INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 Health Financial Systems This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interFORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPI RES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATIONPAND ider CCN: 15-1328 Period: Worksheet S From 01/01/2020 Parts I-III SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: То 7/14/2021 11: 18 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/14/2021 Time: 11:18 am use only 2. []Manually prepared cost report]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 4 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor 5.]Cost Report Status Γ 11. Contractor's Vendor Code: (1) As Submitted use only Δ (2) Settled without Audit 8. [N]Initial Report for this Provider CCN12. [O]If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N]Final Report for this Provider CCN number of times reopened = 0-9. (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 PROVI PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE A 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 INDLANA UNIVERSITY HEALTH BEDFORD (15-1328) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	MI CHAEL	CRAI G	

Officer or Administrator of Provider(s)

CFIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY	_	_				
1.00 Hospital	0	355, 909	-577, 422	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	-2, 588	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200. 00 Total	0	353, 321	-577, 422	0	0	200.00
The above amounts represent "due to" or "due from'	" the applicabl	le program for	the element o	f the above co	omplex indicate	ed.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it dis a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to com and review the information collection is estimated 673 hours per response, including the time to review instructions, search exis 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 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 R 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.

	<u>Financial Systems</u> AL AND HOSPITAL HEALTH CARE COMPLEX	INDIANA UNIVI IDENTIFICATION D.		<u>H BEDFOI</u> ovider Co			I Period: From 01/01		of For Worksh Part I		
								/2020	Date/T 7/14/2		
	1.00	2.0	0	3.00	l .			4.00	// 14/2	021 11.	
	Hospital and Hospital Health Care (Street: 2900 WEST SIXTEENTH STREET	Complex Address: PO Box:				1					1 00
	City: BEDFORD	State: IN	J Zip	Code: 474	421-	Count	y: LAWRENC	E			1.00 2.00
		Component Nar			-	ovi der	Date Cantifian		nt Syst		
			Numb	er Num	ber	Гуре	Certified	1 <u>I,</u>	0, or XVIII		-
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3.00	Hospital and Hospital-Based Compone Hospital	ent Identification INDIANA UNIVERSIT		28 999	215	1	10/01/200	5 N	0	0	3.00
. 00		HEALTH BEDFORD			/13		10/01/200				5.00
. 00 . 00	Subprovi der – IPF Subprovi der – IRF										4.00 5.00
. 00	Subprovider - (Other)										6.00
. 00	Swing Beds - SNF	IU HEALTH BEDFORD) - 15Z3	28 999	915		10/01/200	5 N	0	0	7.00
. 00	Swing Beds - NF	SWING BED									8.00
. 00	Hospital-Based SNF										9.00
	Hospi tal -Based NF Hospi tal -Based OLTC										10.00
	Hospital -Based HHA										12.00
	Separately Certified ASC										13.00
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14.00 15.00
6.00	Hospital-Based Health Clinic - FQHO										16.00
	Hospital-Based (CMHC) Renal Dialysis										17.00 18.00
	Other										19.00
							From 1.0		Tc 2.		-
0.00	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/31		20.00
1.00	Type of Control (see instructions)						2				21.00
					1.	00	2.0	0	3.	00	-
	Inpatient PPS Information										
2.00	Does this facility qualify and is i disproportionate share hospital adj					N					22.00
	§412.106? In column 1, enter "Y" f				ty						
	subject to 42 CFR Section §412.106(column 2, enter "Y" for yes or "N"		dment hospi	:al?) In							
2. 01	Did this hospital receive interim u		payments fo	or this	cost I	N	N				22.01
	reporting period? Enter in column 1	, "Y" for yes or	"N" for no t	for the							
	portion of the cost reporting period column 2, "Y" for yes or "N" for no										
	period occurring on or after Octobe			i opor ti	19						
2.02	Is this a newly merged hospital that	· · · · · · · · · · · · · · · · · · ·				N	N				22. 02
	payments to be determined at cost r Enter in column 1, "Y" for yes or "										
	reporting period prior to October 1	. Enter in column	2, "Y" for	yes or	'N''						
2 03	for no, for the portion of the cost Did this hospital receive a geogram					N	N		Ν	J	22. 03
	as a result of the OMB standards fo	or delineating sta	tistical are	eas adop							22.00
	by CMS in FY2015? Enter in column 1 portion of the cost reporting perio										
	"Y" for yes or "N" for no for the p										
	occurring on or after October 1. (s										
	contain at least 100 but not more 1 with 42 CFR 412.105)? Enter in colu				ce						
3.00	Which method is used to determine N	ledicaid days on I	ines 24 and	′or 25 b			3 N				23.00
	In column 1, enter 1 if date of adm discharge. Is the method of identif		J								
	period different from the method us	sed in the prior c									
	In column 2, enter "Y" for yes or "		In-State I	n-State	Out-o	of	Out-of	Medi ca		ther	
				edi cai d	Stat			Medica HMO daj		di cai d	
		k		ligible	Medi ca		edi cai d		(days	
			unp	aid day	spard d		ligible baid days				
			1.00	2.00	3.00		4.00	5.00		5.00	
				C)	0	0		0	C	24.00
24.00	If this provider is an IPPS hospita		0	C							24.00
4. 00	lf this provider is an IPPS hospita in-state Medicaid paid days in colu Medicaid eligible unpaid days in co	umn 1, in-state	-	C						U	24.00
4.00	in-state Medicaid paid days in colu Medicaid eligible unpaid days in co Medicaid paid days in column 3, out	umn 1, in-state blumn 2, out-of-st :-of-state Medicai	ate d	ſ							, 24. 00
4.00	in-state Medicaid paid days in colu Medicaid eligible unpaid days in co	umn 1, in-state Dlumn 2, out-of-st -of-state Medicai Medicaid HMO paic	ate d	C							, 24.0

	L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION		ALTH BEDFO Provider C		Peri od:		Workst	<u>rm CMS-2</u> neet S-2	
					From 01/	01/2020 31/2020	Part I		
		In-State Medicaid	In-State	Out-of	Out-of	Medi ca		Other di cai d	
		paid days	Medicaid eligible	State Medi cai d	State Medi cai d	HMO da	J .	days	
			unpaid day:	spaid days	eligible			3	
		1.00	2.00	3.00	unpaid day 4.00	s 5.00)	6.00	-
	f this provider is an IRF, enter the in-state Medi	caid C	C	0 0	(0	0100	25.
	paid days in column 1, the in-state Medicaid eligik Inpaid days in column 2, out-of-state Medicaid days								
	column 3, out-of-state Medicaid eligible unpaid days								
	column 4, Medicaid HMO paid and eligible but unpaid								
a	lays in column 5.				Urban/I	Rural St	Date of	° Geogra	3
00 15	nter your standard geographic classification (not	wago) stat	us at tho	bogi ppi pg. c		00	2.	00	26.
	reporting period. Enter "1" for urban or "2" for ru			begi nini ng c		L 2			20.
. 00 E	inter your standard geographic classification (not	wage) stat				2			27.
	reporting period. Enter in column 1, "1" for urban the effective date of the geographic reclassificati			appl i cabl e	, enter				
5. 00 I	f this is a sole community hospital (SCH), enter 1			SCH status	in effec	t O			35.
i	n the cost reporting period.				Pogia	nni ng:	End	i ng:	
						00		00	
	inter applicable beginning and ending dates of SCH		bscript li	ne 36 for n	umber of				36.
	periods in excess of one and enter subsequent dates f this is a Medicare dependent hospital (MDH), ent		ber of per	iods MDH st	atus is ii	0 ר			37.
е	effect in the cost reporting period.								
	s this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y")			37.
	f line 37 is 1, enter the beginning and ending dat					, 			38.
	han 1, subscript this line for the number of perio lates.	ods in exce	ss of one	and enter s	ubsequent				
u					Y	/N	Y	/N	
				+ C		00		00	
	oes this facility qualify for the inpatient hospit hospitals in accordance with 42 CFR §412.101(b)(2)(N ,		N	39.
f	for yes or "N" for no. Does the facility meet the m	nileage rec	uirements	in accordan	ce with 42				
	CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in colu	umn 2 "Y" f	or ves or	"N" for no	(sho				
li			01 905 01	N TOT HO.	(366				
0. 00 1	nstructions) s this hospital subject to the HAC program reducti	on adjustm	ent? Enter	"Y" for ye	s or "N"	N		N	40.
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2. 00 f 5. 00 5. 00 4 5. 00 7. 00 7. 00 7. 00 7. 00 9. 00 9. 00 0. 00	s this hospital subject to the HAC program reducti for no in column 1, for discharges prior to October column 2, for discharges on or after October 1. (see Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paym 22 CFR Section §412.320? (see instructions) s this facility eligible for additional payment ex- to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pf s this a new hospital under 42 CFR §412.300(b) PPS s the facility electing full federal capital payme feaching Hospitals s this a hospital involved in training residents i for no in column 1. If column 1 is "Y", are you imp payment reduction? Enter "Y" for yes or "N" for no f line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for ye lid residents start training in the first month of N" for no in column 2. If column 2 is "Y", complet /kst. D, Parts III & IV and D-2, Pt. II, if applica f line 56 is yes, did this facility elect cost rei MS Pub. 15-1, chapter 21, §2148? If yes, complete wre costs claimed on line 100 of Worksheet A? If yes	on adjustm - 1. Enter e instruct ment for di acception for t. III and S capital? ent? Enter n approvec bacted by C o in column g period du yes or "N" this cost ete Workshe able. mbursement Wkst. D-5. yes, comple	ent? Enter "Y" for ye ions) sproportio r extraord Wkst. L-1, Enter "Y "Y" for y GME progr R 11642 (o 2. ring which for no in reporting et E-4. If for physi te Wkst. D	"Y" for yes s or "N" for nate share i nary ci rcu Pt. I thro for yes or es or "N" f ams? Enter r subsequen resi dents col umn 1. I peri od? Er col umn 2 i ci ans' serv -2, Pt. I. NAHE 413. Y/N	in accorda mstances p ugh Pt. 1 "N" for no or no. "Y" for yo t CR), MA in approvo t cr "Y" for s "N", cor ices as do 85 Works Lin	V 1.00 anc wilt bursualit 1. N M es pr NN GME ed GME 1 is "Y" pr yes c npl ete efi hedNi N heet A he #	XVIII 2.00 h N N N N N N N N N C N C N Criteri	N N N N N N N N N N N N N N	45. 46. 47. 48. 56. 57. 58. 59.
5. 00 1 f 5. 00 2 5. 00 4 5. 00 1 7. 00 1 7. 00 1 7. 00 1 7. 00 1 9. 00 4 1 7. 00 1 9. 00 1 9. 00 4 1 1 1 1 1 1 1 1 1 1 1 1 1	s this hospital subject to the HAC program reducti for no in column 1, for discharges prior to October column 2, for discharges on or after October 1. (see Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paym 2 CFR Section §412.320? (see instructions) s this facility eligible for additional payment ex to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt s this a new hospital under 42 CFR §412.300(b) PPS s the facility electing full federal capital payme reaching Hospitals s this a hospital involved in training residents i for no in column 1. If column 1 is "Y", are you imp payment reduction? Enter "Y" for yes or "N" for no f line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y", complet (kst. D, Parts III & IV and D-2, Pt. II, if applica f line 56 is yes, did this facility elect cost rei MS Pub. 15-1, chapter 21, §2148? If yes, complete are costs claimed on line 100 of Worksheet A? If yes	on adjustm - 1. Enter e instruct ment for di kception fc t. III and S capital? ent? Enter n approvec bo in column g period du yes or "N" this cost able. mbursement Wkst. D-5. yes, comple	ent? Enter "Y" for ye ions) sproportio r extraord Wkst. L-1, Enter "Y Wr" for y GME progr R 11642 (o 2. ring which for no in reporting et E-4. If for physi te Wkst. D	"Y" for yes s or "N" for nate share i nary ci rcu Pt. I thro for yes or es or "N" f ams? Enter r subsequen residents col umn 1. I period? Er col umn 2 i ci ans' serv -2, Pt. I. NAHE 413. Y/N 1.00 ny N	in accorda mstances p ugh Pt. 1 "N" for no or no. "Y" for yo t CR), MA in approvo t cr "Y" for s "N", cor ices as do 85 Works Lin	V 1.00 ance wilt bursualit 1. N N M es pr NN GME ed GME 1 is "Y" pr yes co npl ete efi hedNi N heet A he #	XVIII 2.00 h N N N N N N N N N C N C N C r Criteri	XI X 3.00 N N N N ication on Code	45. 46. 47. 48. 56. 57. 58. 59.
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Ith Financial Systems INDIANA UNIV SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION E		Provi der C	CN: 15-1328 Pe	eriod:	of Form CMS-2 Worksheet S-2	
			Fi To	rom 01/01/2020 b 12/31/2020	Part I Date/Time Pre 7/14/2021 11:	
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1.				0.00		61.0
instructions) 01 Enter the average number of unweighted primary care						61. (
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						
primary care FTEs added under section 5503 of ACA).	e and					61. (
 (see instructions) O3 Enter the base line FTE count for primary care and/o general surgery residents, which is used for determining compliance with the 75% test. (see 	br					61.0
 instructions) 04 Enter the number of unweighted primary care/or surge allopathic and/or osteopathic FTEs in the current of the current of						61. (
reporting period. (see instructions). 05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61.0
primary care and/or general surgery FTE counts (lin 61.04 minus line 61.03). (see instructions) 06 Enter the amount of ACA §5503 award that is being u	sed					61.0
for cap relief and/or FTEs that are nonprimary care general surgery. (see instructions)		acon Non-	Drogrom Carl			
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Direct GME FTE	
		1.00	2.00	3.00	<u>Count</u> 4. 00	1
10 Of the FTEs in line 61.05, specify each new program				0.00) 61. ⁻
specialty, if any, and the number of FTE residents						
each new program. (see instructions) Enter in colum the program name. Enter in column 2, the program co						
Enter in column 3, the IME FTE unweighted count. En						
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 instruction	ons)					
Enter in column 1, the program name. Enter in column						
the program code. Enter in column 3, the IME FTE						
unweighted count. Enter in column 4, the direct GME	FTE					
unweighted count.						
					1.00	-
ACA Provisions Affecting the Health Resources and Se						
00 Enter the number of FTE residents that your hospital		ned in this co	st reporting p	eriod for whic	h your 0.00	62.
hospital received HRSA PCRE funding (see instruction 01 Enter the number of FTE residents that rotated from	a Teac	0	• •	to your hospit	al 0.00	62.
during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovid			10115)			
00 Has your facility trained residents in nonprovider s for yes or "N" for no in column 1. If yes, complete	setting	gs during this			r"Y" N	63.
		<u> </u>	Unweighted		Ratio (col. 1/	
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te	2.00	2.00	-
Section 5504 of the ACA Base Year FTE Residents in I	Nonnro	lider Sottinge	1.00	2.00	3.00	-
reporting period that begins on or after July 1, 200						
00 Enter in column 1, if line 63 is yes, or your facili	tv tra	ained resident	sin 0.00	0.00	0.000000	64
the base year period, the number of unweighted non-r					21 000000	1
			Enter			
						1
FTEs attributable to rotations occurring in all non in column 2 the number of unweighted non-primary car						
in column 2 the number of unweighted non-primary car trained in your hospital. Enter in column 3 the rati	re resi	dent FTEs tha	t			

PITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION	DATA Provider	CCN: 15-1328 Pe	eriod:	u of Form CMS- Worksheet S- Part I	2
				rom 01/01/2020 o 12/31/2020) Date/Time Pr	repare
	Program Name	Program Code	Unweighted	Unweighted	7/14/2021 11 Ratio (col. 3	
			FTEs	FTEs in	(col. 3 + col	
			Nonprovi der	Hospi tal	4))	
F	1.00	2.00	Si te 3.00	4.00	5.00	-
00 Enter in column 1, if line 63 is	S		0.00			0 65.
yes, or your facility trained						
residents in the base year period, the program name						
associated with primary care FTE						
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 car	e					
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	Unweighted	Ratio (col. 1	
			FTEs	FTEsin	(col. 1 + col	
			Nonprovi der	Hospi tal	2))	
			<u>Site</u> 1.00	2.00	3.00	-
Section 5504 of the ACA Current						
reporting periods beginning on o	<u>r after July 1, 20</u>	10	<u></u>			
00 Enter in column 1 the number of attributable to rotations occurr			TES 0.00 Prin	0.00	0. 00000	0 66
column 2 the number of unweighter						
trained in your hospital. Enter						
		tio of (column 1 div	ri ded			
by (column 1 + column 2)). (see	instructions)	tio of (column 1 div			Patio (col. 3	
		tio of (column 1 div Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3 (col. 3 + col	
	instructions)	tio of (column 1 div	Unweighted FTEs Nonprovider			
	instructions) Program Name	tio of (column 1 div Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col 4))	
by (column 1 + column 2)). (see	instructions)	tio of (column 1 div	Unweighted FTEs Nonprovider	FTES in Hospital	(col. 3 + col 4)) 5.00	
by (column 1 + column 2)). (see 0 Enter in column 1, the program name associated with each of you	instructions) Program Name 1.00	tio of (column 1 div Program Code	Unweighted FTEs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col 4)) 5.00	
by (column 1 + column 2)). (see 00 Enter in column 1, the program name associated with each of you primary care programs in which	instructions) Program Name 1.00	tio of (column 1 div Program Code	Unweighted FTEs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col 4)) 5.00	
by (column 1 + column 2)). (see D0 Enter in column 1, the program name associated with each of you primary care programs in which you trained residents. Enter in	instructions) Program Name 1.00	tio of (column 1 div Program Code	Unweighted FTEs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col 4)) 5.00	
by (column 1 + column 2)). (see 00 Enter in column 1, the program name associated with each of you primary care programs in which	instructions) Program Name 1.00	tio of (column 1 div Program Code	Unweighted FTEs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col 4)) 5.00	
by (column 1 + column 2)). (see D0 Enter in column 1, the program name associated with each of you primary care programs in which you trained residents. Enter in column 2, the program code. Ente in column 3, the number of unweighted primary care FTE	instructions) Program Name 1.00	tio of (column 1 div Program Code	Unweighted FTEs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col 4)) 5.00	
by (column 1 + column 2)). (see D0 Enter in column 1, the program name associated with each of you primary care programs in which you trained residents. Enter ir column 2, the program code. Ente in column 3, the number of unweighted primary care FTE residents attributable to	instructions) Program Name 1.00	tio of (column 1 div Program Code	Unweighted FTEs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col 4)) 5.00	
by (column 1 + column 2)). (see D0 Enter in column 1, the program name associated with each of you primary care programs in which you trained residents. Enter in column 2, the program code. Ente in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all	instructions) Program Name 1.00	tio of (column 1 div Program Code	Unweighted FTEs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col 4)) 5.00	
by (column 1 + column 2)). (see D0 Enter in column 1, the program name associated with each of you primary care programs in which you trained residents. Enter in column 2, the program code. Ente 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	instructions) Program Name <u>1.00</u> r	tio of (column 1 div Program Code	Unweighted FTEs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col 4)) 5.00	
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 Health Financial Systems
 INDIANA UNIVERSI

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

NDI ANA	UNI	VERSI TY	H	EALTH	BEDF	ORD		
I FI CATI	ON	DATA		Provi	der	CCN:	15-1	1328

In Lieu of Form CMS-2552-10

	Worksheet	S-2
24 /0000	Devet 1	

 Period:
 Worksheet S-2

 From 01/01/2020
 Part I

 To
 12/31/2020

 Date/Time Prepared:

 7/14/2021

 11:18

			1.00	
	Long Term Care Hospital PPS		1.00	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	na nari ad2 Ent	N N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporti for yes and "N" for no.	ng periou? Ent		81.00
	TEFRA Provi ders			
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for ye			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sect Enter "Y" for yes and "N" for no.	ION §413.40(T)	(1)(11)?	86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under sectio Enter "Y" for yes or "N" for no.	n 1886(d)(1)(E)(vi)?N	87.00
		V	XIX	
		1.00	2.00	
90 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	ves on	Y	90.00
70.00	"N" for no in the applicable column.	yes on	•	70.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in	full onN	N	91.00
92 00	in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.00
72.00	instructions) Enter "Y" for yes or "N" for no in the applicable column.		14	72.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	"Y" N	N	93.00
94 00	for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the app	licablaN	N	94.00
74.00	column.		11	74.00
	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the app column.	licableN	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post	N	Y	98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in c for title V, and in column 2 for title XIX.	olumn 1		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wks	t. C, N	Y	98.01
	Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for t	itle		
08 02	XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	bed N	Y	98. 02
70.02	costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for		I	70. 02
	V, and in column 2 for title XIX.			
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column		N	98.03
	title V, and in column 2 for title XIX.	1 101		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpat		N	98.04
	services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column title XIX.	2 for		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance o	n Wkst.N	Y	98.05
	C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in col	umn 2		
98 06	for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, P	ts I N	Y	98.06
70.00	through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2		I.	70.00
	title XIX.			
105 00	Rural Providers Does this hospital qualify as a CAH?	V		105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payme	nt for N		106.00
107.00	outpatient services? (see instructions)			107 00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N		107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an appr	oved		
	medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" f	or yes		
108 00	or "N" for no in column 2. (see instructions) Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 4	2 CER N		108.00
	Section §412.113(c). Enter "Y" for yes or "N" for no.			
	Physical Occupational	Speech	Respi ratory	
109 00	1.00 2.00 If this hospital qualifies as a CAH or a cost provider, are N	3.00 N	4.00 N	109.00
	therapy services provided by outside supplier? Enter "Y" for			
	yes or "N" for no for each therapy.			

Health Financial Systems INDIANA UNIVERSITY H	EALTH BEDFO	RD	In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet S- Part I Date/Time Pr 7/14/2021 1	repared:
110.00Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter Worksheet E, Part A, lines 200 through 218, and Worksheet E	"Y" for yes	or "N" for no.	If yes, compl	1.00 N ete	110.00
111.00 If this facility qualifies as a CAH, did it participate in Integration Project (FCHIP) demonstration for this cost repo or "N" for no in column 1. If the response to column 1 is Y the FCHIP demo in which this CAH is participating in column Ambulance services; "B" for additional beds; and/or "C" for	orting perio , enter the 2. Enter al	d? Enter "Y" t integration p I that apply:	for yes rong of	2.00	111.00
		1.00	2.00	3.00	_
112.00Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting "Y" for yes or "N" for no in column 1. If column 1 is "Y", 2, the date the hospital began participating in the demonstr column 3, enter the date the hospital ceased participation is demonstration, if applicable.	period? En enter in co ration. In	N ter	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of column 1. If column 1 is yes, enter the method used (A, B, of column 2. If column 2 is "E", enter in column 3 either "93" short term hospital or "98" percent for long term care (incl psychiatric, rehabilitation and long term hospitals provider definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) i percent for ludes	n			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for no.	for yes or	'N'' N			116.00
117.00 Is this facility legally-required to carry malpractice insu	rance? Enter	"Y" N			117.00
for yes or "N" for no. 118.001s the malpractice insurance a claims-made or occurrence pol the policy is claim-made. Enter 2 if the policy is occurrent		lif '	1		118.00
118.01 List amounts of malpractice premiums and paid losses:		1.00 60,672	2.00 2 0	3.00	0118.01
			1.00	2.00	_
118.02Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher amounts contained therein. 119.00D0 NOT USE THIS LINE			N		118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold and applicable amendments? (see instructions) Enter in colur Is this a rural hospital with < 100 beds that qualifies for provision in ACA §3121 and applicable amendments? (see instru- for yes or "N" for no.	nn 1, "Y" fo the Outpati ructions) En	r yes or "N" t ent Hold Harml ter in column	for no. ess 2, "Y"	Ν	120.00
121.00Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devi	ces charged to	D Y		121.00
122.00Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column Worksheet A line number where these taxes are included. Transplant Center Information				5.00	122.00
125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "	N" for no. If	yes, N		125.00
 enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, encolumn 1 and termination date, if applicable, in column 2. 	nter the cer	tification da	te in		126.00
127.00 If this is a Medicare certified heart transplant center, en column 1 and termination date, if applicable, in column 2.	ter the cert	ification date	ein		127.00
128.00 If this is a Medicare certified liver transplant center, en column 1 and termination date, if applicable, in column 2.	ter the cert	ification date	ein		128.00
129.00 If this is a Medicare certified lung transplant center, enter, column 1 and termination date, if applicable, in column 2.	er the certi	fication date	in		129.00
130.00 If this is a Medicare certified pancreas transplant center, column 1 and termination date, if applicable, in column 2.	enter the c	ertification o	date in		130.00
131.00 If this is a Medicare certified intestinal transplant center		certi fi cati or	n date		131.00
in column 1 and termination date, if applicable, in column 2 132.00 If this is a Medicare certified islet transplant center, en column 1 and termination date, if applicable, in column 2.		ification date	ein		132.00
 133. 00Removed and reserved 134. 00 If this is an organ procurement organization (0P0), enter the termination date, if applicable, in column 2. 	he OPO numbe	r in column 1	and		133.00 134.00

Health Financial Systems INDIANA UNIVER		EALTH BEDFOR	RD			In Lieu	of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	TA	Provider CO	CN: 15-1328		eriod:	01/2020	Worksheet S-2 Part I)
				To			Date/Time Pre	
	l						7/14/2021 11:	<u>18 am</u>
					1.	00	2.00	
All Providers 140.00Are there any related organization or home office cos	to oo d	ofined in C	MC Dub 15	· 1	abantar	\ /	15H059	140.00
10? Enter "Y" for yes or "N" for no in column 1. If y						Ŷ	120024	140.00
enter in column 2 the home office chain number. (see	instruc							
1.00 If this facility is part of a chain organization, ent	2.00	: maa 141 +h		+		3.00		
of the home office and enter the home office contract					name a		222	
141.00Name: INDIANA UNIVERSITY HEALTH, INC Contractor's Nar					's Num	ber:0810)1	141.00
142. 00Street: 340WEST 10TH STREETPO Box:143. 00Ci ty:INDI ANAPOLI SState:	L NI		Zip Co	do.		44.00	22	142.00 143.00
143. OQCITY. TINDIANAPOLIS State.	IN			Jue.		4620		143.00
							1.00	
144.00 Are provider based physicians' costs included in Work	sheet A	?					Y	144.00
				ŀ	1.	00	2.00	1
145.00 If costs for renal services are claimed on Wkst. A, I					ent			145.00
services only? Enter "Y" for yes or "N" for no in col dialysis facility include Medicare utilization for th								
for yes or "N" for no in column 2.	IS COST	reporting	periou? E	nter	ř			
146.00Has the cost allocation methodology changed from the						N		146.00
for yes or "N" for no in column 1. (See CMS Pub. 15-2	, chapte	er 40, §402	0) If yes,	ente	er the			
approval date (mm/dd/yyyy) in column 2.								
							1.00	
147.00Was there a change in the statistical basis? Enter "Y							N N	147.00 148.00
148.00Was there a change in the order of allocation? Enter 149.00Was there a change to the simplified cost finding met	hod? En	ter "Y" for	ves or "N	l" for	r no.		N	148.00
		Part A	Part E	3	Ti t	le V	Title XIX	
Does this facility contain a provider that qualifies	for an	1.00	2.00			00	4.00	
lower of costs or charges? Enter "Y" for yes or "N" f							3.	
(See 42 CFR §413.13)								
155.00Hospital 156.00Subprovider - IPF		N N	N N			N N	N N	155.00 156.00
157. 00Subprovi der – IRF		N	N			N	Ň	157.00
158. OOSUBPROVI DER								158.00
159. OQSNF 160. OQHOME HEALTH AGENCY		N N	N N			N N	N N	159.00 160.00
161. OQCMHC		N	N			N	Ň	161.00
							1.00	
Multicampus							1.00	
165.00 s this hospital part of a Multicampus hospital that	has one	or more ca	mpuses in	di ffe	erent (CBSAs?	Enter N	165.00
"Y" for yes or "N" for no.		County	Stata	7: 0 (Codo	CDCA		
Name 0	(County 1.00	State 2.00	<u>21 p (</u> 3. (CBSA 4.00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each campus								166.00
enter the name in column 0, county in column 1, state in column 2, zip								
code in column 3, CBSA in column 4,								
FTE/Campus in column 5 (see								
instructions)								
							1.00	1
Health Information Technology (HIT) incentive in the					nt Act		1 <u>v</u>	1/7 00
167.00 s this provider a meaningful user under §1886(n)? E 168.00 f this provider is a CAH (line 105 is "Y") and is a) ente	er the	Y	167.00 168.00
reasonable cost incurred for the HIT assets (see inst				,	, 0110			100.00
168.01 If this provider is a CAH and is not a meaningful use				y for	r a har	-dship e	xcepti on	168. 01
under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for 169.00If this provider is a meaningful user (line 167 is "Y)5 i s	"N").	enter †	he oor	169.00
transition factor. (see instructions)	, and							
						nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR beginning date and e	ndi na di	ate for the	reportina	peri		00	2.00	170.00
respectively (mm/dd/yyyy)	0			•				

Health Financial Systems	of Form CMS-255	52-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-1328	Period: From 01/01/2020	Worksheet S-2 Part I	
			To 12/31/2020	Date/Time Prepa 7/14/2021 11:18	
			1.00	2.00	
171.00 If line 167 is "Y", does this provid	ler have any days for ir	ndividuals enrolled in se	ection Y	15917	1.00
1876 Medicare cost plans reported or	or yes and				
"N" for no in column 1. If column 1					
in column 2. (see instructions)					

Health Financial Systems	INDIANA UNIVERSITY H	EALTH BEDFORD	
HOSPITAL AND HOSPITAL HEALTH CARE	REIMBURSEMENT QUESTIONNALRE	Provider CCN: 15-1328	Peri od:

In Lieu of Form CMS-2552-10 Worksheet S-2

103111	AL AND HOST THE HEALTH CARE REPUBLICISEMENT QUESTIONWALKE		F	rom 01/01/2020 o 12/31/2020	Part II Date/Time Pre 7/14/2021 11:	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO	responses. En	1.00 ter all dates	2.00 in	
	the mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation Has the provider changed ownership immediately prior to t	he beginning	of the cost re	ortindN		1.00
1.00	period? If yes, enter the date of the change in column 2.			bor tringe		1.00
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare	Program2 If	1.00 res, N	2.00	3.00	2.00
2.00	enter in column 2 the date of termination and in column 3					2.00
3.00	or "l" for involuntary. Is the provider involved in business transactions, includ	ling managemen	Y Y			3.00
0.00	contracts, with individuals or entities (e.g., chain home					0.00
	medical supply companies) that are related to the provide					
	medical staff, management personnel, or members of the bo through ownership, control, or family and other similar r					
	instructions)	erati onsni ps?	(See			
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports Column 1: Were the financial statements prepared by a Ce	rtified Publi	ł y	Α		4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C"			~		4.00
	"R" for Reviewed. Submit complete copy or enter date avai	lable in colu	nn 3.			
F 00	(see instructions) If no, see instructions.	Foront from t	ose N			5.00
5.00	Are the cost report total expenses and total revenues dif on the filed financial statements? If yes, submit reconci		iose n			5.00
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2	. If ves is	the provider	s the N		6.00
0.00	legal operator of the program?		the protruct			0.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see			N		7.00
8.00	Were nursing school and/or allied health programs approve reporting period? If yes, see instructions.	d and/or rene	wed during the	cost N		8.00
9.00	Are costs claimed for Interns and Residents in an approve	d graduate me	dical educatio	n N		9.00
	program in the current cost report? If yes, see instructi					
10.00	Was an approved Intern and Resident GME program initiated reporting period? If yes, see instructions.	or renewed i	n the current	cost N		10.00
11.00	Are GME cost directly assigned to cost centers other than	I&Rinan	Approved Teach	ng N		11.00
	Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If y	es, see instr	uctions.		Y	12.00
	If line 12 is yes, did the provider's bad debt collection			cost reporting	period₽	13.00
14 00	If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-pay	monte waivod?	lf vos soo i	nstructions	N	14.00
	Bed Complement	ments warveu:	TT yes, see t	nstructrons.	IN	14.00
	Did total beds available change from the prior cost repor				Ν	15.00
		Par Y/N	t A	Par Y/N	t B	
		1.00	Date 2.00	3.00	Date 4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?			N		16.00
	either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4 .(see instruction					
17.00	Was the cost report prepared using the PS&R Report for to	tals Y	04/02/2021	Y	04/02/2021	17.00
	and the provider's records for allocation? If either colu					
	or 3 is yes, enter the paid-through date in columns 2 and (see instructions)	4.				
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Re	port N		N		18.00
	data for additional claims that have been billed but are	not				
	included on the PS&R Report used to file this cost report yes, see instructions.	? f				
19.00	Jf line 16 or 17 is yes, were adjustments made to PS&R Re	port N		N		19.00
	data for corrections of other PS&R Report information? If					
	yes, see instructions.					

