IU HEALTH BLACKFORD HOSPITAL 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 interF@RM 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 CERTIFICATION PANDI der CCN: 15-1302 Peri od: Worksheet S From 01/01/2020 Parts I-III SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 7/15/2021 Time: 1:03 pm use only ] 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. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor ]Cost Report Status 11. Contractor's Vendor Code: (1) As Submitted use only (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.

PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE 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 IU HEALTH BLACKFORD HOSPITAL (15-1302) 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. further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ X ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

> (Si gned) JONATHAN VANATOR

> > Officer or Administrator of Provider(s)

number of times reopened = 0-9.

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	103, 609	-23, 142	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	145, 251	0		0	5. 00
6.00 Swing Bed - NF	0				0	6. 00
10.00 RURAL HEALTH CLINIC (RHC) I	0		0		0	10.00
200. 00 Total	0	248, 860	-23, 142	0	0	200. 00
The above amounts represent "due to" or "due from'	the applicab	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.

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Worksheet S-2 Part I Provi der CCN: 15-1302 Peri od: From 01/01/2020 Date/Time Prepared: 12/31/2020 7/15/2021 1:03 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 410 PILGRIM STREET 1.00 PO Box: 1.00 State: IN Zi p Code: 47348 County: BLACKFORD 2.00 City: HARTFORD CITY 2.00 Component Name CCN CBSA Provi der Date Payment System (P. T, 0, or N) Certi fied Number Number Type V XVIII XIX 1.00 2.00 3.00 4.00 5.00 6. 00 7. 00 8. 00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal IU HEALTH BLACKFORD 151302 99915 02/10/2000 N 3.00 HOSPI TAL 4.00 Subprovider - IPF 4.00 Subprovi der – IRF 5.00 5.00 6 00 Subprovider - (Other) 6 00 Swing Beds - SNF 0 BLACKFORD COMMUNITY 99915 0 7.00 15Z302 02/10/2000 Ν 7.00 SWING BED 8.00 Swing Beds - NF 8.00 Hospi tal -Based SNF 9.00 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12 00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC IU HEALTH BLACKFORD 15.00 158558 99915 11/20/2020 Ν 0 15.00 PHYSI CLANS 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19. <u>00</u> From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2020 20. 00 01/01/2020 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost 22.01 reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 Ν 22.02 Ν Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural N Ν N 22.03 as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? 23.00 Ν In column 1, enter 1 if date of admission, 2 if census days, or 3 if da**t**e of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State Out-of Out-of 0ther In-State Medi cai d HMO days Medi cai d Medi cai d Medi cai d State State paid days el i gi bl e Medi cai d Medi cai d days inpaid days paid days el i gi bl e unpai d days 1.00 3.00 2.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CCN: 15-1302   Period:   Worksheet S-From 01/01/2020   Part I	-2
To 12/31/2020 Date/Time Pr 7/15/2021 1:	
In-State   In-State   Out-of   Out-of   Medicaid   Other	
Medicaid   Medicaid   State   State   HMO days   Medicaid   paid days   eligible   Medicaid   Medicaid   days	
unpaid days paid days eligible unpaid days	
1.00 2.00 3.00 4.00 5.00 6.00	
25.00   If this provider is an IRF, enter the in-state Medicaid 0 0 0 0 0 0 0 paid days in column 1, the in-state Medicaid eliqible	25. 00
unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in	
column 4, Medicaid HMO paid and eligible but unpaid	
days in column 5.  Urban/Rural StDate of Geogr	~a
1.00 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost 2 reporting period. Enter "1" for urban or "2" for rural.	26. 00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost 2 reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter	27. 00
the effective date of the geographic reclassification in column 2.	
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect 0 in the cost reporting period.	35. 00
Beginning:   Ending:	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of	36. 00
periods in excess of one and enter subsequent dates. 37.00   f this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in 0	37. 00
effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in	37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent	38. 00
dates. Y/N Y/N	
1.00 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y"	39. 00
for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42	
CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" N N for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in	40. 00
column 2, for discharges on or after October 1. (see instructions)	
V XVIII XIX 1.00 2.00 3.00	
Prospective Payment System (PPS)-Capital  45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with N N	45. 00
42 CFR Section §412.320? (see instructions)	
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuamit N N to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	46. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N	47. 00 48. 00
Teaching Hospitals	
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or NN" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME	56. 00
payment reduction? Enter "Y" for yes or "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME	57. 00
programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y"	37.00
did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete	
Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	F0. 00
58.00   If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. N   NAHE 413.85   Worksheet A   Pass-Through	59.00
Y/N Line # Qualificatio	n
Criterion Coo	de
1.00 2.00 3.00  60.00 Are you claiming nursing and allied health education (NAHE) costs for any N	60.00
programs that meet the criteria under 42 CFR 413.85? (see instructions)	00.00
Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are ybu	
impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Ehter	

