. D, 30		0	00.
.00 Pass through costs appli	cable to Program in	patient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51.
and IV) 2.00 Total Program excludable	cost (sum of lines	50 and $51$				0	52.
3.00 Total Program inpatient			ated. non-phy	sician anest	netist. and		
medical education costs			arou, non phy				
TARGET AMOUNT AND LIMIT (	COMPUTATION						
.00 Program discharges .00 Target amount per discha	200					0.00	
. 00 Target amount (line 54 x	0					0.00	
00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
.00 Bonus payment (see instructions)							58
9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59
0.00 Lesser of Lines 53/54 or	55 from prior year	cost report, upda	ated by the m	arket basket		0.00	60
.00 If line 53/54 is less that	an the lower of line	es 55, 59 or 60 e	nter the less	er of 50% of		0	61
which operating costs (I			(lines 54 x	60), or 1% o [.]	f the target		
amount (line 56), otherw 2.00 Relief payment (see inst		Instructions)				0	62
a. 00 Allowable Inpatient cost		ment (see instruc	tions)			0	
PROGRAM INPATIENT ROUTINE							
1.00 Medicare swing-bed SNF in instructions)(title XVII		sts through Deceml	per 31 of the	cost report	ng period (See	261, 978	64.
5.00 Medicare swing-bed SNF i		sts after Decembe	r 31 of the c	ost reportin	period (See	0	65
instructions)(title XVII	only)						
00 Total Medicare swing-bed	SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	I only). For	261, 978	66
CAH (see instructions) 7.00 Title V or XIX swing-bed	NE inpatient routi	ne costs through l	December 31 o	f the cost r	eporting period	0	67.
(line 12 x line 19)	·	5					
3.00 Title V or XIX swing-bed	NF inpatient routin	ne costs after De	cember 31 of	the cost rep	orting period	0	68.
(line 13 x line 20) 2.00  Total title V or XIX swin	na-hed NF innatient	routine costs (li	ne 67 + line	68)		0	69.
PART III - SKILLED NURSIN	<u>v</u> .			,			
.00 Skilled nursing facility.					)		70
. 00 Adjusted general inpatie			ne 70 ÷ line	2)			71
2.00 Program routine service 3.00 Medically necessary priva	•	· ·	(line 14 x li	ne 35)			72
.00 Total Program general in							74
.00 Capital-related cost all	ocated to inpatient	routine service (	costs (from W	orksheet B, I	Part II, column		75.
26, line 45) 0.00 Per diem capital-related	costs (lino 75 . 1	no 2)					76
2.00 Program capital-related		,					77
00 Inpatient routine service	•						78
.00 Aggregate charges to ben		• •		· · · · · · · · · · · · · · · · · · ·			79
00 Total Program routine se			st limitation	(line 78 mi)	nus line 79)		80
.00  Inpatient routine servic .00  Inpatient routine servic	•						81
. 00 Reasonable inpatient rou			)				83
.00 Program inpatient ancilla							84
5.00 Utilization review - physical and the second s		•					85
0.00 Total Program inpatient PART IV - COMPUTATION OF			Jugn 85)			I	86
7.00 Total observation bed day						694	87
3.00 Adjusted general inpatie	nt routine cost per		ine 2)			2, 847. 59	
0.00 Observation bed cost (lin						1, 976, 227	

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		pared: 19 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	255, 922	3, 900, 019	0. 06562	1 1, 976, 227	129, 682	90.00
91.00 Nursing School cost	0	3, 900, 019	0.00000	0 1, 976, 227	0	91.00
92.00 Allied health cost	0	3, 900, 019	0.00000	1, 976, 227	0	92.00
93.00 All other Medical Education	0	3, 900, 019	0.00000	1, 976, 227	0	93.00

)MPU I	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1306	Period: From 01/01/2018	Worksheet D-1	
		THE YEY		Date/Time Prej 5/28/2019 12:	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	-
00	INPATIENT DAYS			1 402	
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			1, 403 1, 276	
00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		582	
00	Total swing-bed SNF type inpatient days (including private roc		r 31 of the cost	92	
00	reporting period Total swing-bed SNF type inpatient days (including private roc	m dave) after Decomber	21 of the cost	0	
00	reporting period (if calendar year, enter 0 on this line)	Jii days) alter December	ST OF THE COST	0	`
00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	35	
00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	28	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	1
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	5		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	( only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	( only (including privat	e room days)	0	1:
00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	ani (excluding swing-bed	uays)	207	
	Nursery days (title V or XIX only)			31	10
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		11
	reporting period	0			
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	129.14	19
00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line)	3, 900, 019	2
	5 x line 17)	·	5 T C	0	2
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	ng period (line	4, 520	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	pariod (line 9	0	2!
. 00	x line 20)	of the cost reporting	period (inte o	0	2
. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		266, 498	
. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TThe 21 minus TThe 20)		3, 633, 521	2
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 ÷	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	auc line 22) (acc inctore	tions	0.00	
	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lir			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 633, 521	
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see			2, 847. 59	38
~ ~	Program general inpatient routine service cost (line 9 x line	38)		79, 733	39
	Medically necessary private room cost applicable to the Progra	(1) (1) (2)		0	40