Heal [.]	th	Fi nanci a	Systems

INDIANA UNIVERSITY HEALTH BEDFORD

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C		Period:	Worksheet S	-2
				From 01/01/2020 Fo 12/31/2020	Part II Date/Time Pi	renared [.]
					7/14/2021 1	
			ption	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Rep	()	1.00 N	3.00 N	20.00
20.00	data for Other? Describe the other adjustments made to roak kep			IN IN	IN	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		Ν		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	6 HOSPI TALS)			
22.00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se		26		N	22.00
	Have changes occurred in the Medicare depreciation expense			ring the cost	N	22.00
20100	reporting period? If yes, see instructions.	ado to appro		in the coort		20100
24.00	Were new leases and/or amendments to existing leases enter	ed into durir	ng this cost r	eporting perio	d?lf N	24.00
05 00	yes, see instructions			0.16		05 00
	Have there been new capitalized leases entered into during instructions.	the cost rep	borting period	r i yes, see	N	25.00
	Were assets subject to Sec.2314 of DEFRA acquired during t	he cost repor	ting period?	lf ves, see	Ν	26.00
	instructions.		51	, , , , , , , , , , , , , , , , , , ,		
27.00	Has the provider's capitalization policy changed during th	<u>e cost report</u>	ting period?	fyes, submit	сору. N	27.00
28 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	ntered into c	during the cos	t reporting pe	ci od 2 INF	28.00
20.00	yes, see instructions.		during the cos	st reporting pe		20.00
29.00	Did the provider have a funded depreciation account and/or		(Debt Service	Reserve Fund)	treatedN	29.00
	as a funded depreciation account? If yes, see instructions					
	Has existing debt been replaced prior to its scheduled mat Has debt been recalled before scheduled maturity without i					30.00 31.00
	Purchased Services	ssuance of ne	ew debt: Tr ye	s, see matrice	10113. N	51.00
32.00	Have changes or new agreements occurred in patient care se	rvices furnis	shed through c	contractual	N	32.00
	arrangements with suppliers of services? If yes, see instr					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap see instructions.	plied pertair	ning to compet	itive bidding?	IT NO,N	33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	rrangement wi	th provider-b	ased physician	s?lfY	34.00
	yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nents with the	e provider-base	d N	35.00
	physicians during the cost reporting period: in yes, see i		-	Y/N	Date	
				1.00	2.00	
	Home Office Costs			1		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	roparod by th	o homo offica	Y PIFY		36.00 37.00
37.00	ves, see instructions.	repared by th				37.00
38.00	If line 36 is yes, was the fiscal year end of the home of	fice differer	nt from that c	of the N		38.00
	provider? If yes, enter in column 2 the fiscal year end of					
	If line 36 is yes, did the provider render services to oth	er chain comp	onents? If ye	es, see N		39.00
	Instructions. If line 36 is yes, did the provider render services to the	home office?	? If ves, see	e N		40.00
	instructions.					101 00
				_		
	Cost Report Preparer Contact Information	1.	00	2.	00	
	Cost Report Preparer Contact Information Enter the first name, last name and the title/position he	donda		UTTER		41.00
	by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
	Enter the employer/company name of the cost report prepare		RSITY HEALTH			42.00
43.00	Enter the telephone number and email address of the cost 3 report preparer in columns 1 and 2, respectively.	17-902-1093		RUTTER@I UHEALT		43.00
				1		11

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS						
Provi der CCN: 15-1328	Period:	Worksheet S-2				
	To 12/31/2020	Date/Time Pre 7/14/2021 11:	pared: 18 am			
3.00	_					
DURRECTOR			41.00			
			42.00			
			43.00			
	Provi der CCN: 15-1328	Provi der CCN: 15-1328 Peri od: From 01/01/2020 To 12/31/2020 3.00 DdRECTOR er.	Provi der CCN: 15-1328 Peri od: From 01/01/2020 To 12/31/2020 Bate/Time Pre 7/14/2021 11: 3.00 DdRECTOR er.			

alth Financial Systems INDI ISPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTI	ANA UNI VERSI TY CAL DATA	Provi der C	CN: 15-1328	Period: From 01/01/2020		3
				To 12/31/2020	7/14/2021 11: //P Days / 0/P	<u>18 a</u> 1
Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	<u>Visits / Trips</u> Title V	i
	1.00	2.00	3.00	4.00	5.00	
00 Hospital Adults & Peds. (columns 5, 6, 7 an exclude Swing Bed, Observation Bed and Hosp days)(see instructions for col. 2 for the portion of LDP room available beds)	d 8 30.00	19			0	1.
 HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF 			· · ·		0	
00 Total Adults and Peds. (exclude observation beds) (see instructions)		19	6, 95	4 92, 328. 00	-	
DOI NTENSI VE CARE UNI TDOCORONARY CARE UNI TDOBURN I NTENSI VE CARE UNI TDOSURGI CAL I NTENSI VE CARE UNI TDOOTHER SPECI AL CARE (SPECI FY)	31.00	6	2, 19	6 33, 744. 00	0	9 10 11 12
00 NURSERY 00 Total (see instructions) 00 CAH visits 00 SUBPROVIDER - IPF 00 SUBPROVIDER - IRF 00 SUBPROVIDER 00 SKILLED NURSING FACILITY 00 NURSING FACILITY 00 NURSING FACILITY 00 OTHER LONG TERM CARE 00 HOME HEALTH AGENCY 00 AMBULATORY SURGICAL CENTER (D.P.) 00 HOSPICE		25	9, 15	0 126, 072. 00	0 0	
10 HOSPICE (non-distinct part) 00 CMHC - CMHC 00 RURAL HEALTH CLINIC	30.00					24 25 26
 100 Horker Hack In Bernie Der Hack Hack Hack Hack Hack Hack Hack Hack	89.00	25 0	· · ·	D	0	26 27
00 LTCH non-covered days 01 LTCH site neutral days and discharges						33 33

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTI	CAL DATA	Provider CC	F	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 7/14/2021 11:	epared
	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	
.00 Hospital Adults & Peds. (columns 5, 6, 7 an		95	3, 847		10.00	1.0
 exclude Swing Bed, Observation Bed and Hosp days) (see instructions for col. 2 for the portion of LDP room available beds) .00 HMO and other (see instructions) .00 HMO IPF Subprovider 	1, 027 0	386 0				2. (3. (
.00 HMO IRF Subprovider	0	0				4.
.00 Hospital Adults & Peds. Swing Bed SNF	42	0	42			5.
 .00 Hospital Adults & Peds. Swing Bed NF .00 Total Adults and Peds. (exclude observation beds) (see instructions) 	1, 970	0 95	27 3, 916			6. 7.
. 00 INTENSIVE CARE UNIT	662	49	1, 406			8.
. OO CORONARY CARE UNIT O. OO BURN INTENSIVE CARE UNIT 1. OO SURGICAL INTENSIVE CARE UNIT 2. OO OTHER SPECIAL CARE (SPECIFY) 3. OO NURSERY	002		1, 400			9. (10. (11. (12. (13. (
 4.00 Total (see instructions) 5.00 CAH visits 6.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER 9.00 SKILLED NURSING FACILITY 0.00 NURSING FACILITY 1.00 OTHER LONG TERM CARE 2.00 HOME HEALTH AGENCY 3.00 AMBULATORY SURGICAL CENTER (D. P.) 4.00 HOSPICE 4.10 HOSPICE (non-distinct part) 5.00 CMHC - CMHC 	2, 632 0	144 0	5, 322 C		242. 80	15.0 16.0 17.0 18.0 20.0 21.0 22.0 23.0 24.0 24.0
 5.00 CMHC - CMHC 6.00 RURAL HEALTH CLINIC 6.25 FEDERALLY QUALIFIED HEALTH CENTER 7.00 Total (sum of lines 14-26) 8.00 Observation Bed Days 9.00 Ambulance Trips 0.00 Employee discount days (see instruction) 1.00 Employee discount days - IRF 2.00 Labor & delivery days (see instructions) 2.01 Total ancillary labor & delivery room outpatient days (see instructions) 	0 0 0	0 11 0	0 1, 264 0 0 0 0 0 0 0	0.00		
3.00 LTCH non-covered days 3.01 LTCH site neutral days and discharges	0 0					33. 33.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATIST	CAL DATA	Provider C	CN: 15-1328	Period: From 01/01/2020 To 12/31/2020		epared:
	Full Time		Di s	charges		
Component	Equi val ents Ionpai d Workers	Title V	Title XVIII	Title XIX	Total All	
	11.00	12.00	13.00	14.00	Patients 15.00	
 Hospital Adults & Peds. (columns 5, 6, 7 an exclude Swing Bed, Observation Bed and Hosp days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IRF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT O GORONARY CARE UNIT O USUBRN INTENSI VE CARE UNIT O Total Adults and Peds. (seclude observation beds) (see instructions) UNTENSI VE CARE UNIT O CORONARY CARE UNIT O USUBRGICAL INTENSI VE CARE UNIT O Total (see instructions) O THER SPECIAL CARE (SPECIFY) O NURSERY O Total (see instructions) O SUBPROVI DER - IPF O SUBPROVI DER - IPF O SUBPROVI DER - IPF O SUBPROVI DER - IRF O CMHC - CMHC O RURAL HEALTH CLINIC C E FEDERALLY QUALIFIED HEALTH CENTER O OB Ervation Bed Days O Ambulance Trips O OB Employee discount days (see instruction) O Employee discount days (see instruction) O Employee discount days (see instructions) O CAI ancillary	i ce	0	2	25 31 71 119 0 0 0 0 0 0	1, 414	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
outpati ent days (see instructions)33.00LTCH non-covered days33.01LTCH site neutral days and discharges				0		33. 00 33. 01

Heal th	Financial Systems INDIANA UNIVERSITY HE	ALTH BEDFOR	RD	In Lieu	u of Form CMS-2	2552-10
		Provider C	CN: 15-1328	Period:	Worksheet S-1	
				From 01/01/2020	Data (Tima Dua	
				To 12/31/2020	Date/Time Pre 7/14/2021 11:	
					1771472021 11.	TO all
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 o	divided by	line 202 col	umn 8)	0. 236235	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				5, 523, 499	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme			i cai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medic	aid		0	5.00
6.00	Medicaid charges				34, 697, 055	6.00
7.00 8.00	Medicaid cost (line 1 times line 6)		have even of	Linco 2 and E.	8, 196, 659	7.00 8.00
8.00	Difference between net revenue and costs for Medicaid program zero then enter zero)	i (i ne / i	ITTUS SUIL OI	innes z anu s;	if < 2,673,160	8.00
	Children's Health Insurance Program (CHIP) (see instructions	for each I	ine)			
9.00	Net revenue from stand-al one CHIP		The)		0	9.00
	Stand-al one CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
	Difference between net revenue and costs for stand-alone CHI	P (line 11	minus line 9	; if < zero the	n enter 0	12.00
	zero)	()				
	Other state or local government indigent care program (see ir	nstructions	for each li	ne)	_	
13.00	Net revenue from state or local indigent care program (Not in	ncluded on	lines 2, 5 o	r 9)	6, 477	13.00
	Charges for patients covered under state or local indigent ca		n (Not includ	ed in lines 6 o		
	State or local indigent care program cost (line 1 times line				14, 794	
16.00	Difference between net revenue and costs for state or local i	ndigent ca	ire program (line 15 minus l	ne 13; 8,317	16.00
	if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, (CHIP and st	ate/local in	digent care		
17.00	programs (see instructions for each line) Private grants, donations, or endowment income restricted to	funding ch	ari tu caro		0	17.00
17.00	Government grants, appropriations or transfers for support of				0	17.00
	Total unreimbursed cost for Medicaid, CHIP and state and loc			ams (sum of lin	-	19.00
17.00	and 16)	di Thangen	it dui e pi ogi		0,2,1201, 177	17.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire t	°acility (s	ee 3, 933, 71	9 149, 233	4, 082, 952	20.00
	instructions)					
21.00	Cost of patients approved for charity care and uninsured disc	counts (see	929, 28	2 149, 233	1, 078, 515	21.00
~~~~~	instructions)					00.00
22.00	Payments received from patients for amounts previously writte	en off as		0 0	0	22.00
22.00	charity care		929, 28	140 222	1 070 515	22.00
23.00	Cost of charity care (line 21 minus line 22)		929, 28	2 149, 233	1, 078, 515	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pati	ent davs h	evond a Leng	th of stay limi	t N	24.00
24.00	imposed on patients covered by Medicaid or other indigent car			th of Stay IIm	C IV	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond			ram's Length of	stav 0	25.00
	limit					
26.00	Total bad debt expense for the entire hospital complex (see i	nstruction	is)		5, 428, 741	26.00
	Medicare reimbursable bad debts for the entire hospital compl				316, 707	27.00
	Medicare allowable bad debts for the entire hospital complex				487, 242	27.01
28.00	Non-Medicare bad debt expense (see instructions)		-		4, 941, 499	28.00
	Cost of non-Medicare and non-reimbursable Medicare bad debt e	expense (se	e instructio	ns)	1, 337, 890	
	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 416, 405	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			5, 097, 882	31.00

Health Financial Systems INDI	ANA UNI VERSI TY	HEALTH BEDFOI	RD	In Lieu	ı of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provider C	CN: 15-1328 P	eri od:	Worksheet A	
				rom 01/01/2020		
			I'	o 12/31/2020	Date/Time Pre 7/14/2021 11:	pared: 18 am
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
	our ur roo	0 11101	+ col. 2)	ons (See A-6)		
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT		0	0	491, 768		1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0		1, 211, 761	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	82, 995	273, 254	356, 249		3, 573, 030	
5. 00 00500 ADMI NI STRATI VE & GENERAL	1, 239, 580	14, 374, 319	15, 613, 899	-285, 924	15, 327, 975	
7.00 00700 OPERATION OF PLANT	674, 708	1, 490, 571	2, 165, 279		1, 875, 747	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	138, 427	138, 427			8.00
9. 00 00900 HOUSEKEEPI NG	422, 556	344, 263	766, 819		611, 344	9.00
10. 00 01000 DI ETARY	437, 493	367, 103	804, 596			
11. 00 01100 CAFETERI A	0	0	0	152, 124	152, 124	11.00
13.00 01300 NURSING ADMINI STRATION	1, 541, 739	2,020,734	3, 562, 473		3, 240, 468	
14.00 01400 CENTRAL SERVICES & SUPPLY	60, 344	119, 382	179, 726	975, 177	1, 154, 903	14.00
15.00 01500 PHARMACY	603, 912	12, 445, 122	13, 049, 034	-11, 909, 399	1, 139, 635	15.00
17.00 01700 SOCI AL SERVI CE	0	0	0	52, 291	52, 291	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-			1		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 429, 526	2, 055, 675	4, 485, 201		3, 796, 105	30.00
31.00 03100 I NTENSI VE CARE UNI T	1, 343, 322	867, 505	2, 210, 827	-460, 895	1, 749, 932	31.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 165, 411	1, 455, 346	2, 620, 757		1, 885, 661	50.00
51.00 05100 RECOVERY ROOM	333, 715	88, 033	421, 748			51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	989, 200	1, 157, 665	2, 146, 865		1, 486, 614	54.00
56. 00 05600 RADI OI SOTOPE	93, 986	271, 274	365, 260			56.00
57.00 05700 CT SCAN	362, 636	251, 524	614, 160		405, 024	57.00
58.00 05800 MRI	225, 151	117, 882	343, 033		256, 444	58.00
	296, 159	3, 585, 937	3, 882, 096			
65. 00 06500 RESPI RATORY THERAPY	759, 886	385, 407	1, 145, 293		820, 356	
66.00 06600 PHYSI CAL THERAPY	637, 681	188, 968	826, 649			
67.00 06700 OCCUPATI ONAL THERAPY	356, 856	78, 247	435, 103		375, 712	67.00
68.00 06800 SPEECH PATHOLOGY	69, 406	20, 497	89, 903		74,009	
69.00 06900 ELECTROCARDI OLOGY	334, 141	705, 396	1, 039, 537	-255, 486	784, 051	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	95, 209		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	11, 910, 252		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	69, 758	69, 758	76. 97
	000 107	201 210	1 070 007	244 104	1 000 151	00.00
90.00 09000 CLINIC	882, 127	391, 210	1, 273, 337		1, 029, 151	90.00
90. 01 09001 CLINIC - DIABETES	16, 642	54, 803	71, 445		71, 257	90.01
91.00 09100 EMERGENCY	2, 082, 350	1, 654, 125	3, 736, 475	-708, 522	3, 027, 953	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS	17 441 500	44 002 660	62 244 101	224 744	40 470 OF7	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	17, 441, 522	44, 902, 669	62, 344, 191	334, 766	62, 678, 957	118.00
190. 0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18, 713	14, 576	33, 289	-13, 909	19, 380	190 00
192. 0019200 PHYSI CLANS' PRI VATE OFFI CES	0	307, 720	307, 720		61, 526	
194. 0007950 OCCUPATI ONAL HEALTH	48, 740	38, 322	87, 062		76, 901	
194. 0207952 BLOOMNGTN AMBULANCE AND OCC MED	159, 846	74, 848	234, 694		170, 233	
194. 0307953 HOME CARE	137, 040	41	41	-04, 401 -41		194.02
200.00 TOTAL (SUM OF LINES 118 through 199)	17, 668, 821	45, 338, 176				
			000,000,777	•	33, 300, 777	F 00.00

	I Financial Systems I NDI SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	ANA UNI VERSI TY	Provider C			Form CMS-2552 ksheet A
LULA	STITCATION AND ADJUSTMENTS OF TRIAL DALANCE	UI LAFLINGLS	FIOVIDEI C	514. 15-1520	From 01/01/2020	
					To 12/31/2020 Dat	e/Time Prepare 4/2021 11:18 a
	Cost Center Description	Adjustments	Net Expenses			4/2021 11.10 0
		(See A-8)	For Allocation			
		6.00	7.00			
	GENERAL SERVICE COST CENTERS	-				
. 00	00100 CAP REL COSTS-BLDG & FIXT	171, 555	663, 323			1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP	323, 774	1, 535, 535			2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	450, 593				4.
. 00	00500 ADMI NI STRATI VE & GENERAL	-796, 925				5.
. 00	00700 OPERATION OF PLANT	-56, 591				7.
. 00	00800 LAUNDRY & LINEN SERVICE	-766				8.
00	00900 HOUSEKEEPI NG	0	,			9.
0.00	01000 DI ETARY	26, 920				10.
1.00	01100 CAFETERI A	-103, 995				11.
	01300 NURSI NG ADMI NI STRATI ON	-1, 508, 430				13.
	01400 CENTRAL SERVICES & SUPPLY	-2	1, 154, 901			14.
5.00	01500 PHARMACY	99, 199				15.
. 00	01700 SOCI AL SERVI CE	0	52, 291			
	INPATIENT ROUTINE SERVICE COST CENTERS	07/ 7/7	0.010.000			
). 00	03000 ADULTS & PEDIATRICS	-976, 767				30.
. 00	03100 I NTENSI VE CARE UNI T	-243, 858	1, 506, 074			31.
~~~	ANCI LLARY SERVICE COST CENTERS	0(0,001	004 700			
). 00		-960, 881				50.
. 00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	107 717	356, 228			51.
		-127, 717				54.
00 o. 00		0				56.
	05700 CT SCAN 05800 MRI	0				57.
		-283, 428				58. 60.
5.00 6.00	06500 RESPIRATORY THERAPY					65.
b. 00	06600 PHYSI CAL THERAPY	-62, 822				66.
. 00		119, 592 -2, 250				67.
. 00		-2, 250				68.
. 00	06900 ELECTROCARDI OLOGY	0				69.
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0				71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0				72
		0				73.
	07697 CARDI AC REHABI LI TATI ON	0	69, 758			76.
. , ,	OUTPATIENT SERVICE COST CENTERS	0	07,730			/0.
. 00	09000 CLINIC	0	1, 029, 151			90.
0.01	09001 CLINIC - DIABETES	16, 094				90.
	09100 EMERGENCY	-83, 753				91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART	00,700	2, 7 11, 200			92.
	SPECIAL PURPOSE COST CENTERS					
8. 00		-4,000,458	58, 678, 499			118.
2. 0.	NONREI MBURSABLE COST CENTERS	.,				
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 380			190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0				192.
	07950 OCCUPATI ONAL HEALTH	0				194.
	207952 BLOOMNGTN AMBULANCE AND OCC MED	0				194.
	307953 HOME CARE	0	170, 235			194.
	TOTAL (SUM OF LINES 118 through 199)	-4,000,458	Ű			200.

	Financial Systems SIFICATIONS	I NDI	ANA UNI VERSI TY	HEALTH BEDFORD Provider CCN:	:15-1328 Period: Workshee	
					From 01/01/2020	me Prepared: 21 11:18 am
		Increases			///4/20.	21 11:18 am
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
	A – BENEFITS			• •		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ $	EMPLOYEE BENEFI TS DEPARTMENT	$\begin{array}{c} 4. \ 00\\ 0.\ 0.\ 00\\ 0.\ 0.\ 00\\ 0.\ 0.\ 0.\ 00\\ 0.\ 0.\ 0.\ 0.\ 0.\$		2,974,799 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 24.\ 00\\ 25.\ $
26.00	<u> </u>		<u>_</u>	<u> </u>		26.00
	B - DI ETARY/CAFETERI A					
1.00		<u> 11.00</u>	<u>64, 396</u> 64, 396	<u> </u>		1.00
	C – CAPI TAL LEASE		04, 370	07,720		
1.00	CAP REL COSTS-BLDG & FIXT		0	591		1.00
	O D – CARDI OLOGY		0	591		
1.00	CARDI AC_REHABI LI TATI ON	76.97	58, 023	11, 735		1.00
			58, 023	11, 735		
1 00	E - DEPR EXPENSE CAP REL COSTS-BLDG & FIXT	1 00		116 526		1 00
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00	0	446, 536 1, 201, 090		1.00
3.00 4.00		0. 00 0. 00	0	0		3.00 4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00 9.00		0. 00 0. 00	0	0		8.00 9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	О		11.00
12.00		0.00	0	0		12.00
13.00 14.00		0. 00 0. 00	0	0		13.00 14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00 19.00		0. 00 0. 00	0	0		18.00 19.00
20.00		0.00	0	0		20.00
21.00		0. 00	0	0		21.00
22.00		0. 00 0. 00	0	0		22.00 23.00
23.00 24.00		0.00	0	0		23.00
25.00		0.00	Ö	Ő		25.00
26.00		0.00	0	0		26.00
27.00 28.00		0. 00 <u>0.</u> 00	0	0		27.00 28.00
∠o. UU	ert — — — — — –	0.00	0	1, 647, 626		20.00
	F - BI LLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	11, 910, 252		1.00
2.00 3.00		0.00	0	0		2.00 3.00
4.00		0.00	Ő	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00