		FORD HOSPITAL			of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der C	Fi	eriod: rom 01/01/2020	Worksheet S-2 Part I	
			To		7/15/2021 1:0	
	Y/N	IME	Direct GME	I ME	Direct GME	
(1.00 D) down hood by ETF of the water AGA	1.00	2.00	3. 00	4.00	5. 00	(1.00
61.00 Did your hospital receive FTE slots under ACA secti 5503? Enter "Y" for yes or "N" for no in column 1.	on N (see			0. 00	0.00	61. 00
instructions) 61.01 Enter the average number of unweighted primary care						61. 01
FTEs from the hospital's 3 most recent cost reports						01.01
ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary car						61. 02
FTE count (excluding OB/GYN, general surgery FTEs, primary care FTEs added under section 5503 of ACA).	and					
(see instructions)						
61.03 Enter the base line FTE count for primary care and/general surgery residents, which is used for	or 					61. 03
determining compliance with the 75% test. (see						
instructions) 61.04 Enter the number of unweighted primary care/or surg	lerv	i				61. 04
allopathic and/or osteopathic FTEs in the current c						
reporting period. (see instructions). 61.05 Enter the difference between the baseline primary		•				61. 05
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (lin						
61.04 minus line 61.03). (see instructions)	1					
61.06 Enter the amount of ACA §5503 award that is being u for cap relief and/or FTEs that are nonprimary care						61.06
general surgery. (see instructions)						
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE	
		1.00	2.00		Count	
61.10 Of the FTEs in line 61.05, specify each new program	1	1. 00	2. 00	3. 00 0. 00	4. 00 0. 00	61. 10
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	de.					
Enter in column 3, the IME FTE unweighted count. En in column 4, the direct GME FTE unweighted count.	ter					
61.20 Of the FTEs in line 61.05, specify each expanded	•			0.00	0. 00	61. 20
program specialty, if any, and the number of FTE residents for each expanded program. (see instructi	ons)					
Enter in column 1, the program name. Enter in colum						
the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME	FTE					
unwei ghted count.	<u> </u>					
					1. 00	
ACA Provisions Affecting the Health Resources and S 62.00 Enter the number of FTE residents that your hospita				eriod for which	h your 0 00	62. 00
hospital received HRSA PCRE funding (see instruction	ns)					
62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pr				to your hospit	al 0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovi	der Se	ttings		=		
63.00 Has your facility trained residents in nonprovider for yes or "N" for no in column 1. If yes, complete					r "Y" N	63. 00
, , , , , , , , , , , , , , , , , , , ,			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in			sThis base ye			
reporting period that begins on or after July 1, 20 64.00 Enter in column 1, if line 63 is yes, or your facil				0.00	0. 000000	64 00
the base year period, the number of unweighted non-	primar	y care residen	t	. 50	3. 300000	51.00
FTEs attributable to rotations occurring in all non in column 2 the number of unweighted non-primary ca			Enter t			
trained in your hospital. Enter in column 3 the rat						
by (column 1 + column 2)). (see instructions)			1	I		İ

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH BLACKFORD HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-1302 Peri od: Worksheet S-2 From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + colFTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained 0.000000 0.00 0.00 65.00 residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care residert FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs in (col. 1 + col **FTEs** Nonprovi der 2)) Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident FT s 0 00 0 00 0.000000 66.00 attributable to rotations occurring in all nonprovider settings. column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided <u>by (column 1 + column 2)). (see instructions)</u> Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + colFTEs in **FTEs** Nonprovi der Hospi tal 4)) Si te 1.00 2. 00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? N 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the mos 71.00 0 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching progr<mark>a</mark>m in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column s Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subproved the facility (IRF). 75.00 Enter "Y" for yes and "N" for no. 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the mos 0 76.00 ecent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which

program year began during this cost reporting period. (see instructions)