OMPUTATION OF INPATIENT OPERATING CO	ST		Provider C	CN: 15-1306	Period: From 01/01/2018	eu of Form CMS- Worksheet D-1	
					To 12/31/2018		
				e XIX	Hospi tal	PPS	
Cost Center Description	In	Total npatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only)		243, 166	207	1, 174.	71 31		5 42.
Intensive Care Type Inpatient H	ospital Units	0					1 42
. 00 I NTENSI VE CARE UNI T . 00 CORONARY CARE UNI T		0	Ĺ	0.	00 0	) (	) 43. 44.
. OO BURN INTENSIVE CARE UNIT							45
. 00 SURGICAL INTENSIVE CARE UNIT							46.
2. 00 OTHER SPECIAL CARE (SPECIFY)							47.
Cost Center Description						1.00	
.00 Program inpatient ancillary ser	vice cost (Wkst.	. D-3, col. 3	, line 200)			75, 724	4 48.
0.00 Total Program inpatient costs (				ons)		191, 873	3 49.
PASS THROUGH COST ADJUSTMENTS	o Drogram i posti	lant routing	anni ana (fran	What D ou	m of Dorto L and	( 70/	
0.00 Pass through costs applicable 1	o Program inpati	rent routine	services (Iron	IWKSL. D, SU	II OF PARTS F AND	6, 784	4 50.
.00 Pass through costs applicable 1	o Program inpati	ient ancillar	y services (fr	om Wkst. D,	sum of Parts II	7,463	3 51
and IV)	<u> </u>						
2.00  Total Program excludable cost ( 3.00  Total Program inpatient operati			lated non nh	cician anost	botict and	14, 247 177, 626	
medical education costs (line 4			rated, non-phy		netist, and	177,020	5 55
TARGET AMOUNT AND LIMIT COMPUTA		·				1	
. 00 Program di scharges							54
.00 Target amount per discharge .00 Target amount (line 54 x line 5	5)					0.00	
. 00 Difference between adjusted ing		g cost and ta	rget amount (I	ine 56 minus	line 53)		
.00 Bonus payment (see instructions		0	0			0	
0.00 Lesser of lines 53/54 or 55 fro	m the cost repo	rting period	ending 1996, ι	updated and c	ompounded by the	0.00	59
market basket 0.00 Lesser of Lines 53/54 or 55 fro	m prior year cos	st report up	dated by the m	arket basket		0.00	60
1.00 If line 53/54 is less than the					the amount by	(	
which operating costs (line 53)			s (lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise en 2.00 Relief payment (see instruction		structions)					62.
8.00 Allowable Inpatient cost plus i		t (see instru	ctions)				
PROGRAM INPATIENT ROUTINE SWING							
.00 Medicare swing-bed SNF inpatier		through Dece	mber 31 of the	e cost report	ing period (See	0	64
instructions)(title XVIII only) 0.00 Medicare swing-bed SNF inpatier		after Decemb	er 31 of the d	ost reportin	a neriod (See	0	65
instructions)(title XVIII only)							
.00 Total Medicare swing-bed SNF ir	patient routine	costs (line	64 plus line 6	5)(title XVI	ll only). For	0	) 66
CAH (see instructions) 7.00 Title V or XIX swing-bed NF ing	ationt routine (	costs through	December 31 (	of the cost r	eporting period		67
(line 12 x line 19)		costs through	December 31 C		eporting period		07.
3.00 Title V or XIX swing-bed NF inp	atient routine o	costs after D	ecember 31 of	the cost rep	orting period	0	68.
(line 13 x line 20)	NE innationt ro	uting gasta (	ling (7 . ling	(0)			) 69.
P. 00 Total title V or XIX swing-bed PART III - SKILLED NURSING FACI				,			) 69.
. 00 Skilled nursing facility/other					)		70
.00 Adjusted general inpatient rout			ine 70 ÷ line	2)			71
2.00 Program routine service cost (1 3.00 Medically necessary private roo		·	(lipo 14 v li	no 2E)			72
8.00  Medically necessary private roo 9.00  Total Program general inpatient							74
. 00 Capital-related cost allocated		•	,		Part II, column		75
26, line 45)	(1) 75	2)					
. 00 Per diem capital-related costs . 00 Program capital-related costs (	•	,					76
. 00 Inpatient routine service cost		· ·					78
.00 Aggregate charges to beneficiar	•	,	rovider record	ls)			79
. 00 Total Program routine service of	•		ost limitatior	n (line 78 mi	nus line 79)		80
.00 Inpatient routine service cost .00 Inpatient routine service cost	•		)				81
. 00 Reasonable inpatient routine se	•		•				83
.00 Program inpatient ancillary ser	vices (see insti	ructions)					84
5.00 Utilization review - physician							85
D. 00 Total Program inpatient operati PART IV - COMPUTATION OF OBSERV			rougn 85)				86
7.00 Total observation bed days (see						694	1 87
3.00 Adjusted general inpatient rout	ine cost per die	•	line 2)			2, 847. 59	88
0.00 Observation bed cost (line 87 >						1, 976, 227	1 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		pared: 19 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	255, 922	3, 900, 019	0. 06562	1 1, 976, 227	129, 682	90.00
91.00 Nursing School cost	0	3, 900, 019	0.00000	0 1, 976, 227	0	91.00
92.00 Allied health cost	0	3, 900, 019	0.00000	1, 976, 227	0	92.00
93.00 All other Medical Education	0	3, 900, 019	0.00000	1, 976, 227	0	93.00