Inc. Inc. <thinc.< th=""> Inc. Inc. <thi< th=""><th></th><th>Financial Systems SIFICATIONS</th><th>I NDI /</th><th>ANA UNI VERSI TY</th><th><u>HEALTH BEDFORD</u> Provi der CCN: 15</th><th>-1328 Period:</th><th>u of Form CMS-2552-10 Worksheet A-6</th></thi<></thinc.<>		Financial Systems SIFICATIONS	I NDI /	ANA UNI VERSI TY	<u>HEALTH BEDFORD</u> Provi der CCN: 15	-1328 Period:	u of Form CMS-2552-10 Worksheet A-6
Image: Cost Canter Unsatz Other Other Other 1 0 2.00 3.00 -0.00 <td< th=""><th></th><th></th><th></th><th></th><th></th><th>From 01/01/2020 To 12/31/2020</th><th>Date/Time Prepared:</th></td<>						From 01/01/2020 To 12/31/2020	Date/Time Prepared:
Z 00 3.00 4.00 5.80 7.00 10							
7.00							
1 E UMPLANT_SUPPLIES 1 2 0 0 9 200 1 2 0 0 0 0 0 0 2 0 0 0 0 0 0 0 2 0	7.00			0	0		7.00
1.00 IMPL DPV CHARGED TO PATIFRITS 72.00 0 95.209 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 </td <td></td> <td>O G - IMPLANT SUPPLIES</td> <td></td> <td>0</td> <td>11, 910, 252</td> <td></td> <td></td>		O G - IMPLANT SUPPLIES		0	11, 910, 252		
3.00				-			
4.00							
$\begin{array}{c c c c c c c c c c c c c c c c c c c $		$ _ _ _ _ _ _ +$		0	0		
1.00 EMPLOYCE BENETIS DEPARTMENT 4.00 243.967 1.00 0.00 HUBSERFING 0.00 1.305 2.00 0.00 DIFTAR 10.00 8.460 3.00 0.00 TSCAM 0.00 1.067 6.00 0.00 0.00 0.00 0.00 0.00 3.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 1.00 0.00 0.00 0.00 0.00 0.00 0.00 1.00 0.00 0.00 0.00 0.00 0.00 0.00 1.00 0.00 0.00 0.00 0.00 0.00 10.00 1.00 0.00 0.00 0.00 0.00 0.00 10.00 1.00 0.00 0.00 0.00 0.00 0.00 10.00		0		0	95, 209		
3.00 DETARY 10.00 8,460 3.00 4.00 RABIO ON-OLARNOSTIC 57.00 7,175 5.00 5.00 CT SCAN 57.00 1.027 5.00 6.00 0.00 0 0 6.00 6.00 7.00 0.00 0 0 0.00 0 7.00 0.00 0 0 0.00 0 7.00 0.00 0 0 0.00 0 7.00 0.00 0 0 0.00 0 7.00 0.00 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 7.00 0.00 0 <td></td> <td>EMPLOYEE BENEFITS DEPARTMENT</td> <td></td> <td></td> <td></td> <td></td> <td></td>		EMPLOYEE BENEFITS DEPARTMENT					
4.00 RADI QUODCDI AGNOSTI C 54.00 7, 175 4.00 6.00 CT SCAN 0.00 0.00 0.00 0.00 6.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0							
0.00 0.00 0 </td <td>4.00</td> <td>RADI OLOGY-DI AGNOSTI C</td> <td>54.00</td> <td></td> <td>7, 175</td> <td></td> <td>4.00</td>	4.00	RADI OLOGY-DI AGNOSTI C	54.00		7, 175		4.00
2.00 0.00 0 0.00 0.		CT SCAN		0			
9.00 0.00 0.00 0.00 0.00 11.00 0.00 0.00 0.00 0.00 10.00 12.00 0.00 0.00 0.00 0.00 11.00 12.00 13.00 0.00 0.00 0.00 0.00 13.00 13.00 14.00 0.00 0.00 0.00 0.00 14.00 14.00 16.00 0.00 0.00 0.00 0.00 14.00 14.00 16.00 0.00 0.00 0.00 0.00 14.00 14.00 17.00 0.00 0.00 0.00 0.00 10.00 10.00 18.00 0.00 0.00 0.00 0.00 0.00 10.00 20.00 0.00 0.00 0.00 0.00 0.00 2.00 10.00 0.00 0.00 0.00 0.00 0.00 10.00 10.00 0.00 0.00 0.00 0.00 0.00 10.00 10.00					0		
10.00 0.00 0 0.00 10.00 12.00 0.00 0.00 0.00 12.00 13.00 0.00 0.00 0.00 12.00 14.00 0.00 0.00 0.00 12.00 15.00 0.00 0.00 0.00 13.00 16.00 0.00 0.00 0.00 14.00 17.00 0.00 0.00 0.00 17.00 18.00 0.00 0.00 0.00 20.00 21.00 0.00 0.00 0.00 20.00 21.00 0.00 0.00 0.00 20.00 21.00 0.00 0.00 0.00 20.00 21.00 0.00 0.00 0.00 20.00 21.00 0.00 0.00 0.00 0.00 20.00 20.00 0.00 0.00 0.00 0.00 20.00 3.00 1.00 0.00 0.00 0.00 0.00 10.00							
12.00 0.00 0 12.00 12.00 12.00 12.00 12.00 12.00 13.00 14.00 13.00 14.0							
13.00 0.00 0 13.00 13.00 13.00 14.00 0.00 0 0 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 15.00 16.00 16.00 17.00 17.00 17.00 19.00 20.00							
15 00 0.00 0 0 15.00 15.00 15.00 15.00 15.00 15.00 15.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 17.00 18.00 17.00 20.00 21.00 20.00 21.00 21.00 21.00 21.00 20.00 21.00 20.00 21.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
16.00 0.00 0 0 16.00 16.00 17.00 18.00 0.00 0 0 0 18.00 19.00 20.00 0.00 0 0 0 0 19.00 21.00 0 0.00 0 0 0 20.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 31.00 31.00 31.00 31.00 31.00 30.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
18.00 0.00 0 0 0 0 19.00 0 0 19.00 20.00 21.00 0 0 0 0 0 0 20.00 21.00 0 0 0 0 0 20.00 21.00 0 20.00 21.00 0 0 0 0 20.00 21.00 20.00 21.00 20.00 21.00 0				-			
19 0.00 0.00 0 0 0 20.00 21.00 20.00 21.00 20.00 2.00 3.00 4.00 0.00 0 0 2.00 3.00 4.00 0.00 0 0 4.00 5.00 6.00 7.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.00 0.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.							
21.00					-		
0 - - 0 261, 984 1. 00 NEDICAL SUPPLIES CHARGED TO 71.00 204, 949 1.00 9ATLENT 0.00 0 0.00 2.00 9ATLENT 0.00 0 0.00 2.00 9ATLENT 0.00 0 0.00 2.00 9ATLENT 0.00 0 0.00 0.00 9ATLENT 0.00 0.00 0.00 0.00 9ATLENT 0.00 0.00 0.00 0.00 9ATLENT 0.00 0.00 0.00 0.00 7.00 8ATLABLE MEDICAL SUPPLIES 0.00 0.00 0.00 0.00 9.00 1.00 0.00 0.00 0.00 0.00 10.00 11.00 1.00 0.00 0.00 0.00 11.00 12.00 12.00 1.00 0.20 0 44.641 1.00 12.00 14.00 1.00 0.20 0 0.00 0 2.01.01<				0	-		
1.00 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 204,949 1.00 2.00 0.00 0 0 2.00 2.00 4.00 0.00 0 0 2.00 2.00 2.00 4.00 0.00 0 0 0 2.00 2.00 4.00 5.00 0.00 0 0 0 0 4.00 4.00 6.00 0.00 0 0 0 0 6.00 4.00 7.00 0.00 0 0 0 0 0 6.00 8.00 8.00 10.00 0.00 0 0 0 0 10.00 11.00 12.00 11.00 12.00 12.00 13.00 14.00 14.00 15.00 15.01 14.00 14.00 12.00 14.00 12.00 14.01 1.00 2.00 14.01 1.00 2.00 0 10.071 2.00 2.00 1.00 1.00 2.00	21.00	b — — — — — —	0.00				21.00
PATIENT 0.00 0 0 2.00 2.00 3.	1 00				204.040		1.00
3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 4.00 7.00 0.00 0 0 6.00 7.00 8.00 0.00 0 0 0 6.00 7.00 8.00 0.00 0 0 0 9.00	1.00		71.00		204, 949		1.00
4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 5.00 6.00 0.00 0 0 6.00 7.00 8.00 9.00 0.00 0 0 0 8.00 9.00							
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7.00 0.00 0 0 7.00 7.00 7.00 8.00 9.00<							
8.00 0.00 0 0 8.00 9.00 10.00 0.00 0 0 0 9.00 11.00 0.00 0 0 0 10.00 12.00 0.00 0 0 11.00 12.00 13.00 0.00 0 0 0 12.00 13.00 14.00 0.00 0 0 0 14.00 13.00 1.00 CAP REL COSTS-BLOG & FIXT 1.00 0 44.641 2.00 2.00 0 - - 0 55.312 1.00 1.00 0 52.291 - 0 52.291 0 1.00 0 - 52.291 - 0 52.291 0 3.00 3.00 1.00 0 0 14.00 2.8 3.00 3.00 3.00 3.00 3.00 4.00 5.00 3.00 5.00 5.00 5.00 5.00 5.00				-			
10.00 0.00 0 0 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 0 13.00 0.00 0 0 0 14.00 0.00 0 0 0 15.00 0 0 0 0 14.00 0 0 0 0 15.00 0 0 0 0 15.00 0 0 0 0 15.00 15.00 0 44.641 1 0 15.00 1.00 CAP REL COSTS-MUBLE FOULP 2.00 0 10.671 2.00 0 0 52.291 0 0 1.00 3.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 21.398 1.00 3.00 1.00 0 0 0 0 0 3.00 1.00 0 0 0 0 0 <td>8.00</td> <td></td> <td>0. 00</td> <td>-</td> <td></td> <td></td> <td>8.00</td>	8.00		0. 00	-			8.00
11.00 0.00 0 0 11.00 12.00 0.00 0 0 12.00 13.00 0.00 0 0 0 14.00 0.00 0 0 0 0 0 0 0 0 13.00 15.00 0 0 0 0 14.00 0 0 0 0 0 14.00 15.00 0 0 0 0 0 0 15.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 44,641 1.00 2.00 1.00 CAP REL COSTS-MUBLE FOULP 2.00 0 10.671 2.00 2.00 1.00 SOCIAL WORKER 10.00 15.00 21.398 2.00 2.00 1.00 SOCIAL SERVICES & SUPPLY 15.00 21.398 1.00 2.00 2.00 0.00 0 0 0 0 2.00 2.00 0 2.00 1.00 0.00 0 0 0 0							
13.00 0.00 0 0 0 13.00 13.00 14.00 0.00 0 0 0 0 14.00 14.00 15.00 0 0.00 0 0 0 0 14.00 14.00 15.00 0 0 0 0 0 0 0 14.00 1.00 CAP REL COSTS-BLOG & FIXT 1.00 0 44,641 1 0 2.00 0 10,671 0 2.00 0 2.00 0 10,671 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0	11.00		0.00	0	0		11.00
14.00 0.00 0 0 0 14.00 15.00 0 0.00 0 0 0 15.00 J - PROPERTY INSURANCE 1.00 0 44,641 1.00 1.00 204,949 2.00 0 2.04,949 2.00							
0	14.00		0.00	-	õ		14.00
J PROPERTY INSURANCE 1.00 0 44, 641 1.00 2.00 CAP REL COSTS-BLOG & FIXT 1.00 0 10, 671 2.00 0 - 0 55, 312 1.00 2.00 0 10, 671 2.00 1.00 SOCI AL SERVICE - 0 52, 291 0 0 1.00 2.00 0 Nonbil LLABLE DRUGS - 17.00 21, 398 1.00 2.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 28 2.00 3.00 3.00 0 0 0 0 0 4.00 5.00 6.00 0.00 0 0 0 6.00 5.00 6.00 7.00 8.00 9.00 7.00 8.00 9.00 9.00 7.00 8.00 9.00 7.00 8.00 9.00 9.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 <	15.00	<u> </u>		<u>0</u>	204.949		15.00
2.00 CAP REL COSTS-MVBLE FQUIP 2.00 0 10.671 2.00 2.00 1.00 SOCIAL SERVICE 17.00 52.291 0 1.00 1.00 M - NONBILLABLE DRUGS M - NONBILLABLE DRUGS 1.00 21.398 1.00 2.00 2.00 CENTRAL SERVICES & SUPPLY 15.00 21.398 2.00 2.00 3.00 0 0.00 0 0 3.00 3.00 4.00 0.00 0 0 0 5.00 0.00 0 5.00 0.00 0 0 0 0 5.00 6.00 7.00 7.00 8.00 9.00 TOTALS 0.00 0 0 0 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00 9.00 7.00							
0 - 0 55, 312 L - SOCI AL_WORKER - 0 52, 291 0 0 1.00 0 0 52, 291 0 0 1.00 1.00 1.00 1.00 21, 398 1.00 2.00 2.00 2.00 2.00 3.00 1.00 2.00 3.00 0.00 0 0 3.00 3.00 4.00 2.00 3.00 4.00 5.00 0 0.00 0 3.00 4.00 5.00 0.00 0 0.00<							
1.00 SOCI AL SERVICE 17.00 52,291 0 1.00 M - NONBI LLABLE DRUGS 15.00 21,398 1.00 1.00 2.00 CENTRAL SERVICES & SUPPLY 14.00 28 2.00 3.00 0.00 0 0 3.00 4.00 3.00 4.00 0.00 0 0 0 4.00 5.00 6.00 0.00 0 0 0 6.00 5.00 7.00 0.00 0 0 0 6.00 7.00 8.00 0.00 0 0 0 7.00 8.00 9.00 7.00 0.00 0 0 0 9.00 7.00 8.00 9.00 0.00 0 0 0 0 9.00 9.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1,036,232 1.00 9.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1,036,232 1.00 2.00 1.00 0.00 0 0.1,036,232 1.00 2.00 </td <td>21.00</td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>	21.00	0					
O S2, 291 O M - NONBI LLABLE DRUGS 1.00 PHARMACY 15.00 21, 398 2.00 3.00 CENTRAL SERVI CES & SUPPLY 14.00 28 2.00 3.00 0.00 0 0 3.00 4.00 3.00 4.00 0.00 0 0 0 4.00 5.00 6.00 0.00 0 0 0 6.00 5.00 6.00 0.00 0 0 0 6.00 7.00 8.00 0.00 0 0 0 21, 426 9.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1, 036, 232 9.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1, 036, 232 1.00 2.00 OPERATION OF PLANT 7.00 0 621 2.00 3.00 NURSING ADMINISTRATION 13.00 0 4, 151 3.00 3.00 CENTRAL SOTO	1.00		17.00	52, 291	0		1.00
1.00 PHARMACY 15.00 21,398 1.00 2.00 CENTRAL SERVICES & SUPPLY 14.00 28 2.00 3.00 0.00 0 0 3.00 4.00 0.00 0 0 3.00 5.00 0.00 0 0 3.00 6.00 0.00 0 0 4.00 5.00 0.00 0 0 6.00 7.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 0 7.00 8.00 0.00 0 0 0 9.00 TOTALS 0.00 0 0 21,426 9.00 N - NONBI LLABLE MEDI CAL SUPPLI ES 1.00 1.00,6232 1.00 2.00 1.00 CENTRAL SERVI CES & SUPPLY 14.00 0 1.036,232 1.00 2.00 OPERATI ON OF PLANT 7.00 0 621 2.00 3.00 NURSI NG ADMI NI STRATI ON 13.00 0	1.00	0			— — — ₀		
2.00 CENTRAL SERVICES & SUPPLY 14.00 28 2.00 3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 6.00 8.00 0.00 0 0 7.00 8.00 0.00 0 0 9.00 TOTALS 0.00 0 0 9.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1.036, 232 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1.036, 232 1.00 OPERATION OF PLANT 7.00 0 621 2.00 OPERATION OF PLANT 7.00 0 4.00 3.00 NURSING ADMINISTRATION 13.00 0 4,151 3.00 CLINIC - DIABETES 90.01 0 6 5.00	1 00		15.00		21.398		1 00
4.00 0.00 0 0 0 4.00 5.00 0.00 0 0 0 5.00 6.00 0.00 0 0 0 5.00 7.00 0.00 0 0 6.00 7.00 8.00 0.00 0 0 0 7.00 9.00 0 0 0 0 8.00 9.00 0 0 0 21,426 9.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1,036,232 1.00 2.00 OPERATION OF PLANT 7.00 0 621 2.00 3.00 NURSING ADMINISTRATION 13.00 4,151 3.00 4.00 7.01 0 6 3.00 5.00 CLINIC - DIABETES 90.01 0 6 5.00	2.00		14.00		28		2.00
5.00 0.00 0 0 0 0 6.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 0 8.00 9.00 0.00 0 0 0 9.00 TOTALS 0.00 0 0 1.00 9.00 0 21,426 0 1.036,232 1.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1.036,232 1.00 2.00 OPERATION OF PLANT 7.00 0 621 2.00 3.00 NURSI NG ADMI NI STRATI ON 13.00 0 4,151 3.00 4.00 RADI OI SOTOPE 56.00 0 3,017 4.00 5.00 CLI NI C - DI ABETES 90.01 0 6 5.00							
7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 0 8.00 9.00 TOTALS 0 21,426 9.00 9.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1,036,232 1.00 2.00 OPERATION OF PLANT 7.00 0 621 2.00 3.00 NURSI NG ADMI NI STRATI ON 13.00 0 4,151 3.00 4.00 RADI OI SOTOPE 56.00 0 3,017 4.00	5.00		0.00	0	0		5.00
8.00 0.00 0 0 0 0 9.00 TOTALS 0 0 0 0 0 9.00 9.00 TOTALS 0 0 21,426 0 9.00 9.00 9.00 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1,036,232 1.00 1.00 2.00 OPERATION OF PLANT 7.00 0 621 2.00 2.00 3.00 NURSING ADMINISTRATION 13.00 0 4,151 3.00 4.00 4.00 RADIOISOTOPE 56.00 0 3,017 4.00 5.00				0	0		
TOTALS O 21,426 N - NONBI LLABLE MEDI CAL SUPPLI ES N 1.00 0 1,036,232 1.00 2.00 OPERATI ON OF PLANT 7.00 0 621 2.00 2.00 3.00 NURSI NG ADMI NI STRATI ON 13.00 0 4,151 3.00 3.00 4.00 RADI OI SOTOPE 56.00 0 3,017 4.00 5.00				0	0		
N - NONBI LLABLE MEDI CAL SUPPLI SUPPLIES 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 1,036,232 1.00 2.00 OPERATI ON OF PLANT 7.00 0 621 2.00 3.00 NURSI NG ADMI NI STRATI ON 13.00 0 4,151 3.00 4.00 RADI OI SOTOPE 56.00 0 3,017 4.00 5.00 CLI NI C - DI ABETES 90.01 0 6 5.00	9.00			<u>_</u>	$ \frac{0}{21 4 24}$		9.00
2.00 OPERATI ON OF PLANT 7.00 0 621 2.00 3.00 NURSI NG ADMI NI STRATI ON 13.00 0 4,151 3.00 4.00 RADI OI SOTOPE 56.00 0 3,017 4.00 5.00 CLI NI C - DI ABETES 90.01 0 6 5.00		N - NONBILLABLE MEDICAL SUPPL		0			
3. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 4, 151 3. 00 4. 00 RADI OI SOTOPE 56. 00 0 3, 017 4. 00 5. 00 CLI NI C - DI ABETES 90. 01 0 6 5. 00							
4.00 RADI OI SOTOPE 56.00 0 3,017 4.00 5.00 CLI NI C - DI ABETES 90.01 0 6 5.00		NURSING ADMINISTRATION	13.00		4, 151		3.00
				-	3, 017		

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

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

RECLASS	TELCATIONS			Provider	CCN. 13-1320	From 01/01/2020	et A-0
						To 12/31/2020 Date/Ti	me Prepared:
						//14/20	<u>21 11:18 am</u>
		Increases	<u>.</u>		1		
	Cost Center	Line #	Salary	Other			
	2.00	3.00	4.00	5.00			
7.00		0. 00	0	0)		7.00
8.00		0. 00	0	0			8.00
9.00		0.00	0	0			9.00
10.00		0.00	0	0			10.00
11.00		0.00	0	0			11.00
12.00		0.00	0	0			12.00
13.00		0.00	0	0			13.00
14.00		0.00	0	0			14.00
15.00		0.00	0	0			15.00
16.00		0.00	0	0			16.00
17.00		0.00	0	0			17.00
18.00		0.00	0	0			18.00
19.00		0.00	0	0			19.00
	TOTALS	<u></u>	— — — Å	1,044,029	1		17.00
	Grand Total: Increases		174, 710	18, 315, 640			500.00
500.00		I I	174,710	10, 313, 040	1		1000.00

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFORD	In Lieu	of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN: 15-1328	Peri od:	Worksheet A-6

IFICATIONS	From 01/01/2020	
	To 12/31/2020	Dat 7/1
Decreases		

RECEAS	SIFICATIONS					From 01/01/2020 To 12/31/2020 Date/Time	
		Decreases	-		I		11: 18 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	-	
	6.00 A - BENEFITS	7.00	8.00	9.00	10.00		
1.00	ADMINI STRATI VE & GENERAL	5.00	1	150, 837	(1.00
2.00	OPERATION OF PLANT	7.00		117, 831	(2.00
3.00	HOUSEKEEPING	9.00		118, 469	(D	3.00
4.00	DI ETARY	10. 00		73, 154	(4.00
5.00	NURSING ADMINISTRATION	13.00		231, 130	(-	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00		27, 143			6.00
7.00 8.00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00		74, 822 447, 306	(7.00 8.00
9.00	INTENSIVE CARE UNIT	31.00		218, 984			9.00
10.00	OPERATING ROOM	50, 00		167, 384			10.00
11.00	RECOVERY ROOM	51.00		63, 917			11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00		237, 317	(12.00
13.00	RADI OI SOTOPE	56.00		15, 822	()	13.00
14.00	CT SCAN	57.00		39, 425	(14.00
15.00	MRI	58.00		30, 543			15.00
16.00		60.00		24, 384	(16.00
17.00 18.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00		144, 133 108, 002	(17.00 18.00
19.00	OCCUPATIONAL THERAPY	67.00		52, 347			18.00
20.00	SPEECH PATHOLOGY	68.00		15, 455			20.00
21.00	ELECTROCARDI OLOGY	69.00		39, 643	(21.00
22.00	CLI NI C	90. 00		141, 609	(22.00
23.00	EMERGENCY	91.00		360, 408	()	23.00
24.00	GIFT, FLOWER, COFFEE SHOP &	190. 00		13, 295	()	24.00
	CANTEEN						
25.00	OCCUPATIONAL HEALTH	194.00		7,476			25.00
26.00	BLOOMNGTN AMBULANCE AND OCC	194. 02		53, 963	(26.00
		$\vdash +$	— — — d	2,974,799	<u> </u>	-	
	B - DI ETARY/CAFETERI A	I	<u> </u>	2,771,777			
1.00	DI ETARY	10. 00	64, 396	87, 728	(1.00
	0		64, 396	87, 728			
	C – CAPITAL LEASE						
1.00	PHYSICIANS PRIVATE OFFICES	1 <u>92.00</u>	0	<u>591</u>		1	1.00
	U D – CARDI OLOGY		0	591			_
1.00	ELECTROCARDI OLOGY	69.00	58, 023	11, 735	(า	1.00
	0		58, 023	11, 735		-	
	E – DEPR EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 727	ç	9	1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	14, 829			2.00
3.00	OPERATION OF PLANT	7.00	0	159, 352	(3.00
4.00 5.00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8.00 9.00	0	316 232			4.00 5.00
6.00	DI ETARY	9.00 10.00	0	18, 555			6.00
7.00	NURSI NG ADMI NI STRATI ON	13.00	0	14, 949			7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	29, 472			8.00
9.00	PHARMACY	15.00	0	34, 895			9.00
10.00	ADULTS & PEDIATRICS	30. 00	0	33, 874			10.00
11.00	INTENSIVE CARE UNIT	31.00	0	91, 987	(11.00
12.00	OPERATING ROOM	50.00	0	194, 767	(12.00
13.00	RECOVERY ROOM	51.00	0	265			13.00
14.00 15.00	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54.00 56.00	0	376, 934 86, 934	(14.00 15.00
16.00	CT SCAN	57.00	0	86, 270		-	16.00
17.00	MRI	58.00	0	26, 567			17.00
18.00	LABORATORY	60.00	Ö	337			18.00
19.00	RESPI RATORY THERAPY	65.00	0	16, 144			19.00
20.00		66.00	0	7, 107	(20.00
20.00	PHYSI CAL THERAPY	00100		109, 998	(21.00
21.00	ELECTROCARDI OLOGY	69.00	0			-	
21.00 22.00	ELECTROCARDI OLOGY CLI NI C	69.00 90.00	0	1, 760	(D	22.00
21.00 22.00 23.00	ELECTROCARDI OLOGY CLI NI C CLI NI C – DI ABETES	69. 00 90. 00 90. 01	0000	1, 760 194		D	23.00
21.00 22.00 23.00 24.00	ELECTROCARDI OLOGY CLI NI C CLI NI C – DI ABETES EMERGENCY	69.00 90.00 90.01 91.00	0 0 0	1, 760 194 85, 787	((D	23.00 24.00
21.00 22.00 23.00 24.00 25.00	ELECTROCARDI OLOGY CLI NI C CLI NI C – DI ABETES EMERGENCY PHYSI CI ANS' PRI VATE OFFI CES	69.00 90.00 90.01 91.00 192.00		1, 760 194 85, 787 245, 605	((D	23.00 24.00 25.00
21.00 22.00 23.00 24.00 25.00 26.00	ELECTROCARDI OLOGY CLI NI C CLI NI C - DI ABETES EMERGENCY PHYSI CI ANS' PRI VATE OFFI CES OCCUPATI ONAL HEALTH	69. 00 90. 00 90. 01 91. 00 192. 00 194. 00		1, 760 194 85, 787 245, 605 272			23.00 24.00 25.00 26.00
21.00 22.00 23.00 24.00 25.00	ELECTROCARDI OLOGY CLI NI C CLI NI C – DI ABETES EMERGENCY PHYSI CI ANS' PRI VATE OFFI CES	69.00 90.00 90.01 91.00 192.00	0 0 0 0 0 0	1, 760 194 85, 787 245, 605			23.00 24.00 25.00
21.00 22.00 23.00 24.00 25.00 26.00	ELECTROCARDI OLOGY CLI NI C CLI NI C - DI ABETES EMERGENCY PHYSI CI ANS' PRI VATE OFFI CES OCCUPATI ONAL HEALTH BLOOMNGTN AMBULANCE AND OCC	69. 00 90. 00 90. 01 91. 00 192. 00 194. 00		1, 760 194 85, 787 245, 605 272			23.00 24.00 25.00 26.00
21.00 22.00 23.00 24.00 25.00 26.00 27.00	ELECTROCARDI OLOGY CLI NI C - DI ABETES EMERGENCY PHYSI CI ANS' PRI VATE OFFI CES OCCUPATI ONAL HEALTH BLOOMNGTN AMBULANCE AND OCC MED HOME CARE O	69.00 90.00 91.00 192.00 194.00 194.02		1, 760 194 85, 787 245, 605 272 8, 456			23.00 24.00 25.00 26.00 27.00
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00	ELECTROCARDI OLOGY CLINIC - DI ABETES EMERGENCY PHYSICIANS' PRIVATE OFFICES OCCUPATI ONAL HEALTH BLOOMNGTN AMBULANCE AND OCC MED HOME CARE 0 F - BILLABLE DRUGS	69.00 90.01 91.00 192.00 194.00 194.02 1 <u>94.</u> 03		1, 760 194 85, 787 245, 605 272 8, 456 - 41 1, 647, 626			23.00 24.00 25.00 26.00 27.00 28.00
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00	ELECTROCARDI OLOGY CLINIC - DI ABETES EMERGENCY PHYSI CIANS' PRI VATE OFFI CES OCCUPATI ONAL HEALTH BLOOMNGTN AMBULANCE AND OCC MED HOME_CAREO F - BI LLABLE DRUGS PHARMACY	69. 00 90. 01 91. 00 192. 00 194. 00 194. 02 		1, 760 194 85, 787 245, 605 272 8, 456 <u>41</u> 1, 647, 626			23.00 24.00 25.00 26.00 27.00 28.00 1.00
21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00	ELECTROCARDI OLOGY CLINIC - DI ABETES EMERGENCY PHYSICIANS' PRIVATE OFFICES OCCUPATI ONAL HEALTH BLOOMNGTN AMBULANCE AND OCC MED HOME CARE 0 F - BILLABLE DRUGS	69.00 90.01 91.00 192.00 194.00 194.02 1 <u>94.</u> 03		1, 760 194 85, 787 245, 605 272 8, 456 - 41 1, 647, 626			23.00 24.00 25.00 26.00 27.00 28.00

	Financial Systems	I NDI	ANA UNI VERSI T'				of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-1328	Period: From 01/01/2020	Worksheet A-6
					1	Го 12/31/2020	Date/Time Prepared: 7/14/2021 11:18 am
	Coot Conton	Decreases	Colore	Others			
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
4.00	RADI OI SOTOPE	56.00	0	71, 763	3 0		4.00
5.00 6.00	CT SCAN MRI	57.00 58.00	0	35, 464 20, 238			5.00 6.00
7.00	ELECTROCARDI OLOGY	<u>69.00</u>	0	997	70		7.00
			0	11, 910, 252	2		
1.00	G - IMPLANT SUPPLIES	31.00		12	2 0		1.00
2.00	OPERATING ROOM	50.00		94, 629	9 0		2.00
3.00 4.00	CLINIC EMERGENCY	90. 00 91. 00		151 417			3.00 4.00
4.00	0		— — — ₀	95, 209			4.00
1 00	H - ACCRUED PTO	F 00		10.070			1.00
1.00 2.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00		18, 879 12, 970			1.00 2.00
3.00	NURSING ADMINISTRATION	13.00		27, 750	0 0		3.00
4.00 5.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00		1, 796 4, 389			4.00 5.00
6.00	ADULTS & PEDIATRICS	30.00		35, 041			6.00
7.00	INTENSIVE CARE UNIT	31.00		13, 072			7.00
8.00 9.00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00		46, 798 1, 338			8.00 9.00
10.00	RADI OI SOTOPE	56.00		691	1 0		10.00
11.00		58.00		7,964			11.00
12.00 13.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00		19, 571 7, 696			12.00 13.00
14.00	OCCUPATI ONAL THERAPY	67.00		7,044	4 0		14.00
15.00 16.00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68.00 69.00		439 3, 123			15.00 16.00
17.00	CLINIC	90.00		18, 134			17.00
18.00	EMERGENCY	91.00		30, 380			18.00
19.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00		614	4 O		19.00
20.00	OCCUPATI ONAL HEALTH	194.00		2, 344			20.00
21.00	BLOOMNGTN AMBULANCE AND OCC	194.02		1, 951	1 0		21.00
	0	+	o	261, 984	4		
1.00	I – BILLABLE MEDICAL SUPPLIE ADMINISTRATIVE & GENERAL	<u>S</u> 5.00		775	5 0	1	1.00
2.00	DI ETARY	10.00		78			2.00
3.00	NURSING ADMINISTRATION	13.00		36			3.00
4.00 5.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00		2, 672 126			4.00 5.00
6.00	ADULTS & PEDIATRICS	30. 00		7, 958	3 0		6.00
7.00 8.00	INTENSIVE CARE UNIT OPERATING ROOM	31. 00 50. 00		1, 099 157, 118			7.00 8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00		7, 179			9.00
10.00	CT SCAN	57.00		1,860			10.00
11.00 12.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00		605 502			11.00 12.00
13.00	ELECTROCARDI OLOGY	69.00		2, 554	4 0		13.00
14.00 15.00	CLINIC EMERGENCY	90. 00 91. 00		2, 193 20, 194			14.00 15.00
15.00	0		— — — ₀	204, 949			15.00
1 00	J - PROPERTY INSURANCE	F 00	0	FF 012	10		1.00
1.00 2.00	ADMI NI STRATI VE & GENERAL	5.00 0.00	0	55, 312 (2 12 0 12		1.00
	<u> </u>		— — — ō	55, 312	2		
1.00	L - SOCIAL WORKER NURSING ADMINISTRATION	13.00	52, 291		0	[1.00
1.00		<u>13.00</u>	<u>52, 291</u>		<u> </u>		1.00
1 00	M - NONBILLABLE DRUGS			1.02	4		
1.00 2.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00		4, 884 3, 210			1.00
3.00	OPERATING ROOM	50.00		881	1 0		3.00
4.00 5.00	RADI OLOGY-DI AGNOSTI C	54.00		4, 458			4.00
5.00 6.00	CT SCAN RESPI RATORY THERAPY	57.00 65.00		739 2, 133			5.00 6.00
7.00	PHYSI CAL THERAPY	66.00		130	0 0		7.00
8.00 9.00	CLINIC EMERGENCY	90. 00 91. 00		2, 255 2, <u>7</u> 36			8.00 9.00
7.00	TOTALS		- — — d	21, 426			7.00

<u>Heal th</u>	Financial Systems	I ND	IANA UNIVERSITY	/ HEALTH BEDFO	ORD	In Lieu	of Form CMS-2	2552-10
RECLAS	SI FI CATI ONS			Provider (Worksheet A-6	5
						From 01/01/2020 To 12/31/2020	Date/Time Pre 7/14/2021 11:	epared: 18 am
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	N - NONBILLABLE MEDICAL SUPP				-	-		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	248	(C		1.00
	ADMINISTRATIVE & GENERAL	5.00	0	45, 292	(C		2.00
	HOUSEKEEPING	9.00	0	38, 079		C		3.00
	DI ETARY	10. 00	0	2, 612	(C		4.00
	PHARMACY	15.00	0	37, 459		C		5.00
	ADULTS & PEDIATRICS	30. 00	0	160, 033	(C		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	132, 531	(C		7.00
	OPERATING ROOM	50.00	0	72, 927	(C		8.00
	RADI OLOGY-DI AGNOSTI C	54.00	0	39, 446	(C		9.00
	CT SCAN	57.00	0	46, 465	(C		10.00
	MRI	58.00	0	1, 277	(C		11.00
12.00	LABORATORY	60.00	0	9	(C		12.00
13.00	RESPI RATORY THERAPY	65.00	0	142, 351	(C		13.00
14.00	PHYSI CAL THERAPY	66.00	0	9, 043	(C		14.00
15.00	ELECTROCARDI OLOGY	69.00	0	29, 413	(C		15.00
16.00	CLINIC	90.00	0	78, 084	(C		16.00
17.00	EMERGENCY	91.00	0	208, 600	(C		17.00
18.00	OCCUPATI ONAL HEALTH	194.00	0	69	(C		18.00
19.00	BLOOMNGTN AMBULANCE AND OCC	194. 02	0	91	(C		19.00
	MED							
	TOTALS		0	1,044,029				
500.00	Grand Total: Decreases		174, 710	18, 315, 640				500.00

Health Financial Systems	I NDI ANA UNI VERSI TY	HEALTH BEDFO	RD	In Lieu	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1328 P	eriod:	Worksheet A-7	7 epared:
			Acqui si ti ons			
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPIT	AL ASSET BALANCES					
1.00 Land	931, 334	0	0	0	0	1.00
2.00 Land Improvements	1, 119, 735	0	0	0	0	2.00
3.00 Buildings and Fixtures	14, 290, 100	0	0	0	223, 752	3.00
4.00 Building Improvements	5, 169, 109	0	0	0	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	15, 393, 134	689, 328	0	689, 328	689, 112	6.00
7.00 HIT designated Assets	0	0	0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	36, 903, 412	689, 328	0	689, 328	912, 864	8.00
9.00 Reconciling Items	0	0	0	0	0	
10.00 Total (line 8 minus line 9)	36, 903, 412	689, 328	0	689, 328	912, 864	10.00
	Endi ng Bal ance	Fully				
	3	Depreciated				
		Assets				
	6,00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPIT	AL ASSET BALANCES					
1.00 Land	931, 334	0				1.00
2.00 Land Improvements	1, 119, 735	0				2.00
3.00 Buildings and Fixtures	14, 066, 348	0				3.00
4.00 Building Improvements	5, 169, 109	0				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	15, 393, 350	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	36, 679, 876	0	i			8.00
9.00 Reconciling Items	0	0	ĺ			9.00
10.00 Total (line 8 minus line 9)	36, 679, 876		(10.00