lealth Financial Systems IU HEALTH BLACKFORD HOSPITAL  HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1302		u of Form CMS- Worksheet S- Part I	
		Date/Time Pr 7/15/2021 1:	
		1.00	+
Long Term Care Hospital PPS			
Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  Is this a LTCH co-located within another hospital for part or all of the cost rep for yes and "N" for no.  TEFRA Providers	porting period? En	N ter "Y" N	80. 00 81. 00
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Enter "Y" for yes and "N" for no.			85. 00 86. 00
37.00 Is this hospital an extended neoplastic disease care hospital classified under se Enter "Y" for yes or "N" for no.	ection 1886(d)(1)(	)(vi)?N	87. 00
	V	XIX	
Title V and XIX Services	1. 00	2. 00	
20.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" "N" for no in the applicable column.	for yes on	Y	90.00
21.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in part? Enter "Y" for yes or "N" for no in the applicable column.	in full onN	N	91.00
22.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (sinstructions) Enter "Y" for yes or "N" for no in the applicable column.	see	N	92.00
P3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? E for yes or "N" for no in the applicable column.		N	93. 00
04.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the column.	e applicableN	N	94.00
05.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 06.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the column.	0.00 e applicableN	0. 00 N	95. 00 96. 00
07.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 08.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents percentage stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no for title V, and in column 2 for title XIX.		0. 00 Y	97. 00 98. 00
P8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges or Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 f XIX.		Y	98. 0
8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observat costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 V, and in column 2 for title XIX.		Y	98. 0
8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in cottitle V, and in column 2 for title XIX.		N	98. 0
18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of ou services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in co		N	98. 0
title XIX.  8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowar (C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in		Y	98. 0
for title XIX.  88.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in colum title XIX.	· 1	Y	98.00
Rural Providers 05.00Does this hospital qualify as a CAH?	Y	]	 105. 0
06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of poutpatient services? (see instructions)	, l		106. 0
07.00Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for training programs? Enter "Y" for yes or "N" for no in column 1. (see instruction Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "or "N" for no in column 2. (see instructions)	ns) approved		107. 0
08.00 is this a rural hospital qualifying for an exception to the CRNA fee schedule? Section §412.113(c). Enter "Y" for yes or "N" for no.			108. 0
Physical Occupation 1.00 2.00		Respiratory 4.00	-
109.00 f this hospital qualifies as a CAH or a cost provider, are N N therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N	109.00