Health Financial Systems IU HEALTH PAOLI	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1306	Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018		nored.
			To 12/31/2018	Date/Time Pre 5/28/2019 12:	
	Title	e XVIII	Hospi tal	Cost	<u>17 pm</u>
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
			-	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		T	
30. 00 03000 ADULTS & PEDI ATRI CS			346, 397		30.00
31.00 03100 INTENSIVE CARE UNIT			C	D	31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 5085			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4204			
54. 00 O5400 RADI OLOGY-DI AGNOSTI C		0. 2700			
60. 00 06000 LABORATORY		0. 3805			
64.00 06400 INTRAVENOUS THERAPY		0. 1585		, v	
65. 00 06500 RESPI RATORY THERAPY		0. 5331			
66. 00 06600 PHYSI CAL THERAPY		0. 7039			
67.00 06700 OCCUPATI ONAL THERAPY		0.8040			
68.00 06800 SPEECH PATHOLOGY		1. 1863			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6422			
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 1362		0 0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0.3478			
73. 01 07301 DRUGS CHARGED TO PATIENTS		0.0000		0	
74.00 07400 RENAL DI ALYSI S		0.0000		0	
75. 00 07500 ASC (NON-DI STI NCT PART)		0.0000		0	
75. 01 07501 CARDI AC REHAB		0.0000			
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000	00 C	0 0	76.97
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.0000		0	
89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER		0.0000		0	
		2.7614	· · ·	-	
90. 01 09001 VI SI TI NG SPECIALTY CLI NI C		0.0000		0	
91. 00 09100 EMERGENCY		0. 2571			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4829	53 7, 270	3, 511	92.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES		1			05.00
			225 070	122 425	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	- (line (1)		325, 078	132, 425	
201.00 Less PBP Clinic Laboratory Services-Program only charges 202.00 Net charges (line 200 minus line 201)	s (rine 61)		225 070		201.00
202.00 Net charges (line 200 minus line 201)		I	325, 078	2	202.00

lealth Financial Systems IU HEALTH PAOLI				eu of Form CMS-:	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1306	Peri od:	Worksheet D-3	5
	Component	CCN: 15-Z306	From 01/01/2018 To 12/31/2018		narec
	component	0011. 10 2000		5/28/2019 12:	
	Title	e XVIII	Swing Beds - SN		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1			30.0
30. 00  03000 AD0ETS & PEDIATRICS 31. 00  03100 INTENSIVE CARE UNIT					30.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					43.0
50. 00 05000 OPERATING ROOM		0. 5085	44 (	0 0	50.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 4204			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2700			
0. 00 06000 LABORATORY		0.3805			
4. 00 06400 I NTRAVENOUS THERAPY		0. 1585			
5. 00 06500 RESPI RATORY THERAPY		0. 5331		-	
6. 00 06600 PHYSI CAL THERAPY		0.7039			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 8040			
8. 00 06800 SPEECH PATHOLOGY		1. 1863			
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6422			
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1362			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3478			
3. 01 07301 DRUGS CHARGED TO PATIENTS		0.0000			
4. 00 07400 RENAL DI ALYSI S		0.0000			
5. 00 07500 ASC (NON-DI STINCT PART)		0.0000			
5. 01 07501 CARDI AC REHAB		0.0000			75.
6. 97 07697 CARDI AC REHABI LI TATI ON		0.0000		0 0	76.
OUTPATIENT SERVICE COST CENTERS				-	
8. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.
9. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER		0.0000	00	0	89.
0. 00 09000 CLINIC		2.7614		0 0	90.
0.01 09001 VISITING SPECIALTY CLINIC		0.0000		0 0	
1.00 09100 EMERGENCY		0. 2571		0 0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4829		0 0	92.
OTHER REIMBURSABLE COST CENTERS				·	1
5. 00 09500 AMBULANCE SERVICES					95.
00.00 Total (sum of lines 50 through 94 and 96 through 98)			82, 802	45, 083	200.
01.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		(		201.0
202.00 Net charges (line 200 minus line 201)			82, 802	2	202. (