Health Financial Systems IND	ANA UNI VERSI T	Y HEALTH BEDFO	RD	In Lieu	of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Peri od: From 01/01/2020	Worksheet A-7	,
					Date/Time Pre	epared:
					7/14/2021 11:	<u>18 am</u>
		SL	IMMARY OF CAP	ITAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
				instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COL	UMN 2, LINES 7	1 and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3.00
	SUMMARY C	F CAPITAL				
Cost Center Description	Other	Total (1) (sum	1			
	api tal -Rel ate	d of cols. 9				
	Costs (see	through 14)				
	instructions)	U V				
	14.00	15.00	1			
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COL	UMN 2, LINES 7	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	Ő	0				3.00
			1			2.00

Health Financial Systems IN	DIANA UNIVERSIT	Y HEALTH BEDFO	RD	In Lieu	of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2020 Fo 12/31/2020	Worksheet A-7 Part III Date/Time Pre 7/14/2021 11:	pared:
	COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets		Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col. 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS			_	-		
1.00 CAP REL COSTS-BLDG & FIXT	21, 286, 526		21, 286, 526			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	15, 393, 350		15, 393, 350			2.00
3.00 Total (sum of lines 1-2)	36, 679, 876		36, 679, 876			3.00
	ALLOCA	TION OF OTHER	CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relate				
	6,00	d Costs 7.00	through 7) 8.00	9,00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS		7.00	8.00	9.00	10.00	
1.00 CAP REL COSTS-BLDG & FIXT		0		446, 528	0	1.00
2.00 CAP REL COSTS-DEDU & TTAT				1, 524, 864		2.00
3.00 Total (sum of lines 1-2)	0	0		1, 971, 392	0	3.00
	Ĭ	SL	IMMARY OF CAPI			0100
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
				Capi tal -Rel ate		
		Í Í	,	d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS			1			
	170 154	44, 641		0 0	663, 323	1.00
1.00 CAP REL COSTS-BLDG & FIXT	172, 154					
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	172, 154 0 172, 154	10, 671	C	0	1, 535, 535 2, 198, 858	2.00 3.00

Systems INDIANA UNI	/ERS
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RSITY HEALTH BEDFORD

ADJUSTME	inancial Systems ENTS TO EXPENSES			Y HEALTH BEDFORD Provi der CCN: 15-1328	Period: From 01/01/2020	of Form CMS-2 Worksheet A-8	
						Date/Time Pre	
				Expense Classification or		7/14/2021 11:	
				Fo/From Which the Amount is	to be Adjusted		
	Cost Coston Decemintion		Americat	Coot Contor	line #	Must A 7 Daf	
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	<u>Nkst. A-7 Ref.</u> 5.00	
	nvestment income - CAP REL OSTS-BLDG & FIXT (chapter 2)	В	-661, 711	CAP REL COSTS-BLDG & FIXT	1.00	11	1.
. 00 11	nvestment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
	OSTS-MVBLE EQUIP (chapter 2) nvestment income - other		0		0. 00	0	3.
	chapter 2) rade, quantity, and time				0.00	0	
	iscounts (chapter 8)		0		0.00	0	4.
	efunds and rebates of expens chapter 8)	es	0		0.00	0) 5.
00 Re	ental of provider space by		0		0. 00	0	6
	uppliers (chapter 8) elephone services (pay		0		0. 00	0	7.
S	tations excluded) (chapter 2	1)					
	elevision and radio service chapter 21)		0		0.00	0	8
	arking lot (chapter 21) rovider-based physician	A-8-2	0 -4, 928, 574		0.00	0	
a	djustment	102				_	
	ale of scrap, waste, etc. chapter 23)		0		0.00	0) 11
2.00 Re	el ated organization	A-8-1	7, 906, 653			0	12
. 00 La	ransactions (chapter 10) aundry and linen service		0		0. 00	0	13
	afeteria-employees and guest ental of quarters to employe		0		0. 00 0. 00	0	
a	nd others		-			-	
	ale of medical and surgical upplies to other than patien	ts	0		0.00	0	16
	ale of drugs to other than atients		0		0.00	0	17
	ale of medical records and		0		0. 00	0	18
	bstracts ursing and allied health		0		0. 00	0) 19
e	ducation (tuition, fees,		0		0.00	0	
	ooks, etc.) ending machines		0		0. 00	0	20
	ncome from imposition of		0		0. 00	0	21
cl	nterest, finance or penalty harges (chapter 21)						
	nterest expense on Medicare verpayments and borrowings t		0		0.00	0	22
r	epay Medicare overpayments				(5.00		
	djustment for respiratory herapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
	imitation (chapter 14) djustment for physical thera	by A-8-3	0	PHYSI CAL THERAPY	66.00		24
C	osts in excess of limitation	by A-0-3	0	FILISICAL MERAFI	00.00		24
	chapter 14) tilization review –		0	*** Cost Center Deleted ***	* 114.00		25
pl	hysicians' compensation		-				
	chapter 21) epreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26
	OSTS-BLDG & FIXT epreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27
C	OSTS-MVBLE EQUIP					0	
	on-physician Anesthetist hysicians' assistant		0	*** Cost Center Deleted ***	* 19.00 0.00	0	28
). 00 A	djustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	-	30
	herapy costs in excess of imitation (chapter 14)						
	ospice (non-distinct) (see nstructions)		0	ADULTS & PEDIATRICS	30.00		30
1. 00 A	djustment for speech patholo	gy A-8-3	0	SPEECH PATHOLOGY	68.00		31
	osts in excess of limitation chapter 14)						
2. 00 C	AH HIT Adjustment for	А	-35, 258	CAP REL COSTS-MVBLE EQUIP	2.00	9	32
	epreciation and Interest ISCELLANEOUS INCOME	В	-17 634	ADMI NI STRATI VE & GENERAL	5.00	Ω	33

ADJUSTMENTS TO EXPENSES Provider CCN: 15-1328 Period: To 01/01/2020 To 12/31/2020 Period: Date/Time Prepared: 7/14/2021 11: 8 am Cost Center Description Basis/Code (2) Amount Expense Classification on Worksheet A 0/From Which the Amount is to be Adjusted Date/Time Prepared: 7/14/2021 11: 8 am 34.00 MI SCELLANEOUS INCOME B -1,559 OPERATION OF PLANT 7,00 0 34.00 35.00 MI SCELLANEOUS INCOME B -1,559 OPERATION OF PLANT 7,00 0 34.00 36.00 MI SCELLANEOUS INCOME B -103.995 CAFETERIA 11.00 0 35.00 37.00 MI SCELLANEOUS INCOME B -103.995 CAFETERIA 11.00 0 36.00 37.00 MI SCELLANEOUS INCOME B -133.540 NURSING ADMINISTRATION 13.00 0 37.00 38.00 MI SCELLANEOUS INCOME B -123.292 RESPI RATORY HERAPY 65.00 0 0.00 38.00 39.00 MI SCELLANEOUS INCOME B -22.200/CUPATIONAL THERAPY 65.00 0 0.00 0 0.00 0.00 0 38.0	Health Financial Systems		ANA LINI VERSI T	Y HEALTH BEDFORD	Inlie	ı of Form CMS-2	2552-10
To 12/31/2020 Date/Time Prepared: 7/14/2021 Date/Time Prepared: 7/14/2021 <thda< td=""><td></td><td>TND</td><td></td><td></td><td></td><td></td><td></td></thda<>		TND					
Cost Center Description Basi s/Code (2) Amount Cost Center Line # West. A-7 Ref. 34.00 MI SCELLANEOUS I NCOME B -1.00 2.00 3.00 4.00 5.00 35.00 MI SCELLANEOUS I NCOME B -1.559 OPERATION OF PLANT 7.00 0.34.00 36.00 MI SCELLANEOUS I NCOME B -1.559 OPERATION OF PLANT 7.00 0.35.00 36.00 MI SCELLANEOUS I NCOME B -103.995 CALAUNDRY & LINEN SERVICE 8.00 0.35.00 36.00 MI SCELLANEOUS I NCOME B -103.995 CAETERIA 11.00 0.36.00 37.00 MI SCELLANEOUS I NCOME B -103.995 CAETERIA 11.00 0.38.00 38.00 MI SCELLANEOUS I NCOME B -123 PERATION 13.00 0.37.00 39.00 MI SCELLANEOUS I NCOME B -22.250 30.00 0.38.00 39.00 MI SCELLANEOUS I NCOME B -22.250 22.2400 0.00 0.00					rom 01/01/2020		
Cost Center Description Basis/Code (2) Amount Cost Center Line # #kst. A-7 Ref. 34.00 MI SCELLANEOUS INCOME B -1,559 OPERATION OF PLANT 7.00 0.00 3.00 35.00 MI SCELLANEOUS INCOME B -1,559 OPERATION OF PLANT 7.00 0.35.00 36.00 MI SCELLANEOUS INCOME B -766 LAUNDRY & LINE SERVICE 8.00 0.35.00 36.00 MI SCELLANEOUS INCOME B -00 IETARY 10.00 0.00 35.00 36.00 MI SCELLANEOUS INCOME B -103.995 CAFETERIA 11.00 0.00 36.00 37.00 MI SCELLANEOUS INCOME B -132.995 CAFETERIA 11.00 0.00 37.00 38.00 MI SCELLANEOUS INCOME B -22.250 CLAPATIONS & S0.00 0.00 37.00 0.00 37.00 0.00 37.00 0.00 37.00 0.00 37.00 0.00 37.00 0.00 37.00 0.00 37.00 0.00 37.00 0.00 37.00 0.00 0.00							
Cost Center Description Basis/Code (2) Amount Cost Center Line # //kst. A-7 Ref. 34.00 MI SCELLANEOUS I NCOME B -1.5590PERATION OF PLANT 7.00 4.00 5.00 34.00 35.00 MI SCELLANEOUS I NCOME B -766LAUNDY & LI NEN SERVI CE 8.00 0 35.01 36.00 MI SCELLANEOUS I NCOME B -760LAUNDY & LI NEN SERVI CE 8.00 0 35.01 37.00 MI SCELLANEOUS I NCOME B -103.995 CAFETERI A 11.00 0 36.00 38.00 MI SCELLANEOUS I NCOME B -133.540 NURSI MG ADMINI STRATI ON 13.00 0 37.00 39.00 MI SCELLANEOUS I NCOME B -140ADULTS & PEDIATRI CS 30.00 0 38.00 39.00 MI SCELLANEOUS I NCOME B -22500 CCUPATI NANL THERAPY 65.00 0 40.00 40.00 MI SCELLANEOUS I NCOME B -22.500 CCUPATI NANL THERAPY 65.00 0 40.00 41.00 MI SCELLANEOUS I NCOME B -2.2500 CCUPATI NANL THERAPY							
1.00 2.00 3.00 4.00 5.00 34.00 MI SCELLANEOUS INCOME B -1,559 OPERATION OF PLANT 7.00 0 34.00 35.00 MI SCELLANEOUS INCOME B -766 LAUNORY & LINEN SERVICE 8.00 0 35.00 35.00 MI SCELLANEOUS INCOME B -766 LAUNORY & LINEN SERVICE 8.00 0 35.00 36.00 MI SCELLANEOUS INCOME B -103,995 CAFETERIA 11.00 0 36.00 37.00 MI SCELLANEOUS INCOME B -133,540 NURSI NG ADMINI STRATION 13.00 0 37.00 38.00 MI SCELLANEOUS INCOME B -1420ADULTS & PEDIATRICS 30.00 0 38.00 40.00 MI SCELLANEOUS INCOME B -152RADIOLOGY-DI AGNOSTIC 54.00 0 39.00 41.00 MI SCELLANEOUS INCOME B -2,250 OCUPATI ONAL THERAPY 67.00 0 40.01 41.00 MI SCELLANEOUS INCOME B -2,250 OCUPATI ONAL THERAPY 67.00 0 45.02 45.01				To/From Which the Amount is	to be Adjusted		
1.00 2.00 3.00 4.00 5.00 34.00 MI SCELLANEOUS INCOME B -1,559 OPERATION OF PLANT 7.00 0 34.00 35.00 MI SCELLANEOUS INCOME B -766 LAUNORY & LINEN SERVICE 8.00 0 35.00 35.00 MI SCELLANEOUS INCOME B -766 LAUNORY & LINEN SERVICE 8.00 0 35.00 36.00 MI SCELLANEOUS INCOME B -103,995 CAFETERIA 11.00 0 36.00 37.00 MI SCELLANEOUS INCOME B -133,540 NURSI NG ADMINI STRATION 13.00 0 37.00 38.00 MI SCELLANEOUS INCOME B -1420ADULTS & PEDIATRICS 30.00 0 38.00 40.00 MI SCELLANEOUS INCOME B -152RADIOLOGY-DI AGNOSTIC 54.00 0 39.00 41.00 MI SCELLANEOUS INCOME B -2,250 OCUPATI ONAL THERAPY 67.00 0 40.01 41.00 MI SCELLANEOUS INCOME B -2,250 OCUPATI ONAL THERAPY 67.00 0 45.02 45.01							
1.00 2.00 3.00 4.00 5.00 34.00 MI SCELLANEOUS INCOME B -1,559 OPERATION OF PLANT 7.00 0 34.00 35.00 MI SCELLANEOUS INCOME B -766 LAUNORY & LINEN SERVICE 8.00 0 35.00 35.00 MI SCELLANEOUS INCOME B -766 LAUNORY & LINEN SERVICE 8.00 0 35.00 36.00 MI SCELLANEOUS INCOME B -103,995 CAFETERIA 11.00 0 36.00 37.00 MI SCELLANEOUS INCOME B -133,540 NURSI NG ADMINI STRATI ON 13.00 0 37.00 38.00 MI SCELLANEOUS INCOME B -1402 ADULTS & PEDIATRICS 30.00 0 38.00 40.00 MI SCELLANEOUS INCOME B -152 RADIOLOGY -DI AGNOSTIC 54.00 0 99.00 0 41.00 0 55.00 0 0 40.00 45.00 0 94.00 0 0 0 10.00 0 39.00 0 10.00 0 0 0 0							
1.00 2.00 3.00 4.00 5.00 34.00 MI SCELLANEOUS INCOME B -1,559 OPERATION OF PLANT 7.00 0 34.00 35.00 MI SCELLANEOUS INCOME B -766 LAUNDRY & LINEN SERVICE 8.00 0 35.00 36.00 MI SCELLANEOUS INCOME B -766 LAUNDRY & LINEN SERVICE 8.00 0 35.00 36.00 MI SCELLANEOUS INCOME B -103,995 CAFETERIA 11.00 0 36.00 37.00 MI SCELLANEOUS INCOME B -133,540 NURSI NG ADMINI STRATI ON 13.00 0 37.00 38.00 MI SCELLANEOUS INCOME B -140ADULTS & PEDIATRICS 30.00 0 38.00 40.00 MI SCELLANEOUS INCOME B -152 RADIOLOGY -DI AGNOSTIC 54.00 0 39.00 41.00 MI SCELLANEOUS INCOME B -2,250 OCUPATI ONAL THERAPY 67.00 0 40.01 41.00 MI SCELLANEOUS INCOME B -2,250 OCUPATI ONAL THERAPY 67.00 0 45.02 45.01							
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(Transfer to Worksheet A,					4.00	0	
		<i>'</i>	-4,000,458				50.00
	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.

Hoal th	Financial Systems	I NDI ANA UNI VERSI 1		Inlie	u of Form CMS-:	2552-10
	ENT OF COSTS OF SERVICES FROM		HOME Provider CCN: 15-1328	Peri od:	Worksheet A-8	
OFFI CE	COSTS			From 01/01/2020		
				To 12/31/2020	Date/Time Pre	epared: ·18 am
	Line No.	Cost Center	Expense Items	Amount of A	mount Included	
				Allowable Cost		
					column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT (OF TRANSACTIONS WITH RELATE	O ORGANI ZATI ONS	OR	
	CLAIMED HOME OFFICE COSTS:					
1.00			HOME OFFICE	833, 274	0	
2.00			HOME OFFICE	361, 967	0	2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT		3, 496, 635	0	3.00
4.00			HOME OFFICE	10, 475, 004	8, 787, 366	
4.01		EMPLOYEE BENEFITS DEPARTMENT		166, 069	226, 732	
4.02			RELATED PARTY	2, 231, 235	1, 632, 496	
4.03			RELATED PARTY	0	54, 042	
4.04			RELATED PARTY	26, 929	0	
4.05			RELATED PARTY	114, 565	1, 589, 455	
4.06			RELATED PARTY	591, 272	491, 991	
4.07			RELATED PARTY	121, 345	0	
4.08			RELATED PARTY	70, 399		
4.09			EMERGENCY ROOM	2, 947, 394	693, 207	
4.10		EMPLOYEE BENEFITS DEPARTMENT		3, 231	3, 231	
4.11			SHARED EMPLOYEES	3, 380	3, 380	
4.12			SHARED EMPLOYEES	26, 284	26, 284	
4.13			SHARED EMPLOYEES	1, 169, 882	1, 169, 882	
4.14			SHARED EMPLOYEES	292, 629	292, 629	
4.15			SHARED EMPLOYEES	6, 535	6, 535	
4.16			SHARED EMPLOYEES	3, 377, 938	3, 377, 938	
4.17			SHARED EMPLOYEES	447, 813	447, 813	
4.18			SHARED EMPLOYEES	53, 704	53, 704	
4.19			SHARED EMPLOYEES	16, 642	16, 642	
4.20		EMERGENCY	SHARED EMPLOYEES	5, 167	5, 167	
5.00	TOTALS (sum of lines 1-4).			26, 839, 293	18, 932, 640	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2, lir	е				
	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 I not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

The been posted to worksheet A, cordinars r and/or 2, the another arrowable should be marcated in cordinar 4 or this part.									
				Related Organization(s) and/	'or Home Office				
				3 ,					
					_				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
	, , , ,		Ownership		Ownership				
	1.00	2.00	3.00	4.00	5,00				
1.00 2.00 3.00 4.00 3.00									
B. INTERRELATIONSHIP TO RELATED 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 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under tit

AVIII.			
6.00	В	0. 00 I U HEALTH, I NC. 50. 0	0 6.00
7.00	F	0. 00 I UH BLOOMI NGTO 50. 0	0 7.00
8.00		0.00 0.0	0 8.00
9.00		0.00 0.0	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.

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

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

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

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

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFORD	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RE	ELATED ORGANIZATIONS AND HOME Provider CCN: 15-1328	
OFFICE COSTS		From 01/01/2020

			To 12/31/2020 Date/Time Pr 7/14/2021 11	epared: :18 am
	Net Adjustments	Wkst. A-7 Ref.		
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR	
	CLAIMED HOME O			
1.00	833, 274	11		1.00
2.00	361, 967	9		2.00
3.00	3, 496, 635			3.00
4.00	1, 687, 638			4.00
4.01	-60, 663			4.01
4.02	598, 739	0		4.02
4.03	-54,042	0		4.03
4.04	26, 929			4.04
4.05	-1, 474, 890	0		4.05
4.06	99, 281	0		4.06
4.07	121, 345			4.07
4.08 4.09	16, 253	0		4.08 4.09
4.09	2, 254, 187 0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	ō		4.20
5.00	7, 906, 653	-		5.00
- TI		1 1 ()		

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 I not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

F	elated Organization(s) and/c Home Office	r	
_	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATIONSHIP TO RELATIONSHIP	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 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under tit xv/111

AVIII.		· · · · · · · · · · · · · · · · · · ·
6.00	HOME OFFICE	6.00
7.00	HEALTHCARE	7.00
8.00		8.00
9.00		9.00
9. 00 10. 00		10.00
100.00		100.00

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

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.

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization.F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

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

			DIANA UNI VENSI					
PROVI DE	ER BASED PHYSIC	CLAN ADJUSTMENT		Provi der (CCN: 15-1328	Period:	Worksheet A-8	3-2
					!	$\Gamma_0 = \frac{12}{31} \frac{12}{2020}$	0 Date/Time Pre	enared
						10 12/01/2020	7/14/2021 11:	18 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Provi	
		Identifier	Remunerati on	Component	Component		der Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	1, 169, 882					1.00
2.00		INTENSIVE CARE UNIT	292, 629				0	2.00
3.00		OPERATING ROOM	960, 881		0	0	0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	127, 565		0	0	0	4.00
5.00		LABORATORY	295, 465			0	0	5.00
6.00		EMERGENCY	2,731,777				0	6.00
7.00	0.00	EMERGENCI	2,731,777	2, 337, 940	373,037		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
	0.00		0	0	0	0	0	
10.00	0.00		5 570 100	1 000 574		0	0	10.00
200.00			5, 578, 199					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit				ef Mal practi ce	
				Limit	Conti nui ng	of col. 12	Insurance	
					Educati on			
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00		INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00		OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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 #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share		Di sal I owance			
			of col. 14	2	bi our i onunoo			
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0	0	0			1.00
2.00		INTENSIVE CARE UNIT	0	0	0	243, 858		2.00
3.00		OPERATING ROOM	0	0	0	960, 881		3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0		127, 565		4.00
5.00		LABORATORY	0	0	0	283, 428		5.00
6.00		EMERGENCY	0	0	0	2, 337, 940		6.00
		EMERGENCI	0	0	0	2, 337, 940		
7.00	0.00		0	0				7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00	I I		0	0	0	4, 928, 574		200.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1328	Period:	Worksheet B	
					From 01/01/2020	Part I	
					Го 12/31/2020	Date/Time Pre 7/14/2021 11:	epared: 18 am
			CAPI TAL REL	ATED COSTS		1771472021 11.	
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost		WIVDLL LQUIT	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A			DEPARTIVIENT		
		,					
		col. 7)	1 00	2.00	4.00	4.0	
	CENERAL CERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	((2, 222)	(())))		1		1 00
1.00		663, 323	663, 323		-		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 535, 535	2 000	1, 535, 535			2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 023, 623	2, 083				4.00
	00500 ADMI NI STRATI VE & GENERAL	14, 531, 050	97, 165				
	00700 OPERATION OF PLANT	1, 819, 156	73, 396				
8.00	00800 LAUNDRY & LINEN SERVICE	137, 345	3, 144			150, 357	8.00
	00900 HOUSEKEEPI NG	611, 344	7, 186			737, 973	
	01000 DI ETARY	593, 453	15, 541	48, 779		743, 320	
	01100 CAFETERI A	48, 129	8, 164	25, 626			
	01300 NURSING ADMINISTRATION	1, 732, 038	22, 355			2, 166, 074	13.00
	01400 CENTRAL SERVICES & SUPPLY	1, 154, 901	17, 683	55, 502	2 13, 836	1, 241, 922	14.00
	01500 PHARMACY	1, 238, 834	5, 017	15, 746	5 138, 470	1, 398, 067	15.00
17.00	01700 SOCIAL SERVICE	52, 291	586	1, 839	9 11, 990	66, 706	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 819, 338	35, 366	111, 005	5 557, 070	3, 522, 779	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 506, 074	9, 269	29, 093	308, 009	1, 852, 445	31.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	924, 780	43, 704	137, 177	7 267, 216	1, 372, 877	50.00
51.00	05100 RECOVERY ROOM	356, 228	0	(76, 517	432, 745	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 358, 897	19, 500	61, 207	7 226, 813	1, 666, 417	54.00
56.00	05600 RADI OI SOTOPE	193, 067	0	(21, 550	214, 617	56.00
57.00	05700 CT SCAN	405, 024	4, 003	12, 564	4 83, 148	504, 739	57.00
58.00	05800 MRI	256, 444	4, 248	13, 335	5 51, 625	325, 652	58.00
60.00	06000 LABORATORY	3, 573, 938	18, 388	57, 714	4 67, 906	3, 717, 946	60.00
65.00	06500 RESPI RATORY THERAPY	757, 534	8, 568	26, 894	174, 234	967, 230	65.00
66.00	06600 PHYSI CAL THERAPY	813, 761	9, 071	28, 472	146, 213	997, 517	66.00
67.00	06700 OCCUPATI ONAL THERAPY	373, 462	4, 462	14,006	81, 823	473, 753	67.00
	06800 SPEECH PATHOLOGY	74,009	1, 053				
	06900 ELECTROCARDI OLOGY	784, 051	19, 528			928, 184	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	204, 949	0	(204, 949	
	07200 IMPL. DEV. CHARGED TO PATIENTS	95, 209	0	(0	95, 209	
	07300 DRUGS CHARGED TO PATIENTS	11, 910, 252	0	(0	11, 910, 252	
	07697 CARDI AC REHABI LI TATI ON	69, 758	1, 667	5, 232			
/0///	OUTPATIENT SERVICE COST CENTERS	077700	1,007	0/201	10,001	0,,,,01	,,
90 00	09000 CLINIC	1, 029, 151	24, 244	76, 095	5 202, 262	1, 331, 752	90.00
	09001 CLINIC - DIABETES	87, 351	2, 118				
	09100 EMERGENCY	2, 944, 200	19, 469				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 744, 200	19,409	01, 10	477,400	3, 302, 230	
72.00	SPECIAL PURPOSE COST CENTERS	L I				0	/2.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	58, 678, 499	476, 978	1, 497, 120	3, 980, 125	58, 401, 621	118 00
110.00	NONREI MBURSABLE COST CENTERS	50, 070, 477	470, 970	1,477,120	5, 700, 125	50,401,021	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 380	3, 801	11, 93	1 4, 291	39, 403	100 00
	19200 PHYSI CLANS' PRIVATE OFFICES	61, 526	152, 127		4,291	213, 653	
					11, 176		
	07950 OCCUPATI ONAL HEALTH	76, 901	8,438				
	07952 BLOOMNGTN AMBULANCE AND OCC MED	170, 233	21, 979		36, 651	228, 863	
	07953 HOME CARE	0	0				194.03 200.00
200.00			0	,			
201.00		E0 004 E20	((())) () () () () () () ()	1 525 520			201.00
202.00	TOTAL (SUM TIMES TTO LITTOUGH 201)	59, 006, 539	663, 323	1, 535, 535	4, 032, 243	59, 006, 539	KUZ. UU

Health Financial Systems	I NDI	ANA UNI VERSI TY	' HEALTH BEDFO	RD	In Lieu	ı of Form CMS-	2552-10
COST ALLOCATION - GENERAL	SERVI CE COSTS		Provi der C		Period:	Worksheet B	
					From 01/01/2020 To 12/31/2020		enared
				'	10 12/31/2020	7/14/2021 11	:18 am
Cost Center De	scription	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST				I			1 00
1.00 00100 CAP REL COSTS- 2.00 00200 CAP REL COSTS-							1.00 2.00
4. 00 00400 EMPLOYEE BENEF							2.00
5. 00 00500 ADMI NI STRATI VE		15, 217, 414					4.00 5.00
7.00 00700 OPERATION OF P		791, 512	3, 069, 140				7.00
8.00 00800 LAUNDRY & LINE		52, 251	19, 664	222, 272	5		8.00
9. 00 00900 HOUSEKEEPI NG	N SERVICE	256, 457	44, 950	222, 212			9.00
10. 00 01000 DI ETARY		258, 316	97, 206			1, 151, 587	
11. 00 01100 CAFETERI A		33, 599	51,067			1, 131, 387 C	
13.00 01300 NURSI NG ADMI NI	STRATION	752, 745	139, 828		27,710	C	
14.00 01400 CENTRAL SERVIC		431, 588	110, 605		, , , , , , , , , , , , , , , , , , , ,	0	
15. 00 01500 PHARMACY		485, 851	31, 378	-		C	
17.00 01700 SOCI AL SERVI CE		23, 181	3, 665			C	
I NPATI ENT ROUTI NE SE		23, 101	3,005		1, 707	L. L.	17.00
30.00 03000 ADULTS & PEDIA		1, 224, 222	221, 209	79, 235	5 120, 030	843, 359	30.00
31.00 03100 I NTENSI VE CARE		643, 754	57, 977	34, 045		308, 228	
ANCI LLARY SERVICE CO		010,701	01, 711	01,010	01,107	000,220	01.00
50.00 05000 OPERATING ROOM		477, 097	273, 366	39, 713	3 148, 333	C	50.00
51.00 05100 RECOVERY ROOM		150, 386	0			C	
54.00 05400 RADI OLOGY-DI AG	NOSTI C	579, 107	121, 972		66, 183	C	
56. 00 05600 RADI 0I SOTOPE		74, 583	0	0		C	56.00
57.00 05700 CT SCAN		175, 405	25, 038	0	13, 586	C	57.00
58.00 05800 MRI		113, 169	26, 574	0	14, 419	C	58.00
60.00 06000 LABORATORY		1, 292, 046	115, 013	0	62, 407	C	60.00
65.00 06500 RESPI RATORY TH	ERAPY	336, 128	53, 593	0	29, 080	C	65.00
66.00 06600 PHYSI CAL THERA	PY	346, 653	56, 739	0	30, 787	C	66.00
67.00 06700 OCCUPATIONAL T	HERAPY	164, 637	27, 911	0	15, 145	C	67.00
68.00 06800 SPEECH PATHOLO	GY	32, 765	6, 588	0	3, 575	C	68.00
69.00 06900 ELECTROCARDI OL		322, 559	122, 145	0	66, 277	C	69.00
71.00 07100 MEDI CAL SUPPLI	ES CHARGED TO PATIENT	71, 223	0	0	0 0	C	71.00
72.00 07200 IMPL. DEV. CHA	RGED TO PATIENTS	33, 087	0	0	0 0	C	72.00
73.00 07300 DRUGS CHARGED	TO PATIENTS	4, 138, 994	0	0	0 0	C	73.00
76. 97 07697 CARDI AC REHABI	LI TATI ON	31, 263	10, 426	0	5, 657	C	76.97
OUTPATIENT SERVICE (COST CENTERS						
90. 00 09000 CLI NI C		462, 805	151, 642	0		C	90.00
90.01 09001 CLINIC - DIABE	TES	34, 729	13, 250	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	C	
91.00 09100 EMERGENCY		1, 217, 083	121, 774	69, 279	66, 076	C	
	DS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST							
	OF LINES 1 through 117)	15, 007, 195	1, 903, 580	222, 272	2 997, 842	1, 151, 587	118.00
NONREI MBURSABLE COST		10 (00)	00.775		10.001		
190. 0019000 GI FT, FLOWER,		13, 693	23, 775	0			190.00
192. 0019200 PHYSI CI ANS' PR		74, 248	951, 533		-		192.00
194.0007950 OCCUPATI ONAL H		42, 744	52, 776	0	20,001		194.00
194. 0207952 BLOOMNGTN AMBU	LANCE AND ULL MED	79, 534	137, 476		0		194.02
194. 0307953 HOME CARE	uctmonto	0	0			Ĺ	194.03
200.00 Cross Foot Adj 201.00 Negative Cost		_	0	· · · · ·		~	200.00 201.00
5	es 118 through 201)	0 15, 217, 414	3, 069, 140	222, 272	1, 039, 380	1, 151, 587	
202.00 TITAL (Sum TIT		13, 217, 414	5,007,140	222,212	-1 1,037,300	1, 101, 007	¥02.00