Health Financial Systems  IU HEALTH BLACKFORD HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CO	ON 15 1202 Is		of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO	F	Period: From 01/01/2020 To 12/31/2020	Worksheet S- Part I Date/Time Pr 7/15/2021 1:	repared:
·				
110.00Did this hospital participate in the Rural Community Hospital Demonstra Demonstration)for the current cost reporting period? Enter "Y" for yes Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 20	or "N" for no.	If yes, compl		110.00
		1. 00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Integration Project (FCHIP) demonstration for this cost reporting perio or "N" for no in column 1. If the response to column 1 is Y, enter the the FCHIP demo in which this CAH is participating in column 2. Enter al Ambulance services; "B" for additional beds; and/or "C" for tele-health	d? Enter "Y" integration p I that apply:	for yes rong of		111.00
112 OOD: d this best teleparticipate in the Damenturnia Dural Health Madel	1.00	2. 00	3. 00	112.00
112.00Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? En "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in co 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information				112.00
115.00[Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no				0115.00
column 1. If column 1 is yes, enter the method used (A, B, or E only) i column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on definition in CMS Pub.15-1, chapter 22, §2208.1.				
116.00 s this facility classified as a referral center? Enter "Y" for yes or	'N" N			116. 00
117.00 is this facility legally-required to carry malpractice insurance? Enter for yes or "N" for no.	"Y" N			117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter the policy is claim-made. Enter 2 if the policy is occurrence.	lif '	1		118. 00
the periody is ordin made. Effect 2 in the periody is decarrence.	Premi ums	Losses	Insurance	
118 01 ist amounts of mal practice premiums and paid Losses	1.00	2.00	3. 00	0118 01
118.01 List amounts of malpractice premiums and paid losses:	1. 00 24, 86	3 0		0118. 01
	24, 868	1.00		
118.02Are malpractice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing amounts contained therein.	24,868 r than the	1. 00 N		118. 02
118.02Are mal practice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing amounts contained therein.  119.00D0 NOT USE THIS LINE  120.00Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless p and applicable amendments? (see instructions) Enter in column 1, "Y" fo Is this a rural hospital with < 100 beds that qualifies for the Outpatien provision in ACA §3121 and applicable amendments? (see instructions) En	r than the cost centers rovision in Arryes or "N"	1.00 N and CA §3121N for no.		
<ul> <li>118.02Are mal practice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing amounts contained therein.</li> <li>119.00D0 NOT USE THIS LINE</li> <li>120.00 is this a SCH or EACH that qualifies for the Outpatient Hold Harmless p and applicable amendments? (see instructions) Enter in column 1, "Y" fo is this a rural hospital with &lt; 100 beds that qualifies for the Outpatient provision in ACA §3121 and applicable amendments? (see instructions) Enfor yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable deviations.</li> </ul>	r than the cost centers rovision in Adr yes or "N" ent Hold Harmiter in column	1.00 N and CA §3121N for no. ess 2, "Y"	2. 00	118. 02
<ul> <li>118.02Are mal practice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing amounts contained therein.</li> <li>119.00D NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless p and applicable amendments? (see instructions) Enter in column 1, "Y" fo Is this a rural hospital with &lt; 100 beds that qualifies for the Outpatip provision in ACA §3121 and applicable amendments? (see instructions) Enfor yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable deviations? Enter "Y" for yes or "N" for no.</li> </ul>	r than the cost centers rovision in Arryes or "N" ent Hold Harmiter in column ces charged to	1.00 N and  CA §3121N for no. ess 2, "Y"	2. 00 N	118. 02 119. 00 120. 00
<ul> <li>118.02Are mal practice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing amounts contained therein.</li> <li>119.00D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless p and applicable amendments? (see instructions) Enter in column 1, "Y" fo Is this a rural hospital with &lt; 100 beds that qualifies for the Outpatien provision in ACA §3121 and applicable amendments? (see instructions) Enfor yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable deviations? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain heal thcare related taxes as defined in §19 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", en Worksheet A line number where these taxes are included.</li> </ul>	r than the cost centers rovision in Arryes or "N" ent Hold Harmiter in column ces charged to 03(w)(3) of the	and  I. 00  N  and  CA §3121N  for no.  ess 2, "Y"  Y  ne Y	2. 00	118. 02 119. 00 120. 00