	nancial Systems ANCILLARY SERVICE COST APPORTIONMENT	IU HEALTH PAOLI HOSPITAL Provider	CCN: 15-1306	Peri od:	Worksheet D-3	2552-1
	ANOTEEART SERVICE COST ATTORTONMENT	11 ovi del 1	CON. 15 1500	From 01/01/2018	NOT REFLECT D 5	
				To 12/31/2018		pared:
					5/28/2019 12:	
		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	PATIENT ROUTINE SERVICE COST CENTERS		-1			
	DOO ADULTS & PEDIATRICS			50, 283		30.00
	100 INTENSIVE CARE UNIT			0		31.00
	300 NURSERY			41, 925		43.00
	CILLARY SERVICE COST CENTERS				1	
	DOO OPERATING ROOM		0. 5085			
	200 DELIVERY ROOM & LABOR ROOM		0. 4204			
	400 RADI OLOGY-DI AGNOSTI C		0. 2700			
	DOO LABORATORY		0. 3805		9, 408	
	400 I NTRAVENOUS THERAPY		0. 1585		, o	
	500 RESPI RATORY THERAPY		0. 5331		129	65.00
66.00 066	500 PHYSI CAL THERAPY		0. 7039	10 0	0	66.00
67.00 067	700 OCCUPATI ONAL THERAPY		0.8040	06 0	0	67.00
68.00 068	BOO SPEECH PATHOLOGY		1. 1863	46 0	0	68.00
71.00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6422	96 3, 690	2, 370	71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS		0. 1362	73 0	0	72.00
73.00 073	300 DRUGS CHARGED TO PATIENTS		0. 3478	07 35, 146	12, 224	73.0
73.01 073	301 DRUGS CHARGED TO PATIENTS		0.0000	00 0	0	73.0
74.00 074	400 RENAL DI ALYSI S		0.0000	00 0	0	74.00
75.00 075	500 ASC (NON-DISTINCT PART)		0.0000	00 0	0	75.00
75.01 075	501 CARDI AC REHAB		0.0000	00 0	0	75.0
76.97 076	597 CARDI AC REHABI LI TATI ON		0.0000	00 0	0	76.9
	IPATIENT SERVICE COST CENTERS				•	
	BOO RURAL HEALTH CLINIC		0.0000	00 0	0	1 88. 00
89.00 089	POO FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89.00
	DOO CLINIC		2.7614		0	
	DO1 VISITING SPECIALTY CLINIC		0.0000		0	
	100 EMERGENCY		0. 2571			
	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4829			
	HER REIMBURSABLE COST CENTERS		0.1027	2,110	., 010	1
	500 AMBULANCE SERVICES					95.0
200.00	Total (sum of lines 50 through 94 and 9	96 through 98)		186, 760	75, 724	
201.00	Less PBP Clinic Laboratory Services-Pro					201.0
	Net charges (line 200 minus line 201)		1	U U		202.00