	Financial Systems INDI LLOCATION - GENERAL SERVICE COSTS	ANA UNIVERSIT	Y HEALTH BEDFOR Provider CO		Period:	u of Form CMS-2 Worksheet B	2552-10
CUST A	LLUCATION - GENERAL SERVICE CUSIS			UN. 15-1320	From 01/01/2020 To 12/31/2020	Part I	epared: 18 am
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	SOCI AL SERVI CE	
		11.00	13.00	14.00	15.00	17.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A	209, 060					11.00
	01300 NURSI NG ADMI NI STRATI ON	15, 415	3, 149, 934				13.00
	01400 CENTRAL SERVI CES & SUPPLY	1, 927	0	1, 846, 05			14.00
	01500 PHARMACY	6, 744	0	107, 76	53 2, 046, 829		15.00
17.00	01700 SOCI AL SERVI CE	963	0		0 0	96, 504	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	37, 573		251, 15		70, 674	
31.00	03100 INTENSIVE CARE UNIT	15, 415	506, 886	205, 39	92 551	25, 830	31.00
	ANCI LLARY SERVI CE COST CENTERS				-		_
	05000 OPERATI NG ROOM	11, 561	144, 825	115, 08		0	
	05100 RECOVERY ROOM	3, 854	144, 825		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	12, 524	0	60, 42		0	
	05600 RADI OI SOTOPE	963	0	2, 36		0	
	05700 CT SCAN	5, 780		71, 82		0	
	05800 MRI	2, 890	0	3, 74		0	
	06000 LABORATORY	18, 305	0		16 0	0	
	06500 RESPI RATORY THERAPY	9, 634	0	212, 61		0	
	06600 PHYSI CAL THERAPY	8, 671	0	13, 70		0	
	06700 OCCUPATI ONAL THERAPY	3, 854	0		0 0	0	
	06800 SPEECH PATHOLOGY	963			0 0	0	
	06900 ELECTROCARDI OLOGY	3, 854	72, 412	44, 68		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	300, 60		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	139, 64		0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 043, 153	0	
76.97	07697 CARDI AC REHABI LI TATI ON	963	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				al		
	09000 CLINIC	13, 488	289, 649		0 387	0	
	09001 CLINIC – DIABETES	0	0		0 0	0	
	09100 EMERGENCY	27, 939	760, 329	316, 75	55 469	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					l	92.00
	SPECIAL PURPOSE COST CENTERS		i		-		
118.00		203, 280	3, 149, 934	1, 845, 77	75 2, 046, 829	96, 504	118.00
	NONREIMBURSABLE COST CENTERS		,		-		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 OCCUPATI ONAL HEALTH	963	0	10			194.00
	07952 BLOOMNGTN AMBULANCE AND OCC MED	3, 854	0	17	73 0	0	194.02
194.02		0,001					
194. 02 194. 03	07953 HOME CARE	0,001	0		0 0		194.03
194. 02 194. 03 200. 00	07953 HOME CARE Cross Foot Adjustments	0	0		0 0		200.00
194. 02 194. 03	07953 HOME CARE Cross Foot Adjustments Negative Cost Centers	0,001 0 209,060	0 0 3, 149, 934	1, 846, 05	0 0 0 0 57 2, 046, 829	0	200. 00 201. 00

Cost Center Description Subtotal Total Residents Cost & Post Stepdown Total Residents Cost & Stepdown Total Residents Co	CMS-2552-10 et B
Cost Center Description Subtotal Intern & Aljustments Total 6ENERAL SERVICE COST CENTERS 24.00 25.00 26.00 1.00 00100 CAP REL COST S-BLDG & FIXT 24.00 25.00 26.00 2.00 00200 CAP REL COSTS-MUBL E DUI P 4.00 4.00 4.00 4.00 0.00 00200 CAP REL COSTS-WIBL E CUI P 4.00 4.00 4.00 4.00 0.00 00000 OPERATION OF PLANT 5.00 5.00 5.00 5.00 5.00 5.00 0.00000 JUBCRSEEPIN GE COST CENTERS 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 1.00 01100 OT FIARY 1.00 1.00 5.00 5.00 5.00 5.00 5.00 7.602.079 3.100 31300 MUBSING ADMINISTRATION 3.681.982 9.3 5.61 9.2 1.00 10100 OPERATING ROM 2.533.008 0 7.602.079 3.100 33100 INTERSIVE CARE UNI T 3.681.982 9.3 5.61 9.2 9.2 </th <th>11 11 18 am</th>	11 11 18 am
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24.00 25.00 26.00 GENERAL SERVICE COST CENTERS	
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7. 00 00700 OPERATION OF PLANT 8. 00 008000 LANDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CATERIA 13. 00 01300 AURSING ADMINISTRATION 14. 00 1400 CHAOL CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 17. 00 1700 SOCIAL SERVICE COST CENTERS 30. 00 03000 AURTINE CASE UNIT 3. 681, 982 10. 00 3100 INTENSIVE CARE UNIT 3. 681, 982 10. 00 SIOOL PERATING ROOM 2. 583, 008 0 10. 00 SIOOL PERATING ROOM 7.31, 810 7.31, 810 11. 00 SIOOL PERATING ROOM 7.31, 810 0 12. 00 SOOOL PERATING ROOM 7.502, 573 0 13. 00 DSTOOR RESURCE/FUNCE 292, 529 0 14. 00 SOOL PERATING ROOM 7.532 0 2. 507, 733 15. 00 OSTOO CHENATING ROOM 7.544 0 4.86, 444 16. 00 ABORATORY	4.00
8. 00 00800 LAUNDRY & LI NEN SERVICE	5.00
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58.00 05800 MRI 486, 444 0 486, 444 60.00 06000 LABORATORY 5, 205, 733 0 5, 205, 733 65.00 06500 RESPI RATORY THERAPY 1, 608, 646 0 1, 608, 646 66.00 06600 PHYSI CAL THERAPY 1, 454, 094 0 1, 454, 094 67.00 06700 OCCUPATI ONAL THERAPY 685, 300 0 685, 300 68.00 06800 SPEECH PATHOLOGY 138, 173 0 138, 173 69.00 06900 ELECTROCARDI OLOGY 1, 560, 118 0 1, 560, 118 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 576, 778 0 267, 943 0 267, 943 73.00 07300 DRUGS CHARGED TO PATI ENTS 18, 092, 399 0 18, 092, 399 18, 092, 399 0 18, 022, 399 0 18, 022, 399 0 18, 022, 399 0 18, 022, 399 0 18, 022, 399 0 18, 022, 399 0 18, 022, 320 0 0 0 0 0 0 0 0 0 0 1, 55, 102 0 1, 55, 102 0 155, 102 0 155, 102<	57.00
60.00 06000 LABORATORY 5, 205, 733 0 5, 205, 733 65.00 06500 RESPI RATORY THERAPY 1, 608, 646 0 1, 608, 646 66.00 06600 PHYSI CAL THERAPY 1, 454, 094 0 1, 454, 094 67.00 06700 0CCUPATI ONAL THERAPY 685, 300 0 685, 300 68.00 06800 SPEECH PATHOLOGY 138, 173 0 138, 173 69.00 06900 ELECTROCARDI OLOGY 1, 560, 118 0 1, 560, 118 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 576, 778 0 576, 778 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 18, 092, 399 0 18, 092, 399 76.97 CARDI AC REHABI LI TATI ON 138, 270 0 18, 092, 399 76.97 CARDI AC REHABI LI TATI ON 138, 270 0 18, 092, 399 70.00 09000 CLI NI C DI ABETES 155, 102 0 155, 102 90.00 09000 CLI NI C DI ABETES 155, 102 0 155, 102 91.00 090	58.00
65.00 06500 RESPI RATORY THERAPY 1, 608, 646 0 1, 608, 646 66.00 06600 PHYSI CAL THERAPY 1, 454, 094 0 1, 454, 094 67.00 06700 OCCUPATI ONAL THERAPY 685, 300 0 685, 300 68.00 06800 SPEECH PATHOLOGY 138, 173 0 138, 173 69.00 06900 ELECTROCARDI OLOGY 1, 560, 118 0 1, 560, 118 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 576, 778 0 576, 778 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 267, 943 0 267, 943 73.00 07300 RUGS CHARGED TO PATI ENTS 18, 092, 399 0 18, 092, 399 0 18, 092, 399 76.97 07697 CARDI AC REHABI LI TATI ON 138, 270 0 138, 270 0 138, 270 90.00 09000 CLI NI C DI ABETES 155, 102 0 155, 102 155, 102 91.00 09100 EMERGENCY 6, 081, 940 0 6, 081, 940 0 6, 081, 940 0	60.00
66.00 06600 PHYSI CAL THERAPY 1,454,094 0 1,454,094 67.00 06700 OCUPATI ONAL THERAPY 685,300 0 685,300 68.00 06800 SPEECH PATHOLOGY 138,173 0 138,173 69.00 06900 ELECTROCARDI OLOGY 1,560,118 0 1,560,118 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 576,778 0 576,778 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 267,943 0 267,943 73.00 07300 DRUGS CHARGED TO PATI ENTS 18,092,399 0 18,092,399 18,092,399 76.97 07697 CARDI AC REHABI LI TATI ON 138,270 0 138,270 00TPATI ENT SERVICE COST CENTERS 155,102 0 155,102 0 90.00 09000 CLI NI C 0 155,102 0 155,102 91.00 09000 CLI NI C 0 6,081,940 0 6,081,940 0 6,081,940 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 56,978,242 0<	65.00
67.00 06700 OCCUPATI ONAL THERAPY 685, 300 0 685, 300 68.00 06800 SPEECH PATHOLOGY 138, 173 0 138, 173 69.00 06900 ELECTROCARDI OLOGY 1, 560, 118 0 1, 560, 118 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 576, 778 0 576, 778 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 267, 943 0 267, 943 73.00 07300 DRUGS CHARGED TO PATI ENTS 18, 092, 399 0 18, 092, 399 76.97 OADI AC REHABI LI TATI ON 138, 270 0 138, 270 001704 DUTPATI ENT SERVI CE COST CENTERS 155, 102 155, 102 90.00 09000 CLI NI C 2, 332, 005 0 2, 332, 005 91.00 09001 CLI NI C DI ABETES 155, 102 0 155, 102 91.00 09100 EMERGENCY 6, 081, 940 0 6, 081, 940 0 92.00 OSERVATI ON BEDS (NON-DI STI NCT PART 0 56, 978, 242 56, 978, 242 156, 978, 242	66.00
68.00 06800 SPEECH PATHOLOGY 138, 173 0 138, 173 69.00 06900 ELECTROCARDI OLOGY 1, 560, 118 0 1, 560, 118 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 576, 778 0 576, 778 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 267, 943 0 267, 943 73.00 07300 DRUGS CHARGED TO PATI ENTS 18, 092, 399 0 18, 092, 399 76.97 OARDI AC REHABI LI TATI ON 138, 270 0 138, 270 001PATI ENT SERVICE COST CENTERS 155, 102 0 155, 102 90.00 09000 CLI NI C 2, 332, 005 0 2, 332, 005 91.00 09001 CLI NI C DI ABETES 155, 102 0 155, 102 91.00 09100 EMERGENCY 6, 081, 940 0 6, 081, 940 0 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 56, 978, 242 0 56, 978, 242 118.00 SUBTOTALS (SUM OF LI NES 1 through 117) 56, 978, 242 0 56, 978, 242 56, 978,	67.00
69.00 06900 ELECTROCARDI OLOGY 1,560,118 0 1,560,118 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 576,778 0 576,778 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 267,943 0 267,943 73.00 07300 DRUGS CHARGED TO PATIENTS 18,092,399 0 18,092,399 76.97 CARDI AC REHABI LI TATI ON 138,270 0 138,270 00TPATIENT SERVICE COST CENTERS 155,102 0 155,102 90.00 09000 CLINIC 2,332,005 0 2,332,005 90.01 09001 CLINIC DI ABETES 155,102 0 155,102 90.00 09200 DESERVATION BEDS (NON-DI STINCT PART 0 56,978,242 0 56,978,242 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 56,978,242 56,978,242 56,978,242 92.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,978,242 0 56,978,242 56,978,242 918.00 JPHONE IMBURSABLE COST CENTERS 100,00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 576, 778 0 576, 778 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 267, 943 0 267, 943 73.00 07300 DRUGS CHARGED TO PATI ENTS 18, 092, 399 0 18, 092, 399 76.97 CARDI AC REHABI LI TATI ON 138, 270 0 138, 270 0UTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 2, 332, 005 0 2, 332, 005 90.01 09001 CLINIC DI ABETES 155, 102 0 155, 102 91.00 09100 EMERGENCY 6, 081, 940 0 6, 081, 940 0 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 56, 978, 242 0 56, 978, 242 91.00 OP200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 56, 978, 242 0 56, 978, 242 92.00 SUBTOTALS (SUM OF LINES 1 through 117) 56, 978, 242 0 56, 978, 242 1 90.01 OUTPATI ENT SAULE COST CENTERS 1 1 1 390, 735 1 20, 735 1 239, 434	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 267, 943 0 267, 943 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 092, 399 0 18, 092, 399 76.97 CARDIAC REHABILITATION 138, 270 0 138, 270 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2, 332, 005 0 2, 332, 005 90.00 09000 CLINIC DIABETES 155, 102 0 155, 102 91.00 09100 EMERGENCY 6, 081, 940 0 6, 081, 940 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0 56, 978, 242 0 56, 978, 242 91.00 OPDOSE COST CENTERS 1180 SUBTOTALS (SUM OF LINES 1 through 117) 56, 978, 242 0 56, 978, 242 92.00 SUBTOTALS (SUM OF LINES 1 through 117) 56, 978, 242 0 56, 978, 242 90.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 90, 735 0 90, 735 192.00 PHYSI CI ANS' PRI VATE OFFICES 1, 239, 434 0 1, 239, 434	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS 18,092,399 0 18,092,399 76.97 07697 CARDIAC REHABILITATION 138,270 0 138,270 0UTPATIENT SERVICE COST CENTERS 0 138,270 0 138,270 90.00 09000 CLINIC 0 2,332,005 0 2,332,005 90.01 09000 CLINIC DIABETES 155,102 0 155,102 91.00 09100 EMERGENCY 6,081,940 0 6,081,940 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0 56,978,242 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,978,242 0 56,978,242 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,978,242 0 56,978,242 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,978,242 0 56,978,242 120.00 190000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 90,735 0 90,735 192.00 19200 PHYSI CIANS' PRIVATE OFFICES 1,239,434 0 1,239,434 0 </td <td>72.00</td>	72.00
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 2, 332, 005 0 2, 332, 005 90. 01 09001 CLINIC 155, 102 0 155, 102 91. 00 09100 EMERGENCY 6, 081, 940 0 6, 081, 940 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 6 081, 940 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 6 0 6 91. 00 09100 EMERGENCY 6, 081, 940 0 6, 081, 940 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 56, 978, 242 0 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 56, 978, 242 0 56, 978, 242 NONREI MBURSABLE COST CENTERS 190. 00 190000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 90, 735 0 90, 735 192. 00 192000 PHYSI CI ANS' PRI VATE OFFI CES 1, 239, 434 0 1, 239, 434	73.00
90.00 09000 CLINIC 2,332,005 0 2,332,005 90.01 09001 CLINIC - DIABETES 155,102 0 155,102 91.00 09100 EMERGENCY 6,081,940 0 6,081,940 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 6,081,940 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 6,081,940 91.00 09000 CLINIC - DIABETES 0 0 6,081,940 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,978,242 0 56,978,242 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 90,735 0 90,735 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 1,239,434 0 1,239,434 0	76.97
90. 01 09001 CLINIC - DIABETES 155, 102 0 155, 102 91. 00 09100 EMERGENCY 6, 081, 940 0 6, 081, 940 92. 00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 56, 978, 242 0 56, 978, 242 NONREI MBURSABLE COST CENTERS 190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 90, 735 0 90, 735 192. 00 PHYSI CIANS' PRIVATE OFFICES 1, 239, 434 0 1, 239, 434	
91.00 09100 EMERGENCY 6,081,940 0 6,081,940 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,978,242 0 56,978,242 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 100,00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 90,735 0 90,735 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 1,239,434 0 1,239,434	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 SPECI AL PURPOSE COST CENTERS	90.01
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56, 978, 242 0 56, 978, 242 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 90, 735 0 90, 735 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 90, 735 0 90, 735 192.00 PHYSI CI ANS' PRI VATE OFFI CES 1, 239, 434 0 1, 239, 434	91.00
Instruction Substruction Substruction </td <td>92.00</td>	92.00
NONREI MBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 90, 735 0 90, 735 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 1, 239, 434 0 1, 239, 434	
190. 00 0 FILOWER, COFFEE CANTEEN 90, 735 0 90, 735 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 1, 239, 434 0 1, 239, 434	118.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 239, 434 0 1, 239, 434	
	190.00
	192.00
194. 00/07950 OCCUPATI ONAL HEALTH 248, 228 0 248, 228	194.00
194. 02/07952 BLOOMNGTN AMBULANCE AND OCC MED 449, 900 0 449, 900	194.02
194. 03 07953 HOME_CARE 0 0 0	194.03
200.00 Cross Foot Adjustments 0 0 0	200.00
201.00 Negative Cost Centers 0 0 0	201.00
202.00 TOTAL (sum lines 118 through 201) 59,006,539 0 59,006,539	202.00

	al Systems INDI CAPITAL RELATED COSTS	ANA UNI VERSI I	<u>/ HEALTH BEDFO</u> Provider C		Period:	u of Form CMS-: Worksheet B	2552-10
ALLUCATION OF	CAPITAL RELATED COSTS		Provi der C	UN: 15-1328	From 01/01/2020	Part II	
					To 12/31/2020	Date/Time Pre 7/14/2021 11:	epared: :18 am
			CAPI TAL REL	ATED COSTS		• • • •	
0.5		Discotto					
CO	st Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIF	P Subtotal	EMPLOYEE BENEFI TS	
	(apital Related	ł			DEPARTMENT	
		Costs					
		0	1.00	2.00	2A	4.00	
	SERVICE COST CENTERS						1 1 00
	P REL COSTS-BLDG & FIXT P REL COSTS-MVBLE EQUIP						1.00
	PLOYEE BENEFITS DEPARTMENT	0	2, 083	6, 53	37 8, 620	8, 620	
	MINISTRATIVE & GENERAL	0	97, 165			607	
	ERATION OF PLANT	0	73, 396			331	
	UNDRY & LINEN SERVICE	0	3, 144			0	
	USEKEEPI NG	0	7, 186			207	
10.00 01000 DI	ETARY	0	15, 541	48, 7	79 64, 320	183	10.00
11.00 01100 CA	FETERI A	0	8, 164	25, 62	26 33, 790	32	11.00
	RSING ADMINISTRATION	0	22, 355	70, 10		730	
	NTRAL SERVICES & SUPPLY	0	17, 683			30	
15.00 01500 PH		0	5, 017			296	
17.00 01700 SO		0	586	1, 83	39 2, 425	26	17.00
	VT ROUTINE SERVICE COST CENTERS	0	35, 366	111, 00	05 146, 371	1, 194	30.00
	TENSIVE CARE UNIT	0	35, 366 9, 269			658	1
	RY SERVICE COST CENTERS		7,207	27,0	73 30, 302	030	5 31.00
	ERATING ROOM	0	43, 704	137, 1	77 180, 881	571	50.00
51.00 05100 RE		0	0	107,11	0 0	164	
54.00 05400 RA	DI OLOGY-DI AGNOSTI C	0	19, 500	61, 20	07 80, 707	485	54.00
56.00 05600 RA	DI OI SOTOPE	0	0		0 0	46	56.00
57.00 05700 CT		0	4, 003			178	
58.00 05800 MR		0	4, 248			110	
60.00 06000 LA		0	18, 388			145	
	SPI RATORY THERAPY	0	8, 568			372	
	YSI CAL THERAPY	0	9, 071	28, 4		312	
67.00 06700 0C	CUPATI ONAL THERAPY EECH PATHOLOGY	0	4, 462 1, 053			175 34	
	ECTROCARDI OLOGY	0	19, 528			135	
	DI CAL SUPPLIES CHARGED TO PATIENT	0	0	01,2	0 0	0	
	PL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	UGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	RDIAC REHABILITATION	0	1, 667	5, 23	32 6, 899	28	76. 97
	ENT SERVICE COST CENTERS						
90.00 09000 CL		0	24, 244			432	1
	INIC - DIABETES	0	2, 118			8	1
91.00 09100 EM		0	19, 469	61, 10		1, 020	
	SERVATION BEDS (NON-DISTINCT PART				0		92.00
	PURPOSE COST CENTERS BTOTALS (SUM OF LINES 1 through 117)	0	476, 978	1, 497, 12	20 1, 974, 098	9 500	118.00
	BURSABLE COST CENTERS	0	470, 970	1,497,12	20 1, 974, 096	6, 309	110.00
	FT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 801	11, 93	31 15, 732	Q	190.00
	YSICIANS' PRIVATE OFFICES	0	152, 127		0 152, 127		190.00
194,0007950 00	CUPATI ONAL HEALTH	0	8, 438				194.00
194.0207952 BL	OOMNGTN AMBULANCE AND OCC MED	0	21, 979		0 21, 979		194.02
194.0307953 HO		0	0		0 0		194.03
200.00 Cr	oss Foot Adjustments				0		200.00
	gative Cost Centers		0		0 0	0	201.00
	TAL (sum lines 118 through 201)				35 2, 198, 858		202.00

Heal th		IANA UNIVERSITY	HEALTH BEDFO	RD	In Lieu	of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1328	eriod:	Worksheet B	
					rom 01/01/2020 o 12/31/2020	Part II Date/Time Pre	enared
					0 12/31/2020	7/14/2021 11:	18 am
	Cost Center Description	ADMI NI STRATI VE O		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	г г					1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	402, 749					5.00
7.00	00700 OPERATION OF PLANT	20, 947	325, 047				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 383	2, 083	16, 478			8.00
9.00	00900 HOUSEKEEPI NG	6, 787	4, 761	0	41, 497		9.00
10.00	01000 DI ETARY	6, 836	10, 295	0	2, 106	83, 740	10.00
11.00	01100 CAFETERI A	889	5, 408	0	1, 106	0	
13.00	01300 NURSING ADMINISTRATION	19, 921	14, 809	0	3, 029	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	11, 422	11, 714	0	2, 396	0	
15.00	01500 PHARMACY	12, 858	3, 323	0	680	0	
17.00	01700 SOCI AL SERVI CE	613	388	0	79	0	17.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	32, 399	23, 428	5, 874	4, 792	61, 327	30.00
30.00	03100 INTENSIVE CARE UNIT	32, 399	23, 428 6, 140		4,792	22, 413	
51.00	ANCI LLARY SERVICE COST CENTERS	17,037	0, 140	2, 324	1,230	22,413	31.00
50.00	05000 OPERATI NG ROOM	12, 626	28, 952	2, 944	5, 923	0	50.00
51.00	05100 RECOVERY ROOM	3, 980	20, 702	0		0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 326	12, 918		2,642	0	
56.00	05600 RADI OI SOTOPE	1, 974	0	0	0	0	56.00
57.00	05700 CT SCAN	4, 642	2, 652	0	542	0	57.00
58.00	05800 MRI	2, 995	2, 814	0	576	0	58.00
60.00	06000 LABORATORY	34, 194	12, 181	0		0	
65.00	06500 RESPI RATORY THERAPY	8, 896	5, 676	0		0	
66.00	06600 PHYSI CAL THERAPY	9, 174	6, 009	0		0	
67.00	06700 OCCUPATI ONAL THERAPY	4, 357	2, 956	0		0	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	867	698	0	143	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	8, 537 1, 885	12, 936 0	0	2,646	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	876	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	109, 561	0	0	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	827	1, 104	0	226	0	•
	OUTPATIENT SERVICE COST CENTERS		.,				
90.00	09000 CLINIC	12, 248	16, 060	0	3, 285	0	90.00
90.01	09001 CLINIC - DIABETES	919	1, 403	0	287	0	90.01
91.00	09100 EMERGENCY	32, 210	12, 897	5, 136	2, 638	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		397, 186	201, 605	16, 478	39, 839	83, 740	118.00
100.00	NONREI MBURSABLE COST CENTERS	0.0	0 510		545		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	362 1, 965	2, 518 100, 775	0			190.00 192.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	1, 965	5, 589	0			192.00
	07952 BLOOMNGTN AMBULANCE AND OCC MED	2, 105	14, 560	0	1, 143		194.00
	07953 HOME CARE	2, 105	14, 500	0	0		194.02
200.00			0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		402, 749	325, 047	16, 478	41, 497		202.00
					•		•

ALLOCATI ON	ncial Systems INDI OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre	epared:
	Cost Center Description	CAFETERIA	NURSI NG	CENTRAL		7/14/2021 11: SOCI AL SERVI CE	<u>18 am</u>
			ADMI NI STRATI ON	SERVICES & SUPPLY		JOUTAL SERVICE	-
		11.00	13.00	14.00	15.00	17.00	
GENEF	RAL SERVICE COST CENTERS	11100	101 00	11100	101 00	11100	
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2.00
	EMPLOYEE BENEFITS DEPARTMENT						4.00
	ADMI NI STRATI VE & GENERAL						5.00
	OPERATION OF PLANT						7.00
	LAUNDRY & LINEN SERVICE						8.00
	HOUSEKEEPING						9.00
	DI ETARY CAFETERI A	41, 225					10.00
	NURSI NG ADMI NI STRATI ON	3, 040					13.00
	CENTRAL SERVICES & SUPPLY	3, 040		99, 127	,		14.00
	PHARMACY	1, 330		5, 787			15.00
	SOCI AL SERVI CE	190		0, 707		3, 721	
	TENT ROUTINE SERVICE COST CENTERS	170				0,721	
	ADULTS & PEDIATRICS	7,406	52, 388	13, 486	18	2, 725	30.00
	INTENSIVE CARE UNIT	3, 040		11, 029		996	31.00
ANCI L	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2, 280	6, 163	6, 180) 3	0	50.00
	RECOVERY ROOM	760		C	0 0	0	51.00
	RADI OLOGY-DI AGNOSTI C	2,470		3, 245		0	54.00
	RADI OI SOTOPE	190		127		0	56.00
	CT SCAN	1, 140		3, 857		0	57.00
58.00 05800		570		201		0	58.00
		3, 610		1	0	0	60.00
		1,900		11, 417		0	65.00
	PHYSICAL THERAPY	1, 710		736	Ŭ	0	66.00
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	760 190		C	Ŭ	0	67.00
	ELECTROCARDI OLOGY	760		2, 400	Ŭ	0	68.00 69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	780		16, 142		0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	C		7, 499		0	
	DRUGS CHARGED TO PATIENTS	C		, , , , , , C		0	
	CARDI AC REHABI LI TATI ON	190		0		0	
	ATIENT SERVICE COST CENTERS	.,,,			<u> </u>		
		2,660	12, 327	C) 9	0	90.00
90.01 09001	CLINIC - DIABETES	C	0	C	0 0	0	90.01
91.00 09100	EMERGENCY	5, 509	32, 357	17, 005	10	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECI	AL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	40, 085	134, 051	99, 112	45, 037	3, 721	118.00
	I MBURSABLE COST CENTERS			-			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190		C	, v		190.00
	PHYSI CI ANS' PRI VATE OFFI CES	0	-	C	Ŭ		192.00
	OCCUPATIONAL HEALTH	190		6	0		194.00
	BLOOMNGTN AMBULANCE AND OCC MED	760	0	9	0		194.02
194.0307953		C	0	C	0	0	194.03
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0		0		^	200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)	41, 225	134, 051	99, 127	45,037		201.00
202.00		41, 223	134,001	77, IZ/	40,037	ວ, / 2	KUZ. UU