<ul> <li>118.02Are mal practice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing amounts contained therein.</li> <li>119.00D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless p and applicable amendments? (see instructions) Enter in column 1, "Y" fo Is this a rural hospital with &lt; 100 beds that qualifies for the Outpatiprovision in ACA §3121 and applicable amendments? (see instructions) Enfor yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable deviations? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain healthcare related taxes as defined in §19 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", en</li> </ul>	r than the cost centers  rovision in Ar yes or "N" ent Hold Harmiter in column ces charged to 03(w)(3) of the column column	1.00  1.00  N  and  CA §3121N  for no.  ess 2, "Y"  Y  ne Y 2 the	2. 00 N	118. 02 119. 00 120. 00
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<ul> <li>118.02Are mal practice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing amounts contained therein.</li> <li>119.00D NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless p and applicable amendments? (see instructions) Enter in column 1, "Y" fo Is this a rural hospital with &lt; 100 beds that qualifies for the Outpatient provision in ACA §3121 and applicable amendments? (see instructions) Enfor yes or "N" for no.</li> <li>121.00Did this facility incur and report costs for high cost implantable deviations? Enter "Y" for yes or "N" for no.</li> <li>122.00Does the cost report contain healthcare related taxes as defined in §19 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", en Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>125.00Does this facility operate a transplant center? Enter "Y" for yes and "enter certification date(s) (mm/dd/yyyy) below.</li> </ul>	r than the cost centers  rovision in Arryes or "N" ent Hold Harmiter in column  ces charged to (33(w)(3) of the column of the co	and  I.00  N  and  CA §3121N  for no. ess 2, "Y"  Y  Y  te in	2. 00 N	118. 02 119. 00 120. 00 121. 00 122. 00
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L	<u>IU HEALTH BLACK</u> EX IDENTIFICATION DATA	Provi der CO	CN: 15-1302	Peri od:	Worksheet S	<u>-2552-</u> -2
				From 01/01/2020 To 12/31/2020	Date/Time P	
					7/15/2021 1	:03 pm
				1. 00	2. 00	
All Providers  0.00 Are there any related organization	on or home office costs s	ns dofined in C	MC Dub 15 1	chantar/	15H059	140.
10? Enter "Y" for yes or "N" for enter in column 2 the home office	no in column 1. If yes,	and home office			150059	140.
1.00	2. (			3.00		
If this facility is part of a cha of the home office and enter the	in organization, enter of home office contractor r	on lines 141 th	rough 143 the ctor number	e name and addr	ess	
1.00Name: IU HEALTH, INC	Contractor's Name:W			or's Number:081	01	141.
2.00 Street: 340 W. 10TH STREET	PO Box:	N.I.	7: - Code	4/0	0.4	142.
3. Od <mark>City: INDIANAPOLIS</mark>	State: II	<u>IN</u>	Zip Code:	: 462	1	143.
					1. 00	
4.00 Are provider based physicians' co	sts included in Workshee	et A?			Y	144.
				1, 00	2.00	
5.00 f costs for renal services are c	claimed on Wkst. A, line	74, are the co	sts for inpat		2.00	145.
services only? Enter "Y" for yes dialysis facility include Medicar	re utilization for this c					
for yes or "N" for no in column 2 6.00Has the cost allocation methodolo		iously filed c	ost report? E	Enter "Y"N		146.
for yes or "N" for no in column 1	. (See CMS Pub. 15-2, ch					
approval date (mm/dd/yyyy) in col	umn 2.					
					1. 00	-
7.00Was there a change in the statist	ical basis? Enter "Y" fo	or yes or "N" f	or no.		N N	147.
3.00Was there a change in the order of				_	N	148.
0.00Was there a change to the simplif	<u>ied cost finding method?</u>	Part A	yes or "N" f Part B	Title V	N Title XIX	149.
		1, 00	2.00	3.00	4.00	-
Does this facility contain a prov lower of costs or charges? Enter (See 42 CFR §413.13)			rom the appli		•	
5. 00Hospi tal		N	N	N	N	<b>–</b> 155.
. 00 Subprovi der – IPF		N	N	N	N N	156.
7.00Subprovider - IRF 3.00SUBPROVIDER		N	N	N	N N	157.
3. OGSUBPROVI DER 9. OGSNF		N	N	N	l N	158. 159.
D. OOHOME HEALTH AGENCY		N	N	N	N N	160.
			N	N	N N	161.
I. ODJCMHC					1.00	_
1. OD CMHC						
Multicampus					1.00	
Multicampus 5.00Is this hospital part of a Multic	ampus hospital that has	one or more cal	mpuses in dif	ferent CBSAs?	Enter N	165.
Mul ti campus	campus hospital that has		·			
Multicampus 5.00 Is this hospital part of a Multic "Y" for yes or "N" for no.	Name O	one or more can  County 1.00	State Zip		Enter N FTE/Campus 5.00	
Multicampus 5.00 Is this hospital part of a Multic "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each came	Name 0	County	State Zi p	Code CBSA	Enter N FTE/Campus 5.00	
Multicampus 5.00 s this hospital part of a Multicampus "Y" for yes or "N" for no.  5.00 f line 165 is yes, for each campenter the name in column 0, coun	Name 0 ous	County	State Zi p	Code CBSA	Enter N FTE/Campus 5.00	
Multicampus 5.00 Is this hospital part of a Multicampus "Y" for yes or "N" for no.  5.00 If line 165 is yes, for each campenter the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column	Name 0 ous ty	County	State Zi p	Code CBSA	Enter N FTE/Campus 5.00	
Multicampus  5.00 Is this hospital part of a Multical "Y" for yes or "N" for no.  5.00 If line 165 is yes, for each campener the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see	Name 0 ous ty	County	State Zi p	Code CBSA	Enter N FTE/Campus 5.00	
Multicampus  .00 Is this hospital part of a Multical of the model of t	Name 0 ous ty	County	State Zi p	Code CBSA	Enter N FTE/Campus 5.00	