LCUL	Financial         Systems         IU         HEALTH         PAOLI           ATION         OF         REIMBURSEMENT         SETTLEMENT	Provi der CCN: 15-1306	Period: From 01/01/2018	u of Form CMS-2 Worksheet E Part B	
			To 12/31/2018	Date/Time Pre 5/28/2019 12:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		6, 325, 237 0	1. C 2. C
00	OPPS payments			0	3.0
00	Outlier payment (see instructions)			0	4.0
01	Outlier reconciliation amount (see instructions)			0	4. (
00 00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0. 000 0	5. ( 6. (
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.
). 00 . 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 325, 237	10. ( 11. (
. 00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 323, 237	11. (
	Reasonabl e charges				1.0.1
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	12. ( 13. (
	Total reasonable charges (sum of lines 12 and 13)			0	
	Customary charges				
5.00	Aggregate amount actually collected from patients liable for				15.
. 00	Amounts that would have been realized from patients liable fo had such payment been made in accordance with 42 CFR §413.13(		on a chargebasis	0	16.0
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.
8. 00	Total customary charges (see instructions)			0	
. 00	Excess of customary charges over reasonable cost (complete on instructions)	ly if line 18 exceeds li	ne 11) (see	0	19.
0. 00	Excess of reasonable cost over customary charges (complete on	lyifline 11 exceeds li	ne 18) (see	0	20.
	instructions)	<b>j</b>			
. 00	Lesser of cost or charges (see instructions)			6, 388, 489	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	rue (rons)		0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	-			
5.00 5.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	-	suctions)	42, 248 3, 284, 518	
. 00 . 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•	,	3, 264, 516	
	instructions)				
3.00	Direct graduate medical education payments (from Wkst. E-4, I			0	
). 00 ). 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 3, 061, 723	
. 00	Primary payer payments				31.
2. 00	Subtotal (line 30 minus line 31)			3, 061, 048	32.
8. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	CES)		0	33.
	Allowable bad debts (see instructions)			1, 266, 312	
5.00	Adjusted reimbursable bad debts (see instructions)			823, 103	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 117, 096	
7.00 8.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			3, 884, 151 0	
9.00 9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		-	39.
97 97	Demonstration payment adjustment amount before sequestration			0	
9. 98	Partial or full credits received from manufacturers for repla	iced devices (see instruc	ctions)	0	39.
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 3, 884, 151	
). 99 ) 00	Sequestration adjustment (see instructions)			77, 683	
). 00 ). 01				0	
). 00 ). 01 ). 02	Demonstration payment adjustment amount after sequestration			3, 808, 561	
). 00 ). 01 ). 02 . 00	Interim payments			0	
). 00 ). 01 ). 02 . 00 2. 00	Interim payments Tentative settlement (for contractors use only)			-2 003	
). 00 ). 01 ). 02 . 00	Interim payments	nce with CMS Pub. 15-2,	chapter 1,	-2, 093 204, 151	
0. 00 0. 01 0. 02 0. 00 2. 00 3. 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter 1,		
). 00 ). 01 ). 02 . 00 2. 00 3. 00 4. 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR	nce with CMS Pub. 15-2,	chapter 1,	204, 151	44.
). 00 ). 01 ). 02 . 00 2. 00 3. 00 4. 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	nce with CMS Pub. 15-2,	chapter 1,	204, 151	44. 90.
<ol> <li>0. 00</li> <li>0. 01</li> <li>0. 02</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> </ol>	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR	nce with CMS Pub. 15-2,	chapter 1,	204, 151 0 0 0.00	44. 90. 91.

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1306	Period: From 01/01/2018 To 12/31/2018		pared:
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		549, 5	89 0	3, 700, 361 0	1.00 2.00 3.00
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01 3.02	ADJUSTMENTS TO PROVIDER	08/22/2018	191, 8	00 08/22/2018 0	108, 200 0	3.0 ⁴ 3.02
3.02				0	0	3.02
3.04				0	0	3.0
3.05				0	0	3. 0
	Provider to Program				1	
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.5 3.5
3.51				0	0	3.5
3.53				0	0	3.5
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		191, 8	00	108, 200	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		741, 3	89	3, 808, 561	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5.01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.0 [.]
5.02				0	0	5.02
5.03				0	0	5.0
	Provider to Program				-	
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.5 5.5
5.51				0	0	5.5
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. C
5. 01	SETTLEMENT TO PROVIDER			0	0	6.0
6. 02	SETTLEMENT TO PROGRAM		165, 5		2, 093	6.0
7.00	Total Medicare program liability (see instructions)		575, 7		3, 806, 468	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
3.00	Name of Contractor	C	J	1.00	2.00	8.0

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1306	Period: From 01/01/2018	Worksheet E-1 3 Part I	1
		Component (	CCN: 15-Z306	To 12/31/2018		epareo
		Title	XVIII	Swing Beds - SN		
		I npati en	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		281, 9	89	0	) 1.
00	Interim payments payable on individual bills, either			0	C	) 2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	08/22/2018	46, 7		C	
2				0	0	
13				0	0	
)4				0	0	
)5	Dravidar to Dragram			0		) 3
0	Provider to Program ADJUSTMENTS TO PROGRAM		[	0	0	3
50 51	ADSUSTIMENTS TO FROGRAM			0		
52				0		
53				0		
54				0	0	) 3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		46, 7	00	0	) 3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		328, 6	89	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1 )2	TENTATI VE TO PROVIDER			0		
)2 )3				0		
	Provider to Program			0		
50	TENTATI VE TO PROGRAM			0	0	5 5
51				0	0	
52				0	C	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	) 5
	5.50-5.98) Determined net settlement amount (balance due) based on					6
00	the cost report. (1)					°
)1	SETTLEMENT TO PROVIDER			0	0	6 10
)2	SETTLEMENT TO PROGRAM		26, 2	-		
00	Total Medicare program liability (see instructions)		302, 4		C	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