Heal th	Fi na	nci a	al S	yste	ms		
ALLOCA	TI ON	0F	CAPI	TAL	RELATED	COSTS	

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

Hearth Financial Systems INDI	ANA UNIVERSII	I HEALTH BEDFU	RD		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-1328	Period: Worksheet B	
			1	From 01/01/2020 Part II To 12/31/2020 Date/Time P	renared
				7/14/2021 1	1:18 am
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost	-		
		& Post			
		Stepdown			
		Adjustments			
	24.00	25.00	26.00	7	
GENERAL SERVICE COST CENTERS		-			
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15.00
17. 00 01700 SOCI AL SERVI CE					17.00
INPATIENT ROUTINE SERVICE COST CENTERS					17.00
30. 00 03000 ADULTS & PEDI ATRI CS	351, 408	0	351, 408	3	30.00
31. 00 03100 I NTENSI VE CARE UNI T	125, 038	0			31.00
ANCI LLARY SERVICE COST CENTERS	125,050	0	125,050	J	51.00
50. 00 05000 OPERATI NG ROOM	246, 523	0	246, 523	3	50.00
51. 00 05100 RECOVERY ROOM	11,067	0			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	117, 810	0		•	54.00
56. 00 05600 RADI 01 SOTOPE	2, 337	0			56.00
57. 00 05700 CT SCAN	2, 337	0			57.00
58. 00 05800 MRI	24, 849	0			58.00
60. 00 06000 LABORATORY	128, 725	0			60.00
65.00 06500 RESPI RATORY THERAPY	64, 892	0			65.00
		0			66.00
	56, 713	0			67.00
67. 00 06700 OCCUPATI ONAL THERAPY	27, 321	-			
68. 00 06800 SPEECH PATHOLOGY	6, 291	0			68.00
69. 00 06900 ELECTROCARDI OLOGY	111, 318	0	,		69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	18, 027	0	18, 02		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	8, 375	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	154, 518	0			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	9, 274	0	9, 274	1	76.97
OUTPATIENT SERVICE COST CENTERS	1.47 0/0		147.0//		
90. 00 09000 CLINIC	147, 360	0			90.00
90. 01 09001 CLINIC - DIABETES	11, 384	0			90.01
91.00 09100 EMERGENCY	189, 358	0		3	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
SPECIAL PURPOSE COST CENTERS		i		1	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 842, 169	0	1, 842, 169	9	118.00
NONREI MBURSABLE COST CENTERS		i	1		
190.0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 326				190.00
192. 0019200 PHYSI CLANS' PRI VATE OFFI CES	254, 867	0			192.00
194. 0007950 OCCUPATI ONAL HEALTH	43, 005	0	43, 005		194.00
194.0207952 BLOOMNGTN AMBULANCE AND OCC MED	39, 491	0	39, 491	1	194.02
194. 0307953 HOME CARE	0	0	(D	194.03
200.00 Cross Foot Adjustments	0	0	(D	200.00
201.00 Negative Cost Centers	0	0	(D	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 198, 858	0	2, 198, 858	3	202.00
		-		-	•

	ncial Systems IND TION - STATISTICAL BASIS	I ANA UNI VERSI TY	Provider C	CN: 15-1328 F	Period:	<u>of Form CMS-</u> Worksheet B-1	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	epar
		CAPI TAL REL	ATED COSTS		12/01/2020	7/14/2021 11:	
	Cost Center Description	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE	Reconciliation		-
		(SQUARE FEET)	(SQUARE FEET)	BENEFI TS DEPARTMENT		& GENERAL (ACCUM. COST)	
				(GROSS		(ACCOM. COST)	
				SALARI ES)			
la ENER		1.00	2.00	4.00	5A	5.00	-
	AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	167, 529			1		1
	CAP REL COSTS-MVBLE EQUIP	107, 327	123, 557				2
	EMPLOYEE BENEFITS DEPARTMENT	526	526	17, 585, 826	þ		4
	ADMI NI STRATI VE & GENERAL	24, 540	24, 540	1, 239, 580	-15, 217, 414	43, 789, 125	5
	OPERATION OF PLANT	18, 537	18, 537	674, 708		2, 277, 628	
	LAUNDRY & LINEN SERVICE	794	794		-	150, 357	
	HOUSEKEEPI NG DI ETARY	1, 815 3, 925		422, 556 373, 097		737, 973 743, 320	
	CAFETERIA	2, 062	2,062	64, 396		96, 684	
	NURSING ADMINI STRATI ON	5, 646		1, 489, 448		2, 166, 074	
	CENTRAL SERVICES & SUPPLY	4, 466		60, 344		1, 241, 922	
00 01500	PHARMACY	1, 267	1, 267	603, 912	0	1, 398, 067	15
	SOCI AL SERVI CE	148	148	52, 291	0	66, 706	17
	I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	8, 932	8, 932	2, 429, 526	0	3, 522, 779	30
	INTENSIVE CARE UNIT	2, 341	8, 932 2, 341	1, 343, 322		1, 852, 445	
ANCI L	LARY SERVICE COST CENTERS						
	OPERATING ROOM	11, 038		1, 165, 411		1, 372, 877	
	RECOVERY ROOM	0	0	333, 715		432, 745	
	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	4, 925	4, 925 0	989, 200 93, 986		1, 666, 417 214, 617	
	CT SCAN	1, 011	1, 011	362, 636		504, 739	
00 05800		1, 073		225, 151		325, 652	
00 06000	LABORATORY	4, 644	4, 644	296, 159		3, 717, 946	
	RESPI RATORY THERAPY	2, 164		759, 886		967, 230	
	PHYSI CAL THERAPY	2, 291	2, 291	637, 681		997, 517	
		1, 127	1, 127	356, 856 69, 406		473, 753	
	SPEECH PATHOLOGY ELECTROCARDI OLOGY	266 4, 932	266 4, 932	276, 118		94, 282 928, 184	
	MEDICAL SUPPLIES CHARGED TO PATIENT	4, 732	4, 732	270, 110		204, 949	
	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	95, 209	
00 07300	DRUGS CHARGED TO PATIENTS	0	0	C	0 0	11, 910, 252	73
	CARDIAC REHABILITATION	421	421	58, 023	3 0	89, 961	76
	TIENT SERVICE COST CENTERS	6, 123	6, 123	882, 127	/ 0	1, 331, 752	90
	CLINIC - DIABETES	535	535	16, 642	1 1	99, 934	
	EMERGENCY	4, 917		2, 082, 350		3, 502, 236	
	OBSERVATION BEDS (NON-DISTINCT PART						92
<u>SPECI</u> 3. 00	AL PURPOSE COST CENTERS	120 444	120 444	17, 358, 527	15 017 414	42 104 207	110
	SUBTOTALS (SUM OF LINES 1 through 117)	120, 466	120, 466	17, 336, 327	-15, 217, 414	43, 184, 207	110
). 0019000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	960		18, 713	3 0	39, 403	
	PHYSICIANS' PRIVATE OFFICES	38, 421		(, (0	213, 653	
	OCCUPATIONAL HEALTH	2, 131	2, 131	48, 740		122, 999	
	BLOOMNGTN AMBULANCE AND OCC MED HOME CARE	5, 551	0	159, 846		228, 863	194
i. 0307953). 00	Cross Foot Adjustments	0	0	(í í	0	200
. 00	Negative Cost Centers						201
2. 00	Cost to be allocated (per Wkst. B, Pa	rt 663, 323	1, 535, 535	4, 032, 243	3	15, 217, 414	
2 00) nit cost multiplier (Wkst B Part `	3 050/50	10 107714	0 220200		0 247514	202
3. 00 1. 00	Unit cost multiplier (Wkst. B, Part) Cost to be allocated (per Wkst. B, Par		12. 427746			0. 347516 402, 749	
r. UU	(Lost to be allocated (per wkst. B, Par [1])			8, 620	í l	402,749	204
5. 00	Unit cost multiplier (Wkst. B, Part II			0. 000490		0. 009197	205
5. 00	NAHE adjustment amount to be allocated						206
1	(per Wkst. B-2)						1
7.00	NAHE unit cost multiplier (Wkst. D,						207

		ANA UNI VERSI TY	/ HEALTH BEDFO	RD	In Lieu	of Form CMS-2	2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2020	Worksheet B-1	1
				ľτ			
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7/14/2021 11: CAFETERI A	18 am
	bost benter bescription	PLANT			(MEALS SERVED)	(FTE)	
		(SQUARE FEET)	(POUNDS OF	. ,	` ´		
			LAUNDR)				
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	123, 926					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	794	234, 920	77 045			8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 815 3, 925	0	77, 345 3, 925			9.00 10.00
10.00	01100 CAFETERI A	2,062	0	2, 062	44,733	217	
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 646	0	5, 646	Ű	16	
14.00	01400 CENTRAL SERVICES & SUPPLY	4, 466	0	4, 466	0	2	14.00
15.00	01500 PHARMACY	1, 267	0	1, 267	0	7	15.00
17.00		148	0	148	0	1	17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.000	00.744	0.000	20.7/0	20	20.00
30.00 31.00		8, 932 2, 341	83, 744 35, 982	8, 932 2, 341	32, 760 11, 973	39 16	
31.00	ANCI LLARY SERVICE COST CENTERS	2, 341	30, 902	2, 341	11,973	10	31.00
50.00	05000 OPERATI NG ROOM	11, 038	41, 973	11, 038	0	12	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	4	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 925	0	4, 925	0	13	54.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	1	
57.00		1,011	0	1,011	0	6	
58.00 60.00	05800 MRI 06000 LABORATORY	1, 073 4, 644	0	1, 073 4, 644		3 19	
65.00	06500 RESPI RATORY THERAPY	4, 044 2, 164	0	2, 164		19	
66.00	06600 PHYSI CAL THERAPY	2, 104	0	2, 291	0	9	66,00
67.00	06700 OCCUPATI ONAL THERAPY	1, 127	0	1, 127	0	4	67.00
68.00	06800 SPEECH PATHOLOGY	266	0	266	0	1	68.00
69.00		4, 932	0	4, 932	0	4	69.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	
72.00 73.00		0	0	0	0	0 0	
76.97		421	0	421	0	1	76.97
70.77	OUTPATI ENT SERVI CE COST CENTERS	721	0	721	0	•	/0. //
90.00		6, 123	0	6, 123	0	14	90.00
90.01	09001 CLINIC - DIABETES	535	0	535	0	0	90.01
91.00	09100 EMERGENCY	4, 917	73, 221	4, 917	0	29	
92.00							92.00
118.0	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	76, 863	234, 920	74, 254	44, 733	211	118.00
110.0	NONREI MBURSABLE COST CENTERS	70,003	234, 720	74,234	44,733	211	110.00
190. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	0	960	0	1	190.00
192.0	19200 PHYSICIANS' PRIVATE OFFICES	38, 421	0	0	0		192.00
	07950 OCCUPATI ONAL HEALTH	2, 131	0	2, 131	0		194.00
	207952 BLOOMNGTN AMBULANCE AND OCC MED	5, 551	0	0	0		194.02
	307953 HOME CARE	0	0	0	0	0	194.03 200.00
200. 0 201. 0							200.00
201.0		t 3, 069, 140	222, 272	1, 039, 380	1, 151, 587	209,060	
202.0		0,007,110	222,272	1,007,000	1, 101, 007	207,000	202.00
203.0		24. 765909	0. 946160	13. 438231	25.743567	963. 410138	203.00
204.0			16, 478	41, 497	83, 740	41, 225	204.00
	11)						
205.0			0. 070143	0. 536518	1. 871996	189. 976959	
206. 0		1					206.00
207.0	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.0	Parts III and IV)						207.00
			1	I	ı I		1

					eriod:	Worksheet B.	
					rom 01/01/2020 o 12/31/2020	Date/Time Pr	repared
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	SOCI AL SERVI CE	7/14/2021 1	<u>1:18 am</u>
	•	ADMI NI STRATI ON	SERVICES &	(COSTED	(TOTAL PATI		
		(DIRECT NRSING	SUPPLY	REQUIS.)	ENT DAYS)		
		HR)	(COSTED				
		12.00	REQUIS.)	15 00	17.00		
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	17.00		_
	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMI NI STRATI VE & GENERAL						5.0
	00700 OPERATION OF PLANT						7.0
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.0
	01000 DI ETARY						9.0
	01100 CAFETERI A						11.0
	01300 NURSI NG ADMI NI STRATI ON	87					13.00
	01400 CENTRAL SERVICES & SUPPLY	0	1, 258, 614				14.00
	01500 PHARMACY	Ő	73, 471	11, 931, 678			15.00
7.00	01700 SOCI AL SERVI CE	0	0	C	5, 253		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	34	171, 232	4, 884			30.0
	03100 I NTENSI VE CARE UNI T	14	140, 033	3, 210	1, 406		31.00
	ANCI LLARY SERVI CE COST CENTERS	1	70 442	881	0		50.00
	05100 RECOVERY ROOM	4	78, 463 0	001			51.00
	05400 RADI OLOGY-DI AGNOSTI C	- - -	41, 196	4, 458			54.00
	05600 RADI OI SOTOPE	0	1, 613	4, 430 C	-		56.00
	05700 CT SCAN	0	48, 967	739			57.00
	05800 MRI	0	2, 550	C	0		58.00
0.00	06000 LABORATORY	0	11	C	0		60.00
	06500 RESPI RATORY THERAPY	0	144, 958	2, 133	0		65.00
	06600 PHYSI CAL THERAPY	0	9, 344	130			66.00
	06700 OCCUPATI ONAL THERAPY	0	0	C	0		67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0		68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2	30, 467 204, 949		0		69.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	95, 209		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	11, 910, 252	-		73.00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0		76.9
ſ	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	8	0	2, 255	0		90.00
	09001 CLINIC - DIABETES	0	0	C	0		90.0
	09100 EMERGENCY	21	215, 959	2, 736	0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
18.00		07	1 259 422	11 021 679	5 252		118.00
	SUBIDIALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	87	1, 258, 422	11, 931, 678	5, 253		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	0	C	0		192.0
	07950 OCCUPATI ONAL HEALTH	0	74	C	0		194.0
	07952 BLOOMNGTN AMBULANCE AND OCC MED	0	118	C	0		194.0
	07953 HOME CARE	0	0	C	0		194.0
200.00	Cross Foot Adjustments						200.0
201.00	Negative Cost Centers	+ 0.140.004	1 044 057	0.04/ 000	0/ 50/		201.0
202.00	Cost to be allocated (per Wkst. B, Par	t 3, 149, 934	1, 846, 057	2, 046, 829	96, 504		202. 0
203. 00	Unit cost multiplier (Wkst. B, Part I)	26 206 127021	1 166720	0. 171546	10 271216		203. 0
203.00	Cost to be allocated (per Wkst. B, Part)		1. 466738 99, 127	45, 037			203.0
	(1)		77, 127	-5,057	5,721		
205.00	Unit cost multiplier (Wkst. B, Part II) 1, 540. 816092	0. 078759	0.003775	0. 708357		205.0
206.00	NAHE adjustment amount to be allocated						206.0
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,				1 1		207.0

	IANA UNIVERSIT				of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 01/01/2020 Fo 12/31/2020	Worksheet C Part I Date/Time Pre 7/14/2021 11:	epared: 18 am
		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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 602, 079)	7, 602, 079	9 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	3, 681, 982		3, 681, 982	2 0	0	31.00
ANCILLARY SERVICE COST CENTERS	•	•				
50.00 05000 OPERATI NG ROOM	2, 583, 008		2, 583, 008	3 0	0	50.00
51.00 05100 RECOVERY ROOM	731, 810)	731, 810	0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 507, 392		2, 507, 392	2 0	0	54.00
56. 00 05600 RADI OI SOTOPE	292, 529		292, 529	0	0	56.00
57.00 05700 CT SCAN	796, 497		796, 497	0	0	57.00
58. 00 05800 MRI	486, 444		486, 444	1 O	0	58.00
60. 00 06000 LABORATORY	5, 205, 733		5, 205, 733	3 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 608, 646	0	1, 608, 646	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 454, 094		1, 454, 094		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	685, 300	0	685, 300	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	138, 173	0	138, 173	3 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 560, 118		1, 560, 118	3 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	576, 778		576, 778		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	267, 943		267, 943		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18,092,399		18, 092, 399		0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	138, 270		138, 270		0	76.97
OUTPATIENT SERVICE COST CENTERS		•				
90.00 09000 CLINIC	2, 332, 005		2, 332, 005	5 0	0	90.00
90. 01 09001 CLINIC - DIABETES	155, 102		155, 102		0	
91. 00 09100 EMERGENCY	6,081,940		6,081,940		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 863, 313		1, 863, 313		0	
200.00 Subtotal (see instructions)	58, 841, 555				0	200.00
201.00 Less Observation Beds	1, 863, 313		1, 863, 313			201.00
202.00 Total (see instructions)	56, 978, 242					202.00
	1 00, 770, 242	1 0	I 00, 770, 242	-	0	r-02.0

Health Financial Systems INDI	ANA UNI VERSI TY	HEALTH BEDFO	RD	In Lieu	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020		epared: 18 am
			XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	8, 031, 783		8, 031, 78			30.00
31.00 03100 I NTENSI VE CARE UNI T	9, 399, 199		9, 399, 19	9		31.00
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 O5000 OPERATING ROOM	2, 924, 223					
51.00 05100 RECOVERY ROOM	158, 600				0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	744, 896	11, 646, 391			0.000000	
56. 00 05600 RADI OI SOTOPE	164, 845	2, 546, 721	2, 711, 56		0.000000	
57. 00 05700 CT SCAN	644, 194				0.000000	
58.00 05800 MRI	164, 954				0.000000	
60. 00 06000 LABORATORY	3, 627, 528				0.000000	
65.00 06500 RESPI RATORY THERAPY	2, 810, 798				0.000000	
66.00 06600 PHYSI CAL THERAPY	414, 919				0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	433, 680					
68.00 06800 SPEECH PATHOLOGY	67, 755				0.000000	
69. 00 06900 ELECTROCARDI OLOGY	998, 587	8,020,029			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	743, 100	1, 570, 172			0. 000000 0. 000000	
	45, 453					
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 483, 897	61, 774, 104			0. 000000 0. 000000	
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	1, 174, 169	1, 174, 16	9 0. 117760	0.00000	76.97
90. 00 09000 CLINIC	49, 098	12, 790, 702	12, 839, 80	0 0. 181623	0. 000000	90.00
90. 01 09001 CLINIC - DIABETES	49,098	30, 597				
91. 00 09100 EMERGENCY	1, 477, 595					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 927					
200.00 Subtotal (see instructions)	42, 403, 031	198, 790, 257			0.000000	200.00
201. 00 Less Observation Beds	42,403,031	170, 170, 231	241, 173, 20	0		200.00
202.00 Total (see instructions)	42, 403, 031	198, 790, 257	241, 193, 28	8		201.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/14/2021 11:	pare
		Title XVIII	Hospi tal	Cost	<u>10 u</u>
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					[
0. 00 03000 ADULTS & PEDIATRICS					30.
1.00 03100 INTENSIVE CARE UNIT					31.
ANCILLARY SERVICE COST CENTERS					l
0.00 05000 OPERATING ROOM	0. 000000				50.
1.00 05100 RECOVERY ROOM	0. 000000				51.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.
6. 00 05600 RADI OI SOTOPE	0. 000000				56.
7.00 05700 CT SCAN	0. 000000				57.
8. 00 05800 MRI	0. 000000				58.
0. 00 06000 LABORATORY	0. 000000				60.
5. 00 06500 RESPI RATORY THERAPY	0. 000000				65.
6. 00 06600 PHYSI CAL THERAPY	0. 000000				66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.
B. 00 06800 SPEECH PATHOLOGY	0. 000000				68.
9. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.
OUTPATIENT SERVICE COST CENTERS					l I
0. 00 09000 CLINIC	0. 000000				90.
0.01 09001 CLINIC - DIABETES	0. 000000				90.
1.00 09100 EMERGENCY	0. 000000				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					201.
02.00 Total (see instructions)					202.

Health Financial Systems INDI COMPUTATION OF RATIO OF COSTS TO CHARGES		Y HEALTH BEDFO Provider C	CN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/14/2021 11:	epared:
		<u> </u>	e XIX	Hospi tal	Cost	
Orat Oratin December 1 and	Tabal Orat	The survey of the table	Tatal Orata	Costs RCE	Tatal Orata	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 602, 079		7,602,07	79 0	7, 602, 079	30.00
31.00 03100 I NTENSI VE CARE UNI T	3, 681, 982		3, 681, 98	32 0	3, 681, 982	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2, 583, 008		2, 583, 00		2, 583, 008	
51.00 05100 RECOVERY ROOM	731, 810		731, 81		731, 810	
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 507, 392		2, 507, 39		2, 507, 392	
56. 00 05600 RADI OI SOTOPE	292, 529		292, 52		292, 529	
57.00 05700 CT SCAN	796, 497		796, 49		796, 497	
58.00 05800 MRI	486, 444		486, 44		486, 444	
60. 00 06000 LABORATORY	5, 205, 733		5, 205, 73		5, 205, 733	
65. 00 06500 RESPI RATORY THERAPY	1, 608, 646		1, 608, 64		1, 608, 646	
66. 00 06600 PHYSI CAL THERAPY	1, 454, 094		1, 454, 09		1, 454, 094	
67.00 06700 OCCUPATI ONAL THERAPY	685, 300		685, 30		685, 300	
68.00 06800 SPEECH PATHOLOGY	138, 173		138, 17		138, 173	
69. 00 06900 ELECTROCARDI OLOGY	1, 560, 118		1, 560, 11		1, 560, 118	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	576, 778		576, 7		576, 778	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	267, 943		267, 94		267, 943	
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 092, 399		18, 092, 39		18, 092, 399	
76. 97 07697 CARDIAC REHABILITATION	138, 270		138, 27	0 0	138, 270	76.97
OUTPATIENT SERVICE COST CENTERS			-	-		
90. 00 09000 CLINIC	2, 332, 005		2, 332, 00		2, 332, 005	
90.01 09001 CLINIC - DIABETES	155, 102		155, 10		155, 102	
91.00 09100 EMERGENCY	6, 081, 940		6, 081, 94		6, 081, 940	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 863, 313		1, 863, 31		1, 863, 313	
200.00 Subtotal (see instructions)	58, 841, 555		00/011/00		58, 841, 555	
201.00 Less Observation Beds	1, 863, 313		1, 863, 31		1, 863, 313	
202.00 Total (see instructions)	56, 978, 242	0	56, 978, 24	12 0	56, 978, 242	202 00

Health Financial Systems IND	ANA UNI VERSI TY	' HEALTH BEDFO	RD	In Lieu	i of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020		
	-		e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	8, 031, 783		8, 031, 78			30.00
31.00 03100 INTENSIVE CARE UNIT	9, 399, 199		9, 399, 19	19		31.00
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATI NG ROOM	2, 924, 223	18, 650, 186			0. 000000	
51.00 05100 RECOVERY ROOM	158, 600	4, 717, 496	4, 876, 09		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	744, 896	11, 646, 391	12, 391, 28		0. 000000	
56. 00 05600 RADI OI SOTOPE	164, 845	2, 546, 721	2, 711, 56		0. 000000	
57.00 05700 CT SCAN	644, 194	7, 475, 281	8, 119, 47		0. 000000	
58.00 05800 MRI	164, 954	2, 244, 049			0. 000000	
60. 00 06000 LABORATORY	3, 627, 528	15, 370, 383			0. 000000	
65. 00 06500 RESPI RATORY THERAPY	2, 810, 798	2, 969, 951			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	414, 919	2, 228, 131			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	433, 680	866, 656			0. 000000	
68.00 06800 SPEECH PATHOLOGY	67, 755	239, 190			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	998, 587	8, 020, 029			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	743, 100	1, 570, 172			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	45, 453	837, 316			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 483, 897	61, 774, 104			0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1, 174, 169	1, 174, 16	0. 117760	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	49, 098	12, 790, 702			0. 000000	
90.01 09001 CLINIC - DIABETES	0	30, 597			0. 000000	
91.00 09100 EMERGENCY	1, 477, 595	35, 728, 489			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 927	7, 910, 244			0. 000000	
200.00 Subtotal (see instructions)	42, 403, 031	198, 790, 257	241, 193, 28	8		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	42, 403, 031	198, 790, 257	241, 193, 28	8		202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1328	Period: From 01/01/2020	Worksheet C Part I	
			To 12/31/2020	Date/Time Pro 7/14/2021 11	eparec
		Title XIX	Hospi tal	Cost	. 10 an
Cost Center Description	PPS Inpatient	•	• • • • •		Τ
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS					30.0
1.00 03100 INTENSIVE CARE UNIT					31.0
ANCI LLARY SERVI CE COST CENTERS					
0.00 05000 OPERATING ROOM	0. 000000				50.0
1.00 05100 RECOVERY ROOM	0. 000000				51.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.0
6. 00 05600 RADI OI SOTOPE	0. 000000				56.0
7.00 05700 CT SCAN	0. 000000				57.
8.00 05800 MRI	0. 000000				58.0
0.00 06000 LABORATORY	0. 000000				60.
5.00 06500 RESPI RATORY THERAPY	0. 000000				65.
6.00 06600 PHYSI CAL THERAPY	0. 000000				66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.
8.00 06800 SPEECH PATHOLOGY	0. 000000				68.
9.00 06900 ELECTROCARDI OLOGY	0. 000000				69.
1.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 000000				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.
OUTPATIENT SERVICE COST CENTERS	0, 000000				
0. 00 09000 CLINIC - DIABETES	0. 000000				90. 90.
1. 00 09100 EMERGENCY	0. 000000				90.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				91.
00.00 Subtotal (see instructions)	0.000000				200.
01.00 Less Observation Beds					200.
02.00 Total (see instructions)	1				201. 202.

Health Financial Systems INDI	ANA UNIVERSITY	' HEALTH BEDFO	RD	In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020		
			XVIII	Hospi tal	Cost	
Cost Center Description (apital Relate	Notal Charges	Ratio of Cos [.]	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	Wkst. B, Part			. Charges	column 4)	
	II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATI NG ROOM	246, 523					
51.00 O5100 RECOVERY ROOM	11, 067	4, 876, 096				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	117, 810					
56. 00 05600 RADI OI SOTOPE	2, 337	2, 711, 566				56.00
57.00 05700 CT SCAN	29, 581	8, 119, 475				
58.00 05800 MRI	24, 849	2, 409, 003				
60. 00 06000 LABORATORY	128, 725	18, 997, 911				60.00
65. 00 06500 RESPI RATORY THERAPY	64, 892	5, 780, 749				
66. 00 06600 PHYSI CAL THERAPY	56, 713	2, 643, 050				
67.00 06700 OCCUPATI ONAL THERAPY	27, 321	1, 300, 336				
68.00 06800 SPEECH PATHOLOGY	6, 291	306, 945				
69. 00 06900 ELECTROCARDI OLOGY	111, 318	9, 018, 616				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 027	2, 313, 272				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 375	882, 769				
73.00 07300 DRUGS CHARGED TO PATIENTS	154, 518				8, 941	
76. 97 07697 CARDI AC REHABI LI TATI ON	9, 274	1, 174, 169	0. 00789	8 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			-		-	
90. 00 09000 CLINIC	147, 360				14	
90. 01 09001 CLINIC - DIABETES	11, 384	30, 597			0	90.01
91.00 09100 EMERGENCY	189, 358				380	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	86, 132	7, 928, 171				92.00
200.00 Total (lines 50 through 199)	1, 451, 855	223, 762, 306		10, 121, 662	69, 082	200.00

Health Financial Systems	NDIANA UNIVERSIT	Y HEALTH BEDFO	RD	In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR THROUGH COSTS	Y SERVICE OTHER P	ASS Provider (F	Period: From 01/01/2020 Fo 12/31/2020	Worksheet D Part IV Date/Time Pre 7/14/2021 11:	epared: 18 am
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physi ci an	Nursi ng School	Nursi ng Schoo	IAIIied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	C	C) (0 0	0	50.00
51.00 05100 RECOVERY ROOM	C	C) (0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	C) (0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	C	C) (0 0	0	56.00
57.00 05700 CT SCAN	C	C) (0 0	0	57.00
58.00 05800 MRI	C	0) (0 0	0	58.00
60. 00 06000 LABORATORY	C	0) (0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	C	C		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	C	c c		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	C) C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	C) C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	C	c c		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	г с	c c		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	c c		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	c c		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		•	•			
90, 00 09000 CLINIC	C)) (0 0	0	90.00
90. 01 09001 CLINIC - DIABETES	0	c c		0 0	0	90.01
91. 00 09100 EMERGENCY	0			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	г с		(D	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
				•		

Health Financial Systems IN	DIANA UNIVERSIT	Y HEALTH BEDFO	RD	In Lieu	ı of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER P.		F	Period: From 01/01/2020 Fo 12/31/2020	Worksheet D Part IV Date/Time Pre 7/14/2021 11:	epared: 18 am
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0	0	21, 574, 409	0. 000000	
51.00 05100 RECOVERY ROOM	0	0	0	4, 876, 096		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	12, 391, 287	0. 000000	
56. 00 05600 RADI 0I SOTOPE	0	0	0	2, 711, 566		
57.00 05700 CT SCAN	0	0	0	8, 119, 475	0. 000000	
58. 00 05800 MRI	0	0	0	2, 409, 003		
60. 00 06000 LABORATORY	0	0	0	18, 997, 911	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	0	5, 780, 749	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	0	2, 643, 050	0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 300, 336		
68.00 06800 SPEECH PATHOLOGY	0	0	0	306, 945	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	9, 018, 616	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2, 313, 272	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	882, 769		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	71, 258, 001	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0 1, 174, 169	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS	-	-				
90. 00 09000 CLINIC	0	0	0	12, 839, 800	0. 000000	
90.01 09001 CLINIC - DIABETES	0	0	0	30, 597	0. 000000	
91.00 09100 EMERGENCY	0	0	0	37, 206, 084		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7, 928, 171	0. 000000	
200.00 Total (lines 50 through 199)	0	0	C C	223, 762, 306		200.00

Health Financial Systems	DIANA UNIVERSITY H	HEALTH BEDFO	RD	In Lieu	」of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	SERVICE OTHER PASS	S Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 7/14/2021 11:	epared: 18 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS			_			
50.00 05000 OPERATI NG ROOM	0. 000000	886, 900		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	37, 088		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	333, 765		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	106, 732		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	199, 001		0 0	0	57.00
58. 00 05800 MRI	0. 000000	65, 770		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	1, 690, 389		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 335, 131		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	218, 028		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	222, 982		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	34, 084		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	477, 210		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	308, 230		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 627		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 124, 221		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	1, 241		0 0	-	90.00
90.01 09001 CLINIC - DIABETES	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 000000	74, 707		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	4, 556		0 0	0	92.00
200.00 Total (lines 50 through 199)		10, 121, 662	l	0 0	0	200.00

Health Financial Systems IND	I ANA UNI VERSI T	Y HEALTH BEDFO	RD	In Lieu	」of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COS	T Provider C	CN: 15-1328	Period:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part V	narod
				10 12/31/2020	Date/Time Pre 7/14/2021 11:	18 am
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
				. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	•	r	r	-		
50.00 05000 OPERATING ROOM	0. 119726	0	.,		0	
51.00 05100 RECOVERY ROOM	0. 150081	0	1, 122, 74		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 202351	0	2, 897, 95		0	011.00
56. 00 05600 RADI OI SOTOPE	0. 107882		878, 05		0	56.00
57.00 05700 CT SCAN	0. 098097		2, 657, 28		0	57.00
58. 00 05800 MRI	0. 201928		708, 04		0	
60. 00 06000 LABORATORY	0. 274016		4, 635, 46		0	
65. 00 06500 RESPI RATORY THERAPY	0. 278276		1, 128, 57		0	
66.00 06600 PHYSI CAL THERAPY	0. 550158		659, 20		0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 527018		212, 03		0	
68.00 06800 SPEECH PATHOLOGY	0. 450156		34, 78		0	
69.00 06900 ELECTROCARDI OLOGY	0. 172989		2, 475, 73		0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 249334		334, 77		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 303526		118, 31		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 253900					
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 117760	0	552, 14	3 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	0.101/00		F 400.00			
90. 00 09000 CLINIC	0. 181623		-,,		0	
90. 01 09001 CLINIC - DIABETES	5.069190				0	
91.00 09100 EMERGENCY	0. 163466		10, 420, 83			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 235024	0	3, 220, 54		0	
200.00 Subtotal (see instructions)		0	69, 693, 62	7 10, 632		200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges			40 402 42	7 10 422	0	000 00
202.00 Net Charges (line 200 - line 201)	I	0	69, 693, 62	7 10, 632	0	202.00