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Multicampus 5.00 Is this hospital part of a Multicampus 7.00 Is this hospital part of a Multicampus 8.00 If line 165 is yes, for each campus enter the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions)  Health Information Technology (HI	Name  O  Dus  Sty  Lip  4,  T) incentive in the Amer	County 1.00	State Zip 2.00 3	o Code CBSA 3.00 4.00	Enter N  FTE/Campus 5.00  0.0	00166.
Multicampus 5.00 Is this hospital part of a Multicampus 7.00 If line 165 is yes, for each came enter the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions)  Health Information Technology (HI 7.00 Is this provider a meaningful use	Name  0  Dus  iy  ip  4,  T) incentive in the Amerer under §1886(n)? Enter	County 1.00  rican Recovery "Y" for yes o	State Zip 2.00 3 and Reinvestr "N" for no.	D Code CBSA 3.00 4.00	Enter N  FTE/Campus 5.00 0.0	00166.
Multicampus 5.00 Is this hospital part of a Multicampus 5.00 If line 165 is yes, for each campenter the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions)  Health Information Technology (HI 7.00 Is this provider a meaningful use	Name  Ous  Sy  tip  4,  T) incentive in the Amer er under §1886(n)? Enter	County 1.00  rican Recovery - "Y" for yes oningful user (I	State Zip 2.00 3 and Reinvestr "N" for no.	D Code CBSA 3.00 4.00	Enter N  FTE/Campus 5.00  0.0	00166.
5.00 Is this hospital part of a Multic "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each came enter the name in column 0, coun in column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions)  Health Information Technology (HI 7.00 Is this provider a meaningful use B.00 If this provider is a CAH (line 1 reasonable cost incurred for the B.01 If this provider is a CAH and is	Name  Ous  Sy  Sip  4,  T) incentive in the Amer er under §1886(n)? Enter  O5 is "Y") and is a mean HIT assets (see instruct not a meaningful user, d	County 1.00  rican Recovery """ for yes on ingful user (Itions) does this provides	and Reinvestr "N" for no. ine 167 is "V	D Code CBSA 3.00 4.00  ment Act  ("), enter the	Enter N FTE/Campus 5.00 0.0	167.
Multicampus  5.00 Is this hospital part of a Multically "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each campenter the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions)  Health Information Technology (HI 7.00 Is this provider a meaningful use 3.00 If this provider is a CAH (line 1 reasonable cost incurred for the 3.01 If this provider is a CAH and is under §413.70(a)(6)(ii)? Enter "Y	Name  O  Ous  Ey  Zip  4,  T) incentive in the Amer  er under §1886(n)? Enter  105 is "Y") and is a mean  HIT assets (see instruct  not a meaningful user, d  "" for yes or "N" for no.	County 1.00  rican Recovery "Y" for yes oningful user (Itions) does this proviouse instruct	and Reinvestr "N" for no. ine 167 is "Y der qualify fions)	ment Act  "), enter the  or a hardship	Enter N  FTE/Campus 5.00 0.0	167. 168.
Multicampus  5.00 Is this hospital part of a Multically "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each came enter the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions)  Health Information Technology (HI 7.00 Is this provider a meaningful use 3.00 If this provider is a CAH (line 1 reasonable cost incurred for the 3.01 If this provider is a CAH and is under §413.70(a) (6) (ii)? Enter "Y 9.00 If this provider is a meaningful	Name  Ous  Sty  Lip  4,  T) incentive in the Amer er under §1886(n)? Enter O5 is "Y") and is a mean HIT assets (see instruct not a meaningful user, d "for yes or "N" for no. user (line 167 is "Y") a	County 1.00  rican Recovery "Y" for yes oningful user (Itions) does this proviouse instruct	and Reinvestr "N" for no. ine 167 is "Y der qualify fions)	ment Act  "), enter the  or a hardship	Enter N  FTE/Campus 5.00 0.0	167. 168.
Multicampus  5.00 Is this hospital part of a Multical "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each came enter the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions)  Health Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 1 reasonable cost incurred for the 8.01 If this provider is a CAH and is under §413.70(a) (6) (ii)? Enter "Y	Name  Ous  Sty  Lip  4,  T) incentive in the Amer er under §1886(n)? Enter O5 is "Y") and is a mean HIT assets (see instruct not a meaningful user, d "for yes or "N" for no. user (line 167 is "Y") a	County 1.00  rican Recovery "Y" for yes oningful user (Itions) does this proviouse instruct	and Reinvestr "N" for no. ine 167 is "Y der qualify fions)	ment Act  "), enter the  or a hardship	Enter N  FTE/Campus 5.00 0.0	165. 00166. 167. 168. 168. 100169.
Multicampus  5.00 Is this hospital part of a Multically "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each came enter the name in column 0, countin column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions)  Health Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 1 reasonable cost incurred for the 8.01 If this provider is a CAH and is under §413.70(a) (6) (ii)? Enter "Y 9.00 If this provider is a meaningful	Name  Ous  Sy  Lip  4,  T) incentive in the Amer  For under §1886(n)? Enter  105 is "Y") and is a mean  HIT assets (see instruct  not a meaningful user, d  "for yes or "N" for no.  user (line 167 is "Y") a  ons)	County 1.00  1.00  rican Recovery - "Y" for yes oningful user (litions) does this providues instruct and is not a CAM	and Reinvestrr "N" for no. ine 167 is "Yder qualify flons)	ment Act  ("), enter the  or a hardship or a	Enter N  FTE/Campus 5.00  0.0  1.00  Y  exception	167. 168.