Heal th	Financial Systems IU HEALT	H PAOLI HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1306	Period: From 01/01/2018 To 12/31/2018		epared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REP				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALC				
1.00	Total hospital discharges as defined in AARA §4102 fro		14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lin				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lin				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line				5.00
6.00	Total hospital charity care charges from Wkst. S-10, c	ol. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purcha line 168	se of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruct	i ons)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequest	ration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	· · · · · · · · · · · · · · · · · · ·			
30.00	Initial/interim HIT payment adjustment (see instructio	ns)			30.00
	Other Adjustment (specify)	<i>`</i>			31.00
	Balance due provider (line 8 (or line 10) minus line 3	0 and line 31) (see instruction	s)		32.00
			-		

LOOL	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS P	rovider CCN: 15-1306	Peri od:	Worksheet E-2	
	с	component CCN: 15-Z306	From 01/01/2018 To 12/31/2018		
		Title XVIII	Swing Beds - SNF	5/28/2019 12: Cost	19 pi
			Part A	Part B	
			1.00	2.00	
(	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		264, 598	0	1.
	Inpatient routine services - swing bed-NF (see instructions)				2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A		45, 534	0	3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instr Per diem cost for interns and residents not in approved teaching			0.00	4.
	instructions)	g program (see		0.00	4.
	Program days		92	0	5.
	Interns and residents not in approved teaching program (see inst	tructions)		0	
00	Utilization review - physician compensation - SNF optional metho	od only	0		7.
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		310, 132	0	8
	Primary payer payments (see instructions)		0	0	
	Subtotal (line 8 minus line 9)		310, 132	0	
	Deductibles billed to program patients (exclude amounts applicat	ole to physician	0	0	11
	professional services) Subtatal (line 10 minus line 11)		210 122	0	112
	Subtotal (line 10 minus line 11) Coinsurance billed to program patients (from provider records) (	(oveludo, coi psuranco	310, 132 1, 508	0	
	for physician professional services)	(exclude confisulatice	1, 500	U	13
	80% of Part B costs (line 12 x 80%)			0	14
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	)	308, 624	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16
. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16
	Rural community hospital demonstration project (§410A Demonstrat	tion) payment	0		16
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruc	rtions)	0	0	
	Total (see instructions)		308, 624	0	
	Sequestration adjustment (see instructions)		6, 172	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
. 00	Interim payments		328, 689	0	20
. 00	Tentative settlement (for contractor use only)		0	0	21
	Balance due provider/program (line 19 minus lines 19.01, 20, and		-26, 237	0	
	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	9, 917	0	23
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				200
	Cost Reimbursement				
-	Medicare swing-bed SNF inpatient routine service costs (from Wks	st. D-1, Pt. II, line			201
	66 (title XVIII hospital)				
	Medicare swing-bed SNF inpatient ancillary service costs (from W	Wkst. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)	not year of the ourse	nt E voor demonst		204
	Computation of Demonstration Target Amount Limitation (N/A in fi period)	ist year of the curre	int b-year demonst	Tation	
	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time	es line 204)			206
7	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursen	nent			1
7.00	Program reimbursement under the §410A Demonstration (see instruc	ctions)			207
8. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209
	Reserved for future use Comparision of PPS versus Cost Reimbursement				210
	OUDALISTOD OF PPS VALSUS LOST RALMOURSAMANT				1