Health Financial Systems INDI	ancial Systems INDIANA UNIVERSITY HEALTH BEDFORD					In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provider C	CN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pro 7/14/2021 11	epared: :18 am			
		Title	XVIII	Hospi tal	Cost				
· · · · · · · · · · · · · · · · · · ·	ubject To Ded.S & Coins. (see inst.) De	Cost Reimbursed ervices Not Subject To ed. & Coins. (see inst.) 7.00							
ANCILLARY SERVICE COST CENTERS									
ANOTELEATION Service Cost 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 56.00 05600 RADI OLOGY-DI AGNOSTI C 56.00 05600 RADI OLOGY-DI AGNOSTI C 57.00 05700 CT SCAN 58.00 05800 MRI 60.00 06000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 76.97 07697 CARDI AC REHABI LI TATI ON	508, 323 168, 503 586, 405 94, 726 260, 671 142, 975 1, 270, 192 314, 056 362, 667 111, 746 15, 657 428, 274 83, 470 35, 912 7, 104, 873 65, 020	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50.00 51.00 54.00 56.00 57.00 58.00 60.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.97			
OUTPATIENT SERVICE COST CENTERS	00, 020					/0. //			
90.0009000CLINIC90.0109001CLINIC - DIABETES91.0009100EMERGENCY92.00092000BSERVATION BEDS (NON-DISTINCT PART200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program Only Charges	981, 491 22, 548 1, 703, 453 756, 906 15, 017, 868 0	0 930 0 2, 184				90.00 90.01 91.00 92.00 200.00 201.00			
202.00 Net Charges (line 200 - line 201)	15, 017, 868	2, 184				202.00			

Health Fina	ncial Systems IND	I ANA UNI VERSI T	Y HEALTH BEDFO	RD	In Lieu	u of Form CMS-2	2552-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COS	T Provider C	CN: 15-1328	Period:	Worksheet D	
			Component		From 01/01/2020 To 12/31/2020	Part V Date/Time Pre	epared.
						Date/Time Pre 7/14/2021 11:	18 am
			Title		wing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
					Ded. & Coins.		
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
	LARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	OPERATING ROOM	0. 119726	0	(0	0	50.00
	RECOVERY ROOM	0. 150081	0			0	
	RADI OLOGY-DI AGNOSTI C	0. 202351	0			0	
	RADI OI SOTOPE	0. 107882	0		0 0	0	
	CT SCAN	0. 098097	0		0 0	0	
58.00 05800		0. 201928	0		0 0	0	
	LABORATORY	0. 274016		(0 0	0	
65.00 06500	RESPIRATORY THERAPY	0. 278276		(0 0	0	65.00
	PHYSI CAL THERAPY	0. 550158		(0 0	0	
	OCCUPATIONAL THERAPY	0. 527018		(0 0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0. 450156	0	(0 0	0	68.00
69.00 06900	ELECTROCARDI OLOGY	0. 172989	0	(0 0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 249334	0	(0 0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 303526	0	(0 0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 253900	0	(0 0	0	73.00
	CARDIAC REHABILITATION	0. 117760	0	(0 0	0	76.97
	TIENT SERVICE COST CENTERS				-		
	CLINIC	0. 181623		(0 0	0	
	CLINIC - DIABETES	5. 069190		(0 0	0	
91.00 09100		0. 163466		(0 0	0	
	OBSERVATION BEDS (NON-DISTINCT PART	0. 235024	0	(0 0	0	
200. 00	Subtotal (see instructions)		0	(0 0		200.00
201.00	Less PBP Clinic Lab. Services-Program			(0 0	l	201.00
	Only Charges		_			-	
202.00	Net Charges (line 200 - line 201)	I	0	(0 0	0	202.00

Health Financial Systems IND	ANA UNI VERSI TY	HEALTH BEDFO	RD	In Lieu	i of Form CMS-25	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider C	CN: 15-1328	Period:	Worksheet D	
		Component	CCN: 15-Z328	From 01/01/2020 To 12/31/2020	Part V Date/Time Prep	hared
		component	0011.15 2520	10 12/31/2020	7/14/2021 11: 1	18 am
	-	Title	XVIII	Swing Beds - SNF	Cost	
	Cost	-				
Cost Center Description	ost Reimbursed	Cost				
		Reimbursed				
	ubject To Ded.S					
		Subject To				
		ed. & Coins. (see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
60. 00 06000 LABORATORY	0	0				60.00
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
69.00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0				71.00 72.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS	0	0	r			72.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0				10. 71
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 CLINIC - DIABETES	0	0				90.01
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	0			2	200.00
201.00 Less PBP Clinic Lab. Services-Program	0				2	01.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0			2	202.00

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-1328 Period: Worksheet D-1 From 01/01/2020 То 12/31/2020 Date/Time Prepared: 7/14/2021 11:18 am Title XVIII Hospi tal Cost Cost Center Description 1.00 PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 5,180 1.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 2.00 2.005, 111 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do 0 3.00 not complete this line. Semi-private room days (excluding swing-bed and observation bed days) 4.00 3.847 4.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cest 5.00 42 5.00 reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 6.00 0 6.00 reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 27 7.00 reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.00 reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,928 9.00 newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through 10 00 42 10 00 December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12 00 through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 after 0 13.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14 00 15.00 Total nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 16.00 0 16.00 SWING BED ADJUSTMENT 17 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting 17 00 peri od 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting 18 00 peri od Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting 216.95 19.00 19.00 peri od 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting 0.00 20.00 peri od 21.00 Total general inpatient routine service cost (see instructions) 7,602,079 21 00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (I) ne 5 x 0 22.00 line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x 23.00 0 23.00 line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x 5.858 24.00 line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 0 25.00 line 20) 67,772 26.00 26.00 Total swing-bed cost (see instructions) 7, 5<u>34, 307</u> General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 Private room charges (excluding swing-bed charges) 29 00 0 29 00 30.00 Semi -private room charges (excluding swing-bed charges) 0 30.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 0.00 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33 00 0 00 33 00 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 0 General inpatient routine service cost net of swing-bed cost and private room cost differential (I ne 27, 534, 307 37.00 37 00 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1 474 14 38 00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 2, 842, 142 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,842,142 41.00

	· · · · · · · · · · · · · · · · · · ·	I ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lieu	of Form CN	<u>IS-2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od:	Worksheet	D-1
					rom 01/01/2020 o 12/31/2020	Date/Time	Prepared:
						7/14/2021	11:18 am
	Cost Center Description	Total Inpatient	Total	XVIII Average Per	Hospital Program Days	Program Cos	
	cost center bescription	Cost	npatient Days			(col. 3 x c	
				col. 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
43 00	Intensive Care Type Inpatient Hospital Uni INTENSIVE CARE UNIT	3, 681, 982	1, 406	2, 618. 76	662	1, 733, 6	619 43.00
	CORONARY CARE UNIT	3,001,702	1, 400	2,010.70	002	1,755,0	44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	_
48.00	Program inpatient ancillary service cost (Wkst. D-3, col.	3, line 200)			2, 531, 6	689 48.00
	Total Program inpatient costs (sum of line			ions)		7, 107, 4	450 49.00
	PASS THROUGH COST ADJUSTMENTS						
	Pass through costs applicable to Program i					and III)	0 50.00
51.00	Pass through costs applicable to Program i IV)	npatient ancilla	ary services (from Wkst. D,	sum of Parts	II and	0 51.00
52,00	Total Program excludable cost (sum of line	s 50 and 51)					0 52.00
	Total Program inpatient operating cost exc		related, non-p	hysician anes	thetist, and m	edi cal	0 53.00
	education costs (line 49 minus line 52)	5 1		5			
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	0 54.00
	Target amount per discharge Target amount (line 54 x line 55)					0.	00 55.00
	Difference between adjusted inpatient oper	ating cost and	target amount	(line 56 minu	s line 53)		0 57.00
	Bonus payment (see instructions)	atting cost and	tal got allount				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost	reporting perio	d ending 1996,	updated and	compounded by	the 0.	. 00 59. 00
	market basket						
	Lesser of lines 53/54 or 55 from prior yea						. 00 60. 00
61.00	If line 53/54 is less than the lower of li operating costs (line 53) are less than ex						0 61.00
	56), otherwise enter zero (see instruction		THES 54 X 00),	OF TA OF LINE	target amount	(THE	
62.00	Relief payment (see instructions)						0 62.00
	Allowable Inpatient cost plus incentive pa	yment (see inst	ructions)				0 63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through De	cember 31 of t	he cost repor	ting period (S	ee 61, 9	914 64.00
65 00	Medicare swing-bed SNF inpatient routine c	osts after Dece	mber 31 of the	cost reporti	na period (See		0 65.00
00.00	instructions)(title XVIII only)			0001 10001 11	ing point our (obo		0 001 00
66.00	Total Medicare swing-bed SNF inpatient rou	tine costs (line	e 64 plus line	e 65)(title XV	'III only). For	CAH 61, 9	914 66.00
	(see instructions)						
67.00	Title V or XIX swing-bed NF inpatient rout	ine costs throu	gh December 31	of the cost	reporting peri	od (line	0 67.00
68 00	12 x line 19) Title V or XIX swing-bed NF inpatient rout	ing costs after	December 31 c	of the cost re	norting period	(line	0 68.00
00.00	13 x line 20)		December 31 C	in the cost re	por tring period	(THE	0 00.00
69.00	Total title V or XIX swing-bed NF inpatien	t routine costs	(line 67 + li	ne 68)			0 69.00
	PART III - SKILLED NURSING FACILITY, OTHER						
	Skilled nursing facility/other nursing fac				7)		70.00
	Adjusted general inpatient routine service Program routine service cost (line 9 x lin		(line /0 ÷ lin	ie 2)			71.00 72.00
	Medically necessary private room cost appl	· ·	am (line 14 x	line 35)			72.00
	Total Program general inpatient routine se						74.00
75.00	Capital-related cost allocated to inpatien	t routine servi	ce costs (from	Worksheet B,	Part II, colu	mn 26,	75.00
	line 45)						
	Per diem capital-related costs (line 75 ÷	,					76.00
	Program capital-related costs (line 9 x li Inpatient routine service cost (line 74 mi	,					77.00 78.00
	Aggregate charges to beneficiaries for exc	,	provider reco	ords)			79.00
	Total Program routine service costs for co	•		,	inus line 79)		80.00
	Inpatient routine service cost per diem li						81.00
	Inpatient routine service cost limitation						82.00
	Reasonable inpatient routine service costs Program inpatient ancillary services (see		uns)				83.00 84.00
	Utilization review - physician compensatio	,	ions)				84.00
	Total Program inpatient operating costs (s	um of lines 83	through 85)				86.00
	PART IV - COMPUTATION OF OBSERVATION BED PART	ASS THROUGH COS					
	Total observation bed days (see instructio						264 87.00
	Adjusted general inpatient routine cost pe	•	,				. 14 88. 00
07.00	Observation bed cost (line 87 x line 88) (3)			1,003,3	313 89.00

Health Financial Systems IND	ANA UNI VERSI T	Y HEALTH BEDFO	RD	In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2020	Worksheet D-1		
					Date/Time Pre 7/14/2021 11:	epared: 18 am	
		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	351, 408	7, 602, 079	0. 04622	5 1, 863, 313	86, 132	90.00	
91.00 Nursing School cost	0	7, 602, 079	0. 00000	0 1, 863, 313	0	91.00	
92.00 Allied health cost	0	7, 602, 079	0. 00000	0 1, 863, 313	0	92.00	
93.00 All other Medical Education	0	7,602,079	0. 00000	0 1, 863, 313	0	93.00	

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-1328 Period: Worksheet D-1 From 01/01/2020 То 12/31/2020 Date/Time Prepared: 7/14/2021 11:18 am Title XIX Hospi tal Cost Cost Center Description 1.00 PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 5,180 1.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 2.00 2.005, 111 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do 0 3.00 not complete this line. Semi-private room days (excluding swing-bed and observation bed days) 4.00 3.847 4.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cest 5.00 42 5.00 reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 6.00 0 6.00 reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 27 7.00 reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.00 reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 95 9.00 newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through 10 00 10 00 0 December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12 00 through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 13.00 after 0 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14 00 15.00 Total nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 16.00 0 16.00 SWING BED ADJUSTMENT 17 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting 17 00 peri od 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting 18 00 peri od Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting 216.95 19.00 19.00 peri od 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting 0.00 20.00 peri od 21.00 Total general inpatient routine service cost (see instructions) 7,602,079 21 00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (I) ne 5 x 0 22.00 line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x 23.00 0 23.00 line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x 5.858 24.00 line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 0 25.00 line 20) 67,772 26.00 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 7, 5<u>34, 307</u> 27.00 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 Private room charges (excluding swing-bed charges) 29 00 0 29 00 30.00 Semi -private room charges (excluding swing-bed charges) 0 30.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 0.00 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33 00 0 00 33 00 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 0 General inpatient routine service cost net of swing-bed cost and private room cost differential (I ne 27, 534, 307 37.00 37 00 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1 474 14 38 00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 140,043 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 140,043 41.00 41.00 Total Program general inpatient routine service cost (line 39 + line 40)

		DI ANA UNI VERSI TY				of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO		eriod: rom 01/01/2020	Worksheet D-	1
						Date/Time Pr	
				e XIX	Hospi tal	7/14/2021 11 Cost	:18 am_
	Cost Center Description	Total Inpatien		Average Per	Program Days		
		Cost	Inpatient Days	Diem (col. 1 +		(col. 3 x col.	
		1.00	2.00	col. 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Uni	ts			1 1		42.00
	INTENSIVE CARE UNIT	3, 681, 982	1, 406	2, 618. 76	49	128, 319	
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00 46.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description				•		
10.00			0.11.000			1.00	
	Program inpatient ancillary service cost (Total Program inpatient costs (sum of line			ions)		148, 500 416, 862	
47.00	PASS THROUGH COST ADJUSTMENTS	5 41 through 40		.1013)		410, 802	49.00
	Pass through costs applicable to Program i						50.00
51.00	Pass through costs applicable to Program i	npatient ancill	ary services (from Wkst. D,	sum of Parts I	I and C	51.00
52.00	IV) Total Program excludable cost (sum of line	s 50 and 51)				C	52.00
	Total Program inpatient operating cost exc		related, non-p	hvsi ci an anes	thetist, and me		53.00
	education costs (line 49 minus line 52)	3 - 1		J	,		
F 4 . 0 0	TARGET AMOUNT AND LIMIT COMPUTATION						54.00
	Program discharges Target amount per discharge						0 54.00 0 55.00
	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient oper	ating cost and	target amount	(line 56 minu	s line 53)	C	57.00
	Bonus payment (see instructions)					C	
59.00	Lesser of lines 53/54 or 55 from the cost market basket	reporting perio	d ending 1996,	updated and	compounded by t	:he 0.00	59.00
60, 00	Lesser of lines 53/54 or 55 from prior yea	r cost report.	updated by the	e market baske	t	0.00	60.00
	If line 53/54 is less than the lower of li						
	operating costs (line 53) are less than ex		ines 54 x 60),	or 1% of the	target amount	(line	
62.00	56), otherwise enter zero (see instruction:	s)				(42.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive pa	vment (see inst	ructions)			C	0 62.00 0 63.00
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST		ruetrons)				00.00
64.00	Medicare swing-bed SNF inpatient routine c	osts through De	cember 31 of t	he cost repor	ting period (Se	e (64.00
4E 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine c	anto often Deen	mbor 21 of the	and reporti	na pariod (Saa	(65.00
65.00	instructions) (title XVIII only)	USIS aller Dece		e cost reporti	ng period (see	Ĺ	05.00
66.00	Total Medicare swing-bed SNF inpatient rou	tine costs (lin	e 64 plus line	e 65)(title XV	III only). For	CAH (66.00
	(see instructions)				•		
67.00	Title V or XIX swing-bed NF inpatient rout	ine costs throu	gh December 31	of the cost	reporting peri	od (line C	67.00
68 00	12 x line 19) Title V or XIX swing-bed NF inpatient rout	ine costs after	December 31 o	of the cost re	porting period	(line (68.00
00100	13 x line 20)				por tring por rod	(00100
69.00	Total title V or XIX swing-bed NF inpatien					(69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER				7)		70.00
	Skilled nursing facility/other nursing fac Adjusted general inpatient routine service				/)		70.00 71.00
	Program routine service cost (line 9 x lin						72.00
	Medically necessary private room cost appl	0	•	,			73.00
	Total Program general inpatient routine se	•		· ·	Dort II oolu	nn 24	74.00
75.00	Capital-related cost allocated to inpatien line 45)	t routine servi	ce costs (from	worksneet B,	Part II, colur	in 26,	75.00
76.00	Per diem capital-related costs (line 75 ÷	line 2)					76.00
	Program capital-related costs (line 9 x li	· ·					77.00
	Inpatient routine service cost (line 74 mi			(male)			78.00
	Aggregate charges to beneficiaries for exc Total Program routine service costs for co	•	•		inus line 79)		79.00 80.00
	Inpatient routine service cost per diem li	•					81.00
82.00	Inpatient routine service cost limitation	(line 9 x line					82.00
	Reasonable inpatient routine service costs		ons)				83.00
	Program inpatient ancillary services (see Utilization review - physician compensatio	,	ions)				84.00 85.00
	Total Program inpatient operating costs (s						86.00
	PART IV - COMPUTATION OF OBSERVATION BED P	ASS THROUGH COS					
	Total observation bed days (see instruction Adjusted general inpatient routing cost pa	,	+ line 2)				1 87.00
	Adjusted general inpatient routine cost pe Observation bed cost (line 87 x line 88) (•	,			1, 474. 14 1, 863, 313	
200			- /		1	., 555, 516	

Health Financial Systems IND	ANA UNI VERSI T	Y HEALTH BEDFO	RD	In Lieu	of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2020	Worksheet D-1	
					Date/Time Pre 7/14/2021 11:	epared: 18 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	351, 408	7, 602, 079	0. 04622	5 1, 863, 313	86, 132	90.00
91.00 Nursing School cost	0	7, 602, 079	0.00000	0 1, 863, 313	0	91.00
92.00 Allied health cost	0	7, 602, 079	0. 00000	0 1, 863, 313	0	92.00
93.00 All other Medical Education	0	7,602,079	0. 00000	0 1, 863, 313	0	93.00

Health Financial Systems	NDIANA UNIVERSITY HEALTH BEDFO	RD	In L	ieu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1328	Period:	Worksheet D-	3
			From 01/01/20 To 12/31/20	020 Date/Time Pro	epared [.]
			10 12/01/20	7/14/2021 11	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos			
		To Charges	9	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			4, 020, 0	157	30.00
31. 00 03100 I NTENSI VE CARE UNI T			4, 165, 1		31.00
ANCI LLARY SERVICE COST CENTERS			1,100,1		
50. 00 05000 OPERATI NG ROOM		0. 11972	26 886, 9	00 106, 185	50.00
51.00 05100 RECOVERY ROOM		0. 15008	81 37, 0	88 5, 566	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 2023	51 333, 7	65 67, 538	54.00
56. 00 05600 RADI 0I SOTOPE		0. 1078	82 106, 7	32 11, 514	56.00
57.00 05700 CT SCAN		0. 0980			
58. 00 05800 MRI		0. 20192			
60.00 06000 LABORATORY		0. 2740			1
65. 00 06500 RESPI RATORY THERAPY		0. 2782			
66.00 06600 PHYSI CAL THERAPY		0. 5501			
67.00 06700 OCCUPATI ONAL THERAPY		0. 5270			
68.00 06800 SPEECH PATHOLOGY		0. 4501			68.00
69.00 06900 ELECTROCARDI OLOGY		0. 17298			69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 2493			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 30352			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 25390			
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 11770	50	0 0	76.97
90. 00 09000 CLINIC		0. 1816	23 1, 2	225	90.00
90. 01 09001 CLINIC - DIABETES		5. 06919		0 0	
91. 00 09100 EMERGENCY		0. 16340			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 23502			92.00
200.00 Total (sum of lines 50 through 94 al		0.2000	10, 121, 6		
201.00 Less PBP Clinic Laboratory Services		6	,	0	201.00
202.00 Net charges (line 200 minus line 20			10, 121, 6	62	202.00
	<i>,</i>	I			1 50

Health Financial Systems INDIANA UNIVERSITY H	EALTH BEDFO	RD	In Lieu	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1328	Period:	Worksheet D-3	
	Common and	CON 15 7000	From 01/01/2020		
	Component	CCN: 15-Z328	To 12/31/2020	Date/Time Pre 7/14/2021 11:	18 am
	Title	e XVIII	Swing Beds - SNI	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS			0		31.00
50. 00 05000 OPERATING ROOM		0. 1197:	26 0	0	50.00
51. 00 05100 RECOVERY ROOM		0. 1500		0	
54. 00 105400 RADI OLOGY-DI AGNOSTI C		0. 2023		151	
56. 00 05600 RADI OI SOTOPE		0. 1078		0	
57. 00 05700 CT SCAN		0. 0980		0	57.00
58. 00 05800 MRI		0. 2019		0	58.00
60. 00 06000 LABORATORY		0. 2740	16 3, 572	979	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 2782	76 1, 105	307	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 5501	58 11, 773	6, 477	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 5270	18 23, 247	12, 252	67.00
68.00 06800 SPEECH PATHOLOGY		0. 4501			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1729			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2493			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3035		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2539			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1177	50 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC		0. 1816	02	0	90.00
90. 01 09001 CLINIC - DIABETES		5. 0691		0	
91. 00 09100 EMERGENCY		0. 1634		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2350		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.2000	56, 294		
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61	6	0		201.00
202.00 Net charges (line 200 minus line 201)		1	56, 294		202.00
		•	•	•	•

Health Financial Systems INDIANA UNIVERSITY HE	ALTH BEDFORD	In Lieu	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1328	Period:	Worksheet D-3	
		From 01/01/2020 To 12/31/2020	Date/Time Pre	narod
			7/14/2021 11:	18 am
	Title XIX	Hospi tal	Cost	
Cost Center Description	Ratio of Co		Inpati ent	
	To Charges		Program Costs	
		Charges	(col. 1 x col.	
	1.00	2.00	<u>2)</u> 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		190, 275		30.00
31.00 03100 I NTENSI VE CARE UNI T		270, 168		31.00
ANCI LLARY SERVI CE COST CENTERS	-			
50. 00 05000 OPERATI NG ROOM	0. 1197	26 12, 799	1, 532	50.00
51.00 05100 RECOVERY ROOM	0. 1500	81 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 2023			54.00
56. 00 05600 RADI 0I SOTOPE	0. 1078			
57.00 05700 CT SCAN	0. 0980			57.00
58.00 05800 MRI	0. 2019			
	0. 2740			
65. 00 06500 RESPIRATORY THERAPY	0. 2782			
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0. 5501 0. 5270			
68. 00 06800 SPEECH PATHOLOGY	0. 5270		3, 604	
69. 00 106900 ELECTROCARDI OLOGY	0. 4301			69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 2493			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 3035		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 2539		57,078	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 1177	60 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 1816		0	
90. 01 09001 CLINIC - DIABETES	5. 0691		0	
91.00 09100 EMERGENCY	0. 1634			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 2350		0	12.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		623, 718		200.00 201.00
201.00 Less PBP Clinic Laboratory Services-Program only charge 202.00 Net charges (line 200 minus line 201)		623, 718		201.00 202.00
202. 04 Inter charges (The 200 linhus the 201)	I	025,710	l	202.00

Health Financial Systems INDIANA UNIVERSITY	HEALTH BEDFO	RD	In Lieu	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1328	Period:	Worksheet D-3	3
	Component	CCN: 15-Z328	From 01/01/2020	Date/Time Pre	narod
	Component	CCN. 13-2320		7/14/2021 11:	
	Titl		Swing Beds – SNI	Cost	
Cost Center Description		Ratio of Cos		I npati 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	0		30, 00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
ANCI LLARY SERVICE COST CENTERS			0		31.00
50. 00 05000 OPERATI NG ROOM		0. 1197	26 0	0	50.00
51.00 05100 RECOVERY ROOM		0. 1500		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2023		0	54.00
56. 00 05600 RADI OI SOTOPE		0. 1078	82 0	0	56.00
57.00 05700 CT SCAN		0. 0980	97 0	0	57.00
58. 00 05800 MRI		0. 2019		0	00.00
60. 00 06000 LABORATORY		0. 2740		0	
65. 00 06500 RESPI RATORY THERAPY		0. 2782		0	
66. 00 06600 PHYSI CAL THERAPY		0. 5501		0	
67.00 06700 OCCUPATI ONAL THERAPY		0. 5270		0	
68.00 06800 SPEECH PATHOLOGY		0. 4501		0	
69.00 06900 ELECTROCARDI OLOGY		0. 1729		0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 2493		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3035		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2539		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 1177	60 0	0	76.97
90. 00 09000 CLINIC		0. 1816	23 0	0	90.00
90. 01 09001 CLINIC - DIABETES		5. 0691		0	
91. 00 09100 EMERGENCY		0. 1634		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2350		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.2000	0	-	200.00
201.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61	5	0		201.00
202.00 Net charges (line 200 minus line 201)]	0		202.00
			•	•	

From 01/07/2000 Part B. From 01/07/2000 Part B. From 01/07/2000 Part B. Note of the second secon		Financial Systems INDIANA UNIVERSITY H ATION OF REIMBURSEMENT SETTLEMENT	EALTH BEDFORD Provider CCN: 15-1328	Period:	<u>j of Form CMS-2</u> Worksheet E	2552-10
Title XVIII Hospital Cost PART B HEDICAL AND OTHER HEALTH SERVICES 1.00 1.00 1.00 1.00 Modical and other services (see instructions) 15,020,022 0.00 2.00 Modical and other services reinbursed under OPPS (see instructions) 0.00 0.00 2.00 Derb spaments 0.00				From 01/01/2020	Part B Date/Time Pre	epared:
WAT B. JEDICAL AND OTHER HEALTH SERVICES 10 Medical and other services (see instructions) 15,620,652 12 Medical and other services (see instructions) 0 12 Medical payer 15,620,652 0 Detroft the hospital (see instructions) 0 11 0 Instructions) 0 12 0 Anciliary service other pass through costs from 0kst. D. Pt. IV. col. 13, line 200 0 11 0 Tradit Cost (sum of lines 1 and 10) (see instructions) 15.620,652 12 0 Anciliary service charges 15.620,652 12 0 Anciliary service charges 15.620,652 13 0 Cost and the services on a charge basi is a charge service services on a charge basi is a charge service services on a charge basi is a charge service services on a charge basi is a charge service services on a charge basi is a charge service services on a charge basi is a charge service services on a charge service service service services on a charge service			Title XVIII	Hospi tal		18 am
1.00 Medical and other services (see instructions) 15,020,052 1 0.00 Despinyments (see instructions) 3 0.00 Despinyments (see instructions) 3 0.00 Despinyments (see instructions) 3 0.00 Despinyments (see instructions) 0 0.00 Sim of lines 3, 4, and 4.01, divided by line 6 0 0 0.00 Transitional corticing payment to cost from Mixst. D. Pt. IV, col. 13, line 200 0 0 0.00 Organ acquisitions 15,020,052 15,020,052 0 0 1.00 Total ines 1 and 10,0 (see instructions) 0 0 0 0 0 1.00 Organ acquisitions 0 15,020,052 10 0 10 0 0 10 0 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 0 10 10 10 10					1.00	
2.00 Medical and other services relations dunder QPPS (see instructions) 0 0 0 0.00 Depression 0					15,020,052	1.00
4.00 Outlie'r payment (see instructions) 0 0 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0 0 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0 0 6.00 Une State 0<			uctions)			2.00
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33.00Composite rate ESRD (from Wkst. 1-5, line 11)03334.00All owable bad debts (see instructions)435,5363435.00Adjusted reimbursable bad debts (see instructions)283,0983536.00All owable bad debts for dual eligible beneficiaries (see instructions)-16,7063637.00Subtotal (see instructions)2,631,0543738.00MSP-LCC reconciliation amount from PS&R2,631,0543739.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)03939.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)393939.97Demonstration payment adjustment (see instructions)393939.98Partial or full credits received from manufacturers for replaced devices (see instructions)3939.99RECOVERY OF ACCELERATED DEPRECIATION03940.00Subtotal (see instructions)2,631,0544040.01Sequestration adjustment (see instructions)17,3654040.02Demonstration payment adjustment amount after sequestration404041.00Interim payments-PARHM404142.01Interim payments-PARHM41414143.00Balance due provider/program (see instructions)424243.00Balance due provider/program (see instructions)434344.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744.00Protested amounts (nonallowable cost report items			/ICES)		2, 347, 956	32.00
35.00Adj usted reimbursable bad debts (see instructions)283,0983536.00Allowable bad debts for dual eligible beneficiaries (see instructions)-16,7063637.00Subtotal (see instructions)2,631,0543738.00MSP-LCC reconciliation amount from PS&R03839.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)03939.50Pioneer AC0 demonstration payment adj ustment (see instructions)03939.97Demonstration payment adj ustment amount before sequestration03939.98Partial or full credits received from manufacturers for replaced devices (see instructions)03939.99RECOVERY OF ACCELERATED DEPRECIATION03940.00Subtotal (see instructions)003940.01Sequestration adj ustment amount after sequestration0041.00Interim payments004042.01Tentative settlement (for contractors use only)04043.00Bal ance due provider/program (see instructions)04243.00Bal ance due provider/program -PARHM (see instructions)-577, 4224344.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773, 07744	33.00	Composite rate ESRD (from Wkst. I-5, line 11)				33.00
36.00Allowable bad debts for dual eligible beneficiaries (see instructions)-16,7063637.00Subtotal (see instructions)2,631,0543738.00MSP-LCC reconciliation amount from PS&R03839.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)03939.50Pioneer ACO demonstration payment adjustment (see instructions)393939.97Demonstration payment adjustment amount before sequestration03939.98Partial or full credits received from manufacturers for replaced devices (see instructions)03939.99RECOVERY OF ACCELERATED DEPRECIATION03940.00Subtotal (see instructions)03940.01Sequestration adjustment (see instructions)03941.00Interim payments17,3654041.00Interim payments04041.00Interim payments-PARHM3,191,1114141.01Interim payments-PARHM4142.01Tentative settlement -PARHM (for contractor use only)04243.00Bal ance due provider/program (see instructions)-577,4224344.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744		, , , , , , , , , , , , , , , , , , ,				
38.00MSP-LCC reconciliation amount from PS&R03839.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)03939.50Pioneer ACO demonstration payment adjustment (see instructions)3939.97Demonstration payment adjustment amount before sequestration3939.98Partial or full credits received from manufacturers for replaced devices (see instructions)3939.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)2, 631, 05440.01Sequestration adjustment (see instructions)17, 36540.02Demonstration payment adjustment amount after sequestration040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments3, 191, 11141.01Interim payments (for contractors use only)042.01Tentative settlement (for contractor use only)4243.00Balance due provider/program (see instructions)-577, 42243.01Balance due provider/program -PARHM (see instructions)-577, 42244.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744TO BE COMPLETED BY CONTRACTOR40			structions)			
39.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)03939.50Pioneer ACO demonstration payment adjustment (see instructions)3939.97Demonstration payment adjustment amount before sequestration039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)2, 631, 0544040.01Sequestration adjustment (see instructions)17, 3654040.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs3, 191, 1114141.00Interim payments - PARHM3, 191, 1114142.00Tentative settlement (for contractors use only)424243.00Bal ance due provi der/program (see instructions)-577, 4224343.01Bal ance due provi der/program -PARHM (see instructions)-577, 4224344.00Protested amounts (nonal I owable cost report i tems) in accordance with CMS Pub. 15-2, chapter 1, \$115.2773, 07744		, , , , , , , , , , , , , , , , , , ,				
39. 50Pioneer ACO demonstration payment adjustment (see instructions)3939. 97Demonstration payment adjustment amount before sequestration039. 98Partial or full credits received from manufacturers for replaced devices (see instructions)039. 99RECOVERY OF ACCELERATED DEPRECIATION040. 00Subtotal (see instructions)040. 01Sequestration adjustment (see instructions)17,36540. 02Demonstration payment adjustment amount after sequestration040. 03Sequestration adjustment -PARHM pass-throughs041. 00Interim payments3, 191, 11141. 01Interim payments3, 191, 11141. 02Tentative settlement (for contractors use only)042. 01Tentative settlement-PARHM (for contractor use only)4343. 00Bal ance due provider/program (see instructions)-577, 42243. 00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773, 07744						38.00 39.00
39.98Partial or full credits received from manufacturers for replaced devices (see instructions)03939.99RECOVERY OF ACCELERATED DEPRECIATION03940.00Subtotal (see instructions)2,631,0544040.01Sequestration adjustment (see instructions)17,3654040.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs404041.00Interim payments3,191,1114141.01Interim payments-PARHM4142.00Tentative settlement (for contractors use only)4243.00Bal ance due provider/program (see instructions)-577,42243.00Protested amounts (nonal lowabl e cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744	39.50	Pioneer ACO demonstration payment adjustment (see instruction				39.50
39.99RECOVERY OF ACCELERATED DEPRECIATION03940.00Subtotal (see instructions)2,631,0544040.01Sequestration adjustment (see instructions)17,3654040.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments3,191,1114141.01Interim payments3,191,1114142.00Tentative settlement (for contractors use only)04242.01Tentative settlement-PARHM (for contractor use only)4243.00Bal ance due provider/program (see instructions)-577,4224343.01Bal ance due provider/program-PARHM (see instructions)434144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744				ructions)		
40.01Sequestration adjustment (see instructions)17,3654040.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments3,191,11141.01Interim payments-PARHM3,191,11142.00Tentative settlement (for contractors use only)042.01Tentative settlement-PARHM (for contractor use only)043.00Balance due provider/program (see instructions)-577,42243.01Balance due provider/program-PARHM (see instructions)-577,42244.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744TO BE COMPLETED BY CONTRACTOR-						1
40.02Demonstration payment adjustment amount after sequestration04040.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments3, 191, 11141.01Interim payments-PARHM4142.00Tentative settlement (for contractors use only)4242.01Tentative settlement-PARHM (for contractor use only)4243.00Bal ance due provider/program (see instructions)-577, 42243.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773, 07744TO BE COMPLETED BY CONTRACTOR40						
40.03Sequestration adjustment-PARHM pass-throughs4041.00Interim payments3, 191, 11141.01Interim payments-PARHM4142.00Tentative settlement (for contractors use only)4242.01Tentative settlement-PARHM (for contractor use only)4243.00Bal ance due provider/program (see instructions)-577, 42243.01Bal ance due provider/program-PARHM (see instructions)-577, 42244.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773, 07744TO BE COMPLETED BY CONTRACTOR43					-	
41.01Interim payments-PARHM4142.00Tentative settlement (for contractors use only)4242.01Tentative settlement-PARHM (for contractor use only)4243.00Bal ance due provider/program (see instructions)-577, 42243.01Bal ance due provider/program-PARHM (see instructions)-577, 42244.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744	40.03	Sequestration adjustment-PARHM pass-throughs			Ū	40.03
42.00Tentative settlement (for contractors use only)04242.01Tentative settlement-PARHM (for contractor use only)4243.00Bal ance due provider/program (see instructions)-577, 42243.01Bal ance due provider/program-PARHM (see instructions)-577, 42244.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744TO BE COMPLETED BY CONTRACTOR44		1 5			3, 191, 111	41.00
42.01Tentative settlement-PARHM (for contractor use only)4243.00Balance due provider/program (see instructions)-577,42243.01Balance due provider/program-PARHM (see instructions)4344.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2773,07744TO BE COMPLETED BY CONTRACTOR44					0	41.01
43.01 Balance due provider/program-PARHM (see instructions) 43 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 773,077 44 TO BE COMPLETED BY CONTRACTOR 43	42.01	Tentative settlement-PARHM (for contractor use only)				42.01
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §1 5.2 773,077 44 TO BE COMPLETED BY CONTRACTOR					-577,422	43.00
		Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-	2, chapter 1, §1	15.2 773,077	1
	90 00				0	90.00
)			90.00
92.00 The rate used to calculate the Time Value of Money 0.00 92		3				
						93.00 94.00