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL			u of Form CMS-	<u> 2552-10</u>
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der CCN: 15-1302	Peri od: From 01/01/2020	Worksheet S- Part I	2
			To 12/31/2020	Date/Time Pr	
				7/15/2021 1:	03 pm
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provi	der have any days for in	ndividuals enrolled in se	ction N	(	171. 00
1876 Medicare cost plans reported o	n Wkst. S-3, Pt. I, line	e 2, col. 6? Enter "Y" fo	r yes and		
"N" for no in column 1. If column 1	is yes, enter the number	er of section 1876 Medica	re days		
in column 2. (see instructions)	-				

iOSPL!	Financial Systems I U HEALTH BLACK FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1302	Peri od:	worksheet S-	
	THE THIS THOUSE THE HELLETT STATE WE THE MESTIVE GOEST STATE WE	1		From 01/01/2020	Part II Date/Time Pr	
				To 12/31/2020	7/15/2021 1:	
				Y/N	Date	
	10	N. Garantii NO		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter the mm/dd/yyyy format.	N for all NO	responses. E	inter all dates	ın	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to t			reportingN		1.0
	period? If yes, enter the date of the change in column 2.	(see instruc		Dete	\/ (I	
			1, 00	2.00	V/I 3. 00	+
. 00	Has the provider terminated participation in the Medicare	Program? If		2.00	3.00	2.0
	enter in column 2 the date of termination and in column 3					
	or "I" for involuntary.					
. 00	Is the provider involved in business transactions, includ					3.0
	contracts, with individuals or entities (e.g., chain home 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 re					
	instructions)	<u> </u>	Ì			
			Y/N	Type	Date	
	Financial Data and Danarta		1.00	2. 00	3. 00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Ce	rtified Public	ł Y	l A	02/25/2021	4.0
. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C"			, ,	02, 20, 2021	1.0
	"R" for Reviewed. Submit complete copy or enter date avai					
	(see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues dif		ose N			5.0
	on the filed financial statements? If yes, submit reconci	iration.	l .	Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2	: If yes, is	the provider	s the N		6. 0
00	legal operator of the program?			N.		7.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see Were nursing school and/or allied health programs approve		wed during th	N N		7. 0 8. 0
. 00	reporting period? If yes, see instructions.	a anazor rene	wed ddi i ng ti	ie cost ii		0.0
. 00	Are costs claimed for Interns and Residents in an approve	d graduate med	dical educati	on N		9. 0
	program in the current cost report? If yes, see instructi					
0. 00	Was an approved Intern and Resident GME program initiated	or renewed i	n the current	t cost N		10.0
1 00	reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than	I & Pin an	Annroyed Tead	china N		11.0
1.00	Program on Worksheet A? If yes, see instructions.	I & K III all /	appi oved Teac	Silling in		111.0
	1 g.,			•	Y/N	
					1. 00	
	Bad Debts	· · · · · · · · · · · · · · · · · · ·				
	Is the provider seeking reimbursement for bad debts? If y If line 12 is yes, did the provider's bad debt collection			s cost roporting	Y noriod®	12.0
3.00	If yes, submit copy.	port by charge	e durring times	s cost reporting	perrouv	13.0
4. 00	If line 12 is yes, were patient deductibles and/or co-pay	ments waived?	If yes, see	instructions.	N	14.0
	Bed Complement					
5.00	Did total beds available change from the prior cost repor			nstructions.	N N	15. 0
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
		1.00	2.00	0.00	1.00	
	PS&R Data					7 4/ 0
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	lf N		N		16.0
6. 00	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date	of		N		16.0
	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4 (see instruction	of s)	04/00/0004		04/00/0001	
	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4 (see instruction was the cost report prepared using the PS&R Report for to	of s) tals Y	04/02/2021		04/02/2021	
	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4 (see instruction Was the cost report prepared using the PS&R Report for to and the provider's records for allocation? If either columns is the cost report prepared using the PS&R Report for to and the provider's records for allocation?	of s) tals Y mn 1	04/02/2021		04/02/2021	
	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4 (see instruction Was the cost report prepared using the PS&R Report for to and the provider's records for allocation? If either column 3 is yes, enter the paid-through date in columns 2 and	of s) tals Y mn 1	04/02/2021		04/02/2021	
7. 00	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4 (see instruction Was the cost report prepared using the PS&R Report for to and the provider's records for allocation? If either columns is the cost report prepared using the PS&R Report for to and the provider's records for allocation?	of s) tals Y mn 1 4.	04/02/2021		04/02/2021	17. C
7. 00	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4. (see instruction Was the cost report prepared using the PS&R Report for to and the provider's records for allocation? If either coluor 3 is yes, enter the paid-through date in columns 2 and (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Redata for additional claims that have been billed but are	of s) tals Y mn 1 4. port N not	04/02/2021	Y	04/02/2021	17. C
7. 00	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4. (see instruction Was the cost report prepared using the PS&R Report for to and the provider's records for allocation? If either columns 3 is yes, enter the paid-through date in columns 2 and (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Redata for additional claims that have been billed but are included on the PS&R Report used to file this cost report	of s) tals Y mn 1 4. port N not	04/02/2021	Y	04/02/2021	17. C
7. 00 8. 00	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4. (see instruction Was the cost report prepared using the PS&R Report for to 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) If line 16 or 17 is yes, were adjustments made to PS&R Redata for additional claims that have been billed but are included on the PS&R Report used to file this cost report yes, see instructions.	of s) tals Y mn 1 4. port N not ? If	04/02/2021	Y	04/02/2021	16. 0 17. 0 18. 0
7. 00 8. 00	Was the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4. (see instruction Was the cost report prepared using the PS&R Report for to and the provider's records for allocation? If either columns 3 is yes, enter the paid-through date in columns 2 and (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Redata for additional claims that have been billed but are included on the PS&R Report used to file this cost report	of s) tals Y mn 1 4. port N not ? If	04/02/2021	Y	04/02/2021	17. 0