		H PAOLI HOSPITAL		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1306	Period: From 01/01/2018	Worksheet E-3 Part V	
			To 12/31/2018		narec
			10 12/31/2010	5/28/2019 12:	
		Title XVIII	Hospi tal	Cost	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR M			1.00	
1.00	Inpatient services	EDICARE PARTA SERVICES - CC	JSI KEIMDUKSEMENI	639, 296	1 1.0
2.00	Nursing and Allied Health Managed Care payment (see in	structions)		037,270	
3.00	Organ acqui si ti on			0	
4.00	Subtotal (sum of lines 1 through 3)			639, 296	
5.00	Primary payer payments			0	
5.00	Total cost (line 4 less line 5). For CAH (see instruct	i ons)		645, 689	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	
3.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
0.00	Total reasonable charges			0	10.
	Customary charges			0	1
1.00	Aggregate amount actually collected from patients liab			0	
2.00	Amounts that would have been realized from patients li	1 5	s on a charge basis	0	12.
3. 00	had such payment been made in accordance with 42 CFR 4 Ratio of line 11 to line 12 (not to exceed 1.000000)	(13. 13(e)		0. 000000	13.
4.00	Total customary charges (see instructions)			0.000000	
5.00	Excess of customary charges over reasonable cost (comp	lete only if line 14 exceeds	line 6) (see	0	
5.00	instructions)	fete only in the in exceeds	11110 0) (300	0	13.
6.00	Excess of reasonable cost over customary charges (comp	olete only if line 6 exceeds l	ine 14) (see	0	16.
	instructions)	2	<i>,</i> .		
7.00	Cost of physicians' services in a teaching hospital (s	see instructions)		0	17.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
8.00	Direct graduate medical education payments (from Works	sheet E-4, line 49)		0	
9.00	Cost of covered services (sum of lines 6, 17 and 18)			645, 689	
0.00	Deductibles (exclude professional component)			72, 312	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21) Coinsurance			573, 377 0	
4.00	Subtotal (line 22 minus line 23)			573, 377	
5.00	Allowable bad debts (exclude bad debts for professiona	al services) (see instructions	:)	21, 791	
6.00	Adjusted reimbursable bad debts (see instructions)		· /	14, 164	
7.00	Allowable bad debts for dual eligible beneficiaries (s	see instructions)		19, 021	
8.00	Subtotal (sum of lines 24 and 25, or line 26)			587, 541	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see inst	ructions)		0	29.
9.99	Demonstration payment adjustment amount before sequest			0	29.
0. 00	Subtotal (see instructions)			587, 541	30.
0. 01	Sequestration adjustment (see instructions)			11, 751	30.
0. 02	Demonstration payment adjustment amount after sequestr	ation		0	
1.00	Interim payments			741, 389	
2.00	Tentative settlement (for contractor use only)			0	
3.00	Balance due provider/program (line 30 minus lines 30.0			-165, 599	
34.00	Protested amounts (nonallowable cost report items) in §115.2	accordance with CMS Pub. 15-2	2, chapter 1,	24, 648	34.

	Financial Systems IU HEALTH PAOL E SHEET (If you are nonproprietary and do not maintain SHEET (If you are nonproprietary and company for a second	Provider Co		Period:	u of Form CMS-: Worksheet G	
nd-t Iy)	ype accounting records, complete the General Fund column			rom 01/01/2018 To 12/31/2018		
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	14, 521, 853			0	1 1
00	Temporary investments	0	(		0	
00	Notes receivable	106, 804	(	0 0	0	3
00	Accounts receivable	2, 661, 135	0		0	
00	Other receivable	-1, 019, 959	(	0	0	
00	Allowances for uncollectible notes and accounts receivable	0	(	0	0	
00 00	Inventory Prepaid expenses	476, 763 126, 792	(		0	
00	Other current assets	120, 772		0	0	
. 00	Due from other funds	0	(		0	
00	Total current assets (sum of lines 1-10)	16, 873, 388	(	0 0	0	11
	FIXED ASSETS			11		
00	Land	148,000	(		0	
. 00	Land improvements	438, 464	(		0	
	Accumulated depreciation Buildings	-350, 620 7, 320, 569			0	
	Accumulated depreciation	-3, 348, 241			0	
	Leasehold improvements	791, 602	(		0	
	Accumul ated depreciation	-364, 990	(		0	
. 00	Fixed equipment	0	(	0 0	0	19
	Accumulated depreciation	0	(		0	
	Automobiles and trucks	31, 751	(		0	
	Accumulated depreciation	0	(		0	
	Major movable equipment	9,836,603	(		0	
	Accumulated depreciation Minor equipment depreciable	-6, 153, 242			0	
	Accumulated depreciation	0	(		0	
	HIT designated Assets	0	(		0	
	Accumulated depreciation	0	(	0 0	0	
. 00	Minor equipment-nondepreciable	0	(		0	
. 00	Total fixed assets (sum of lines 12-29)	8, 349, 896	(	00	0	30
00	OTHER ASSETS	F02 00/			0	1
. 00 . 00	Investments Deposits on Leases	583, 096 0	(		0	
. 00	Due from owners/officers	0			0	
. 00	Other assets	7, 319, 813	(	0	0	
. 00	Total other assets (sum of lines 31-34)	7, 902, 909	(		0	
. 00	Total assets (sum of lines 11, 30, and 35)	33, 126, 193	(	0 0	0	36
	CURRENT LI ABI LI TI ES			11		
	Accounts payable	1, 118, 771	(		0	
. 00	Salaries, wages, and fees payable	756, 502	(		0	
	Payroll taxes payable Notes and Loans payable (short term)	8, 415			0	
	Deferred income	0			0	
. 00	Accel erated payments	0			Ū	42
. 00	Due to other funds	0	(	0 0	0	43
	Other current liabilities	3, 012, 387	(		0	
. 00	Total current liabilities (sum of lines 37 thru 44)	4, 896, 075	(	00	0	45
00	LONG TERM LI ABI LI TI ES					
. 00 . 00	Mortgage payable Notes payable	0	(		0	
	Unsecured Loans	0	r i		0	
. 00	Other long term liabilities	28, 259	(		0	
	Total long term liabilities (sum of lines 46 thru 49)	28, 259	(	0	0	
	Total liabilities (sum of lines 45 and 50)	4, 924, 334	(	0 0	0	51
	CAPITAL ACCOUNTS					
	General fund balance	28, 201, 859				52
00	Specific purpose fund		C			53
. 00 . 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54
. 00	Governing body created - endowment fund balance - unrestricted			0		56
. 00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	28, 201, 859	(	0 0	0	59
. 00	Total liabilities and fund balances (sum of lines 51 and	33, 126, 193	(	ol	0	60