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part I Date/Time Pre	
					7/14/2021 11:	18
			XVIII	Hospi tal	Cost	1
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4,00	
00	Total interim payments paid to provider	1100	6, 102, 58		3, 191, 111	1
00	Interim payments payable on individual bills, either			0	0	
	submitted or to be submitted to the contractor for servic	es				
	rendered in the cost reporting period. If none, write "N					
	or enter a zero					
00	List separately each retroactive lump sum adjustment amou					3
	based on subsequent revision of the interim rate for the					
	reporting period. Also show date of each payment. If none	ı				
	write "NONE" or enter a zero. (1)					
)1	Program to Provider ADJUSTMENTS TO PROVIDER		i	0	0	3
)2	ADJUSTMENTS TO PROVIDER			0	0	-
)2)3				0	0	
)4				0	0	
)5				0	0	
-	Provider to Program			-		
0	ADJUSTMENTS TO PROGRAM			0	0	3
1				0	0	:
52				0	0	
53				0	0	
54				0	0	-
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		6, 102, 58	24	3, 191, 111	4
0	(transfer to Wkst. E or Wkst. E-3, line and column as		0, 102, 50	94	3, 191, 111	4
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
0	List separately each tentative settlement payment after d	esk				1
	review. Also show date of each payment. If none, write "N	ONE"				
	or enter a zero. (1)					
	Program to Provider		i	-		
1	TENTATI VE TO PROVI DER			0	0	
)2)3				0	0	
3	Provider to Program			U	0	
0	TENTATI VE TO PROGRAM		1	0	0	5
51				0	0	
2				0	0	
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	Ę
	5. 50-5. 98)					
0	Determined net settlement amount (balance due) based on t	he				6
	cost report. (1)					1
)1	SETTLEMENT TO PROVIDER		355, 90)9	0	
)2	SETTLEMENT TO PROGRAM		/ 450 10	0	577, 422	
00	Total Medicare program liability (see instructions)		6, 458, 49	Contractor	2,613,689 NPR Date	7
				Number	(Mo/Day/Yr)	
		()	1,00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		er CCN:15	F	eriod: rom 01/01/2020		
		Compone	ent CCN:1	5-Z328 T	o 12/31/2020	Date/Time Pr 7/14/2021 11	repare
		Ti	tle XVI	l Sv	ing Beds - SNI		
		Inpat	tient Par	rt A	Par	t B	
		mm/dd/yyy	yy A	Amount	mm/dd/yyyy	Amount	
		1.00		2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for service rendered in the cost reporting period. If none, write "No or enter a zero List separately each retroactive lump sum adjustment amoun based on subsequent revision of the interim rate for the	DNE" nt		85, 889 0			0 1. 0 2. 3.
	reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider					ı	
01	ADJUSTMENTS TO PROVIDER			0		(0 3
02				0			0 3
03 04				0			0 3 0 3
04 05				0			0 3
-	Provider to Program						
0	ADJUSTMENTS TO PROGRAM			0			0 3
51 52				0			0 3 0 3
52 53				0			0 3
54				0			0 3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		(0 3
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)			85, 889		(0 4
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after de review. Also show date of each payment. If none, write "No	esk DNE''					5
	or enter a zero. (1)						
)1	Program to Provider TENTATIVE TO PROVIDER		-	0	i		0 5
)2				0			0 5
03				0		(0 5
	Provider to Program						
50 51	TENTATIVE TO PROGRAM			0			0 5 0 5
52				0			0 5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		(0 5
0	5.50-5.98) Determined net settlement amount (balance due) based on th cost report. (1)	ne					6
01	SETTLEMENT TO PROVIDER			Ω			0 6
02	SETTLEMENT TO PROGRAM			2, 588			0 6
JZ	Total Medicare program liability (see instructions)			83, 301			0 7
00					Contractor	NPR Date	
					Number	(Mo/Day/Yr)	

Health Financial Systems INDIANA UNIVER	SITY HEALTH BEDFORD	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020	Worksheet E- Part II Date/Time Pr 7/14/2021 1	repared:
	Title XVIII	Hospi tal	Cost	
			1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REF				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALC				
1.00 Total hospital discharges as defined in AARA §4102 fro		ine 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, o				6.00
7.00 CAH only - The reasonable cost incurred for the purcha	ase of certified HII technolo	gy Wkst. S-2, Pt.	I line	7.00
8.00 Calculation of the HIT incentive payment (see instruct	tions)			8.00
9.00 Sequestration adjustment amount (see instructions)				9.00
10.00 Calculation of the HIT incentive payment after sequest	tration (see instructions)			10.00
I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				
30.00 Initial/interim HIT payment adjustment (see instruction	ons)			30.00
31.00 Other Adjustment (specify)				31.00
32.00 Balance due provider (line 8 (or line 10) minus line 3	30 and line 31) (see instruct	i ons)		32.00

ALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1328			2
		Period: From 01/01/2020	Worksheet E-2 Date/Time Pre	
		To 12/31/2020	7/14/2021 11:	
	Title XVIII S	wing Beds - SNF Part A	Cost Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES	222)	40 500	0	1 1 00
.00 Inpatient routine services - swing bed-SNF (see instructi 2.00 Inpatient routine services - swing bed-NF (see instruction		62, 533	0	1.00
.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for	⁻ Part A, and sum of Wkst. I) Part 25,017	0	
V, cols. 6 and 7, line 202, for Part B) (For CAH and swin instructions)	ng-bed pass-through, see			
8.01 Nursing and allied health payment-PARHM (see instructions	5)			3. 01
.00 Per diem cost for interns and residents not in approved t	teaching program (see instru	· · ·	0.00	
 00 Program days 00 Interns and residents not in approved teaching program (s 	see instructions)	42	0	
.00 Utilization review - physician compensation - SNF optiona		0		7.00
 00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 00 Primary payer payments (see instructions) 		87, 550	0	
0.00 Primary payer payments (see instructions) 0.00 Subtotal (line 8 minus line 9)		87, 550	0	
1.00 Deductibles billed to program patients (exclude amounts a	applicable to physician	0	0	11.00
professional services) 2.00 Subtotal (line 10 minus line 11)		87, 550	0	12.00
3.00 Coinsurance billed to program patients (from provider rec	cords) (excl ude coi nsurance		0	
physi ci an professi onal servi ces)				
4.00 80% of Part B costs (line 12 x 80%) 5.00 Subtotal (see instructions)		83, 854	0	
6.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		03,034	0	
6.50 Pioneer ACO demonstration payment adjustment (see instruc				16.50
6.55 Rural community hospital demonstration project (§410A Dem (see instructions)	nonstration) payment adjustr	nent O		16.55
6.99 Demonstration payment adjustment amount before sequestrat	tion	0	0	-
7.00 Allowable bad debts (see instructions)7.01 Adjusted reimbursable bad debts (see instructions)		0	0	
8.00 Allowable bad debts for dual eligible beneficiaries (see	instructions)	0	0	
9.00 Total (see instructions)		83, 854	0	
9.01 Sequestration adjustment (see instructions)9.02 Demonstration payment adjustment amount after sequestrati	on)	553 0	0	
9.03 Sequestration adjustment-PARHM pass-throughs		J J	0	19.03
0.00 Interim payments		85, 889	0	20.00
0.01 Interim payments-PARHM 1.00 Tentative settlement (for contractor use only)		0	0	20.01
1.01 Tentative settlement-PARHM (for contractor use only)				21.01
 Balance due provider/program (line 19 minus lines 19.01, Balance due provider/program-PARHM (see instructions) 	20, and 21)	-2, 588	0	22.00
3.00 Protested amounts (nonallowable cost report items) in acc	cordance with CMS Pub. 15-2.	4, 461	0	22.01
chapter 1, §115.2				
Rural Community Hospital Demonstration Project (§410A Dem 00.00 Is this the first year of the current 5-year demonstratio				200. OC
Cures Act? Enter "Y" for yes or "N" for no.	in period under the 21st cer	itur y		200.00
Cost Reimbursement				001 00
01.00 Medicare swing-bed SNF inpatient routine service costs (f (title XVIII hospital))	FOM WKSL. D-1, PL. II, IING	60		201.00
02.00 Medicare swing-bed SNF inpatient ancillary service costs	(from Wkst. D-3, col. 3, li	ne 200		202.00
(title XVIII swing-bed SNF)) 03.00 Total (sum of lines 201 and 202)				203.00
04.00 Medicare swing-bed SNF discharges (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/	'A in first year of the curi	rent 5-year		
demonstration period) 05.00 Medicare swing-bed SNF target amount		1 1		205.00
06.00 Medicare swing-bed SNF inpatient routine cost cap (line 2				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Rei		1 1		
07.00 Program reimbursement under the §410A Demonstration (see 08.00 Medicare swing-bed SNF inpatient service costs (from Wkst		s 1 and		207.00 208.00
3)				
09.00 Adjustment to Medicare swing-bed SNF PPS payments (see in 10.00 Reserved for future use	nstructions)			209. 00 210. 00
		<u> </u>		∠ 10. UU
Comparision of PPS versus Cost Reimbursement 15.00 Total adjustment to Medicare swing-bed SNF PPS payment (I				

LCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1328	Peri od:	Worksheet E	<u>-2552-1</u> -2
	Component CCN: 15-Z328	From 01/01/2020 To 12/31/2020		
	Title XIX	Swing Beds - SN		
		Part A 1.00	Part B 2.00	
COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
00 Inpatient routine services - swing bed-SNF (see instruc	ctions)	0		1.00
00 Inpatient routine services - swing bed-NF (see instruct		0		2.00
00 Ancillary services (from Wkst. D-3, col. 3, line 200, f		D, Part O		3.00
V, cols. 6 and 7, line 202, for Part B) (For CAH and sw instructions)	wing-bed pass-through, see			
01 Nursing and allied health payment-PARHM (see instruction	ons)			3. 01
00 Per diem cost for interns and residents not in approved	d teaching program (see inst	ructions) 0.00		4.00
00 Program days		0		5.00
00 Interns and residents not in approved teaching program 00 Utilization review - physician compensation - SNF optic				6.00 7.00
00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	mar method onry	0		8.00
00 Primary payer payments (see instructions)		0		9.00
0.00 Subtotal (line 8 minus line 9)		0		10.00
.00 Deductibles billed to program patients (exclude amounts	s applicable to physician	0		11.00
professional services)				12.00
2.00 Subtotal (line 10 minus line 11) 2.00 Coinsurance billed to program patients (from provider r	ecords) (exclude coinsuranc	e for 0		12.00 13.00
physician professional services)				13.00
.00 80% of Part B costs (line 12 x 80%)		0		14.00
.00 Subtotal (see instructions)		0		15.00
0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
 D Pioneer ACO demonstration payment adjustment (see instructs) Rural community hospital demonstration project (§410A E 		tmont		16.5
(see instructions)	payment aujus			10. 5.
0.99 Demonstration payment adjustment amount before sequestr	ati on	0		16.99
.00 Allowable bad debts (see instructions)		0		17.00
01 Adjusted reimbursable bad debts (see instructions)		0		17.0
 Allowable bad debts for dual eligible beneficiaries (se Total (see instructions) 	e instructions)			18.00 19.00
0.01 Sequestration adjustment (see instructions)				19.0
0.02 Demonstration payment adjustment amount after sequestra	ation)	0		19. 02
0.03 Sequestration adjustment-PARHM pass-throughs				19.03
0.00 Interim payments 0.01 Interim payments-PARHM		0		20.00 20.0
.00 Tentative settlement (for contractor use only)		0		20.0
.01 Tentative settlement-PARHM (for contractor use only)				21.0
.00 Balance due provider/program (line 19 minus lines 19.01	l, 20, and 21)	0		22.00
. 01 Balance due provider/program-PARHM (see instructions)				22.0
c. 00 Protested amounts (nonallowable cost report items) in a chapter 1, §115.2	accordance with CMS Pub. 15-	2, 0		23.00
Rural Community Hospital Demonstration Project (§410A D	emonstration) Adjustment			
0.00 Is this the first year of the current 5-year demonstrat		entury		200.00
Cures Act? Enter "Y" for yes or "N" for no.				
Cost Reimbursement 1.00 Medicare swing-bed SNF inpatient routine service costs	(from West D 1 Pt 11 Li	no 66		201.00
(title XVIII hospital))				201.00
2.00 Medicare swing-bed SNF inpatient ancillary service cost	ts (from Wkst. D-3, col. 3,	line 200		202.00
(title XVIII swing-bed SNF))				
3.00 Total (sum of lines 201 and 202)				203.00
4.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cu	rrent 5-vear		204.00
demonstration period)	with this your of the ou	Front o your		
5.00 Medicare swing-bed SNF target amount				205.00
6.00 Medicare swing-bed SNF inpatient routine cost cap (line				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient F 7.00 Program reimbursement under the §410A Demonstration (se			1	207.00
8.00 Medicare swing-bed SNF inpatient service costs (from W	<i>,</i>	es 1 and		207.00
3)				Γ
9.00 Adjustment to Medicare swing-bed SNF PPS payments (see	instructions)			209.00
0.00 Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement 5.00 Total adjustment to Medicare swing-bed SNF PPS payment	(Line 200 plus Line 210) (c	00	1	215.00
instructions)	(inte 207 plus little 210) (S	~~	1	F 10.00

	Financial Systems INDIANA UNIVERSI ATION OF REIMBURSEMENT SETTLEMENT	TY HEALTH BEDFORD Provider CCN: 15-1328	Period:	of Form CMS-2 Worksheet E-3	
LOOL			From 01/01/2020	Part V	
			To 12/31/2020	Date/Time Prep 7/14/2021 11:	
		Title XVIII	Hospi tal	Cost	10
		· · ·			
				1.00	
00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MED Inpatient services	JICARE PART A SERVICES - C	USI REIMBURSEMEN	7, 107, 450	1 1
00	Nursing and Allied Health Managed Care payment (see inst	tructions)		0	
00	Organ acquisition			Ő	
00	Subtotal (sum of lines 1 through 3)			7, 107, 450	4
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instruction	ons)		7, 178, 525	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
~~	Reasonable charges				
00	Routine service charges			0	
00 00	Ancillary service charges Organ acquisition charges, net of revenue			0	-
	Total reasonable charges				
. 00	Customary charges			0	
. 00	Aggregate amount actually collected from patients liable	e for payment for services	on a charge basi	s 0	11
	Amounts that would have been realized from patients liab				12
	such payment been made in accordance with 42 CFR 413.13(5		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13
	Total customary charges (see instructions)				
. 00	Excess of customary charges over reasonable cost (comple	ete only if line 14 exceeds	iline 6) (see	0	15
	instructions)				
. 00	Excess of reasonable cost over customary charges (comple	ete only if line 6 exceeds	line 14) (see	0	16
00	instructions) Cast of physicianal convision in a teaching beenitel (cas	i notructi onc)		0	17
. 00	Cost of physicians' services in a teaching hospital (see COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 ''
. 00	Direct graduate medical education payments (from Workshe	et E-4. line 49)		0	118
	Cost of covered services (sum of lines 6, 17 and 18)			7, 178, 525	19
	Deductibles (exclude professional component)			710, 732	
. 00	Excess reasonable cost (from line 16)			0	21
	Subtotal (line 19 minus line 20 and 21)			6, 467, 793	22
	Coi nsurance				
	Subtotal (line 22 minus line 23)			6, 467, 793	
	Allowable bad debts (exclude bad debts for professional	services) (see instruction	is)	51, 706	
	Adjusted reimbursable bad debts (see instructions)			33, 609	
	Allowable bad debts for dual eligible beneficiaries (see	e Instructions)		21, 926	
	Subtotal (sum of lines 24 and 25, or line 26) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			6, 501, 402 0	
	Pioneer ACO demonstration payment adjustment (see instru	ictions)			
	Demonstration payment adjustment amount before sequestra				
	Subtotal (see instructions)			6, 501, 402	
	Sequestration adjustment (see instructions)				
	Demonstration payment adjustment amount after sequestrat	tion			
	Sequestration adjustment-PARHM				30
	Interim payments			6, 102, 584	
	Interim payments-PARHM				31
	Tentative settlement (for contractor use only)			0	
	Tentative settlement-PARHM (for contractor use only)	20.00.01		055 000	32
	Balance due provider/program (line 30 minus lines 30.01,	30.02.31. and 32)		355,909	33
	Bal ance due provider/program-PARHM (lines 2, 3, 18, and		01 and 22 01		33

	E SHEET (If you are nonproprietary and do not maintain fur ting records, complete the General Fund column only)	iu-typevider C	F	eriod: rom 01/01/2020	Worksheet G	
			Т	o 12/31/2020	Date/Time Pre 7/14/2021 11:	epar :18
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	82, 385, 089	C	0	0	
00	Temporary investments	0	0	0	0	-
)0)0	Notes receivable Accounts receivable	0 10, 298, 049		0	0	
00	Other receivable	-4, 741, 170		0	0	
00	Allowances for uncollectible notes and accounts receivabl		C C	0	0	
00	Inventory	1, 699, 878	C	0	0	
00	Prepai d'expenses	167, 330		0	0	
00	Other current assets	205, 546	0	0	0	
	Due from other funds	0 014 722	0	0	0	
00	Total current assets (sum of lines 1-10) FIXED ASSETS	90, 014, 722		<u> </u>	0	11.
00	Land	931, 334	C	0	0	12
	Land improvements	1, 119, 735		0	0	
00	Accumulated depreciation	-1,073,695	C	0	0	14
	Bui I di ngs	19, 235, 457	C	0	0	
	Accumulated depreciation	-13, 086, 107	0	0	0	
	Leasehold improvements Accumulated depreciation	0		0	0	
	Fixed equipment	0		0	0	1
	Accumulated depreciation	0	C C	Ő	0	1
	Automobiles and trucks	242, 498	C	0	0	21
	Accumulated depreciation	-213, 076		0	0	
	Major movable equipment	15, 150, 854		0	0	
	Accumulated depreciation Minor equipment depreciable	-11, 300, 996		0	0	
	Accumulated depreciation	0		0	0	1
	HIT designated Assets	0		0	0	1
	Accumulated depreciation	0	C	0	0	
	Minor equipment-nondepreciable	669, 179		0	0	
00	Total fixed assets (sum of lines 12-29)	11, 675, 183	C	0	0	30
00	OTHER ASSETS Investments	0			0	31
	Deposits on Leases	0		0	0	
	Due from owners/officers	0	C	0	0	
	Other assets	5, 263, 774	C	0	0	
	Total other assets (sum of lines 31-34)	5, 263, 774		0	0	
00	Total assets (sum of lines 11, 30, and 35)	106, 953, 679	C	0	0	36
00	CURRENT LI ABI LI TI ES Accounts payable	1, 599, 033		0	0	37
	Salaries, wages, and fees payable	988, 701		0	0	
	Payrol I taxes payable	1, 139, 790		0	0	
	Notes and loans payable (short term)	58, 709	C	0	0	1 10
	Deferred income	0	C	0	0	41
	Accel erated payments	10, 878, 901			0	42
	Due to other funds Other current liabilities	3, 546, 997		0		43
	Total current liabilities (sum of lines 37 thru 44)	18, 212, 131		0		45
	LONG TERM LI ABI LI TI ES	10/212/101		<u> </u>		
	Mortgage payable	0	C	0	0	46
	Notes payable	0	C	0	0	
	Unsecured Loans	0	0	0		48
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	298, 728 298, 728		0	0	
	Total liabilities (sum of lines 45 and 50)	18, 510, 859		0	0	
	CAPITAL ACCOUNTS					
	General fund balance	88, 442, 820				52
	Specific purpose fund		C			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55 56
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	Ω	50
	Plant fund balance - reserve for plant improvement,					58
	replacement, and expansion				0	
00	Total fund balances (sum of lines 52 thru 58)	88, 442, 820	c c	0	0	59
00	Total liabilities and fund balances (sum of lines 51 and	59106 953 679		0	0	60

Health Financial Systems IND STATEMENT OF CHANGES IN FUND BALANCES	I ANA UNI VERSI TY	Provi der C		Period: From 01/0	01/2020	of Form CMS-2 Worksheet G-7 Date/Time Pre 7/14/2021 11:	l epared:
	General	Fund	Speci al	Purpose Fi	und E	ndowment Fund	
	1.00	2.00	3.00	4. (00	5.00	
1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 ROUNDING 5.00 6.00 7.00 8.00 9.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	1 0 0 0 0 0 0 0 0 0 0 0 0 0	67, 467, 515 20, 975, 304 88, 442, 819 1 88, 442, 820 0 88, 442, 820		0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00
	Endowment Fund	PI ant					
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00ROUNDING5.006.007.00100	6.00 0	7.00	8.00	0			1.00 2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00	0 0	000000000000000000000000000000000000000		0 0			8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 	0	0 0 0		0 0			15.00 16.00 17.00 18.00 19.00

Health Financial Systems INDIANA UNIVERSIT	Y HEALTH BEDFORD	In Lieu	of Form CMS-2	2552-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN: 15-1328	Period: From 01/01/2020 To 12/31/2020		epared:
Cost Center Description	Inpatient 1.00	Outpatient 2.00	Total 3.00	
PART I – PATIENT REVENUES	1.00	2.00	3.00	
General Inpatient Routine Services				
1.00 Hospital	7, 972, 8	37	7, 972, 837	1
2.00 SUBPROVIDER - IPF				2.00
3. 00 SUBPROVI DER – I RF 4. 00 SUBPROVI DER				3.00 4.00
5.00 Swing bed - SNF	58,9	46	58,946	
6.00 Swing bed - NF		0	0, 140	1
7. 00 SKILLED NURSING FACILITY			-	7.00
8.00 NURSING FACILITY				8.00
9.00 OTHER LONG TERM CARE				9.00
10.00 Total general inpatient care services (sum of lines 1-9)	8, 031, 7	83	8, 031, 783	10.00
Intensive Care Type Inpatient Hospital Services	0 200 1	00	0.200.100	11 00
11. 00 I NTENSI VE CARE UNI T 12. 00 CORONARY CARE UNI T	9, 399, 1	99	9, 399, 199	11.00
13.00 BURN INTENSIVE CARE UNIT				12.00
14. 00 SURGICAL INTENSIVE CARE UNIT				14.00
15.00 OTHER SPECIAL CARE (SPECIFY)				15.00
16.00 Total intensive care type inpatient hospital services (s	um of lines 11-15) 9,399,1	99	9, 399, 199	16.00
17.00 Total inpatient routine care services (sum of lines 10 a	nd 16) 17, 430, 9	82	17, 430, 982	17.00
18.00 Ancillary services	23, 427, 4		165, 757, 655	
19.00 Outpatient services	1, 544, 6		58,004,652	
20.00 RURAL HEALTH CLINIC		0 0	0	1
21.00 FEDERALLY QUALIFIED HEALTH CENTER 22.00 HOME HEALTH AGENCY		0 0	0	21.00
23. 00 AMBULANCE SERVICES				22.00
24. 00 CMHC				24.00
25.00 AMBULATORY SURGICAL CENTER (D. P.)				25.00
26. 00 H0SPI CE				26.00
27.00 PHYSICIAN REVENUE		0 1, 498, 469	1, 498, 469	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer col	umn 3 to Wkst. G-3,42,403,0	31 200, 288, 727	242, 691, 758	28.00
line 1)				
PART II - OPERATING EXPENSES		63, 006, 997		20.00
29.00 Operating expenses (per Wkst. A, column 3, line 200) 30.00 ADD (SPECIFY)		03,000,997		29.00 30.00
31.00		0		31.00
32.00		0		32.00
33.00		0		33.00
34.00		0		34.00
35. 00		0		35.00
36.00 Total additions (sum of lines 30-35)		0		36.00
37.00 DEDUCT (SPECIFY)		0		37.00
38.00		0		38.00
39.00 40.00		0		39.00 40.00
40.00		0		40.00
42.00 Total deductions (sum of lines 37-41)		Ŭ O		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus I	ine 42)(transfer to	63, 006, 997		43.00
Wkst. G-3, line 4)				
	-			

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu	」 of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1328 Period:	Worksheet G-3
From 01/01/2020 To 12/31/2020	
	7/14/2021 11:18 am
	1.00
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	242, 691, 758 1.00
2.00 Less contractual allowances and discounts on patients' accounts	161, 466, 096 2.00
3.00 Net patient revenues (line 1 minus line 2)	81, 225, 662 3.00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	63, 006, 997 4. 00
5.00 Net income from service to patients (line 3 minus line 4) OTHER INCOME	18, 218, 665 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 services	0 8.00
9.00 Revenue from television and radio service	0 9.00
10.00 Purchase di scounts	0 10.00
11.00 Rebates and refunds of expenses	0 11.00
12.00 Parking lot receipts	0 12.00
13.00 Revenue from Laundry and Linen service	0 13.00
14.00 Revenue from meals sold to employees and quests	0 14.00
15.00 Revenue from rental of Living guarters	0 15.00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0 16.00
17.00 Revenue from sale of drugs to other than patients	0 17.00
18.00 Revenue from sale of medical records and abstracts	0 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 MISCELLANEOUS INCOME	2, 320, 015 24. 00
24.50 COVI D-19 PHE Fundiing	436, 624 24. 50
25.00 Total other income (sum of lines 6-24)	2, 756, 639 25. 00
26.00 Total (line 5 plus line 25)	20, 975, 304 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)	20, 975, 304 29. 00