Health Financial Systems IU HEAL HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIO	LTH BLACKFOI DNNAI RE		CCN: 15-1302	Period: From 01/01/2020 To 12/31/2020		S-2 Prepared:
			iption	Y/N	Y/N	
			0	1.00	3. 00	
20.00 If line 16 or 17 is yes, were adjustments made to data for Other? Describe the other adjustments:	o PS&R Repo	rt		N	N	20. 00
quata for other: bescribe the other adjustments.		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21.00 Was the cost report prepared only using the provi	i der' s	N		N		21.00
records: 11 yes, see Histractions.	<u> </u>					
					1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS	ONLY (EXCE	PT CHILDREN	S HOSPI TALS)			
Capital Related Cost  22.00 Have assets been relifed for Medicare purposes? I	If yes see	instructio	ine		N	22. 00
23.00 Have changes occurred in the Medicare depreciation reporting period? If yes, see instructions.				during the cost	N	23. 00
24.00 Were new leases and/or amendments to existing leaves, see instructions	ases entere	d into duri	ng this cost	reporting perio	d?lf N	24. 00
25.00 Have there been new capitalized leases entered in instructions.	nto during	the cost re	porting peri	od? If yes, see	N	25. 00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired instructions.	d during th	e cost repo	rting period	? If yes, see	N	26. 00
27.00 Has the provider's capitalization policy changed Interest Expense	during the	cost repor	ting period?	If yes, submit	сору. М	27. 00
28.00 Were new loans, mortgage agreements or letters of yes, see instructions.	f credit en	tered into	during the c	ost reporting pe	riod? INF	28. 00
29.00 Did the provider have a funded depreciation accounts as a funded depreciation account? If yes, see ins		bond funds	(Debt Servic	e Reserve Fund)	treatedN	29. 00
30.00 Has existing debt been replaced prior to its sche		ritv with n	ew deht? If	ves see instruc	tions N	30.00
31.00 Has debt been recalled before scheduled maturity						31.00
Purchased Services 32.00 Have changes or new agreements occurred in patier			shed through	contractual	N	32.00
arrangements with suppliers of services? If yes, 33.00 If line 32 is yes, were the requirements of Sec.			ning to comp	etitive bidding?	If no,	33. 00
see instructions.						_
Provider-Based Physicians  34.00 Are services furnished at the provider facility u	undor an ar	rangomont w	i th provi dor	hasod physician	-2 If V	34.00
yes, see instructions.	unuer an ar	rangement w	i tii providei	-baseu physician	5: 11 1	34.00
35.00 If line 34 is yes, were there new agreements or a			ments with t	he provi der-base	d N	35. 00
physicians during the cost reporting period? If y	yes, see m	STI UCTI OHS.		Y/N	Date	
				1.00	2. 00	
Home Office Costs						
36.00 Were home office costs claimed on the cost report				Y		36.00
37.00 If line 36 is yes, has a home office cost stateme	ent been pr	epared by t	he home offi	cePlf Y		37. 00
yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the	he home off	ice differe	nt from that	of the N		38. 00
provider? If yes, enter in column 2 the fiscal yes 39.00 If line 36 is yes, did the provider render service				yes, see N		39. 00
instructions. 40.00 If line 36 is yes, did the provider render service	ces to the	home office	? If ves. s	ee N		40. 00
instructions.			, ,			
		1.	. 00	2.	00	
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/pos by the cost report preparer in columns 1, 2, and		ADNO		UTTER		41. 00
respectively.	rt propark	71 ANIA 11NILVE	DCITV HEALTH			42.00
42.00 Enter the employer/company name of the cost repor 43.00 Enter the telephone number and email address of 1			NJIII HEALIH	RUTTER@I UHEALT	H. ORG	42.00
report preparer in columns 1 and 2, respectively.				1		li .

Health Financial Systems	FORD HOSPITAL	In Lieu	u of Form CMS-2	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT OF	UESTI ONNAI RE	E Provider CCN: 15-1302 Period: Worksheet			<u>)</u>
			From 01/01/2020 To 12/31/2020	Part II   Date/Time Pre	narod:
			10 12/31/2020	7/15/2021 1:0	
		3. 00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the tit	le/position he	DURECTOR, GOVERNMENT PRO	GRAMS		41.00
by the cost report preparer in columns 1, 2	2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the cost	report prepare	er.			42.00
43.00 Enter the telephone number and email addres	ss of the cost				43.00
report preparer in columns 1 and 2, respect	i vel v.				

Period: Worksheet S-3
From 01/01/2020 Part I 
 Health Financial
 Systems
 IU HEALTH E

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provi der CCN: 15-1302

				j .	o 12/31/2020	Date/Time Pre	
			I			1/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Li ne Number	No. of beas	Avai I abl e	CAIT HOULS	II LIE V	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 an		2.00				1.00
1.00	exclude Swing Bed, Observation Bed