Heal th	Financial Systems	IU HEALTH PAOL	I HOSPI TAL		In L	ieu of Form CMS-	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-1306	Period: From 01/01/20 To 12/31/20	Worksheet G-1	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY CAPITAL TRANSFER Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	5, 334, 857 0 0 0 0 0 0 0 0 0 0 0	5, 320, 144 -1, 983, 431 33, 536, 713 33, 536, 713 33, 536, 716 5, 334, 857 28, 201, 859		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund			
1.00	Fund half and at having in affinited	6.00	7.00	8.00			1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY CAPITAL TRANSFER Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0 0		0 0 0 0 0		7.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CO	CN: 15-1306	Period: From 01/01/2018 To 12/31/2018		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services		4 5 ( 4 . 0)	24	1 5 ( 1 . 001	1 1 00
1.00 2.00	Hospi tal SUBPROVI DER – I PF		1, 564, 39	71	1, 564, 391	1.00
2.00 3.00	SUBPROVIDER - IPF					3.00
1.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		103, 12	24	103, 124	
5.00 5.00	Swing bed - NF		100, 12	0	0	
7.00	SKILLED NURSING FACILITY			0		7.00
3.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
0.00	Total general inpatient care services (sum of lines 1-9)		1, 667, 5 [.]	15	1, 667, 515	10.00
	Intensive Care Type Inpatient Hospital Services		•			
1.00	INTENSIVE CARE UNIT			0	0	11.00
2.00	CORONARY CARE UNIT		1			12.00
3.00	BURN INTENSIVE CARE UNIT					13.00
4.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
6.00	Total intensive care type inpatient hospital services (sum	oflines		0	0	16.00
	11-15)					
7.00	Total inpatient routine care services (sum of lines 10 and	16)	1, 667, 51		1, 667, 515	
8.00	Ancillary services		2, 892, 72			
9.00	Outpatient services		192, 9			
20.00	RURAL HEALTH CLINIC				0 0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER				0 0	
22.00	HOME HEALTH AGENCY					
23.00 24.00	AMBULANCE SERVICES CMHC			0	0	23.00 24.00
24.00	AMBULATORY SURGICAL CENTER (D. P. )					24.00
26.00	HOSPICE					26.00
27.00	OTHER NRCC			0 78,05	6 78, 056	
28.00	Total patient revenues (sum of lines 17-27)(transfer colum	n 3 to Wkst	4, 753, 19			
	G-3, line 1)	e to moti	1,700,1			20100
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			24, 095, 20	3	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)				C	36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
10.00				0		40.00
11.00				0		41.00
12.00	Total deductions (sum of lines 37-41)			04.005.00		42.00
13.00	Total operating expenses (sum of lines 29 and 36 minus lin to Wkst. G-3, line 4)	e 42)(transfer		24, 095, 20	5	43.00

Heal th	Financial Systems IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEN	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1306 Period:			Worksheet G-3	
	From 01/01/2018 To 12/31/2018				
1.00		20)		1.00 58,602,685	1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				1.00
2.00	Less contractual allowances and discounts on patients' accoun	ts		36, 842, 974	2.00
3.00	Net patient revenues (line 1 minus line 2)	(2)		21, 759, 711	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		24, 095, 208	4.00
5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			-2, 335, 497	5.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00					9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	5 1				16.00
17.00					17.00
18.00					18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			352, 066	24.00
25.00	Total other income (sum of lines 6-24)			352, 066	25.00
26.00	Total (line 5 plus line 25)			-1, 983, 431	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1, 983, 431	29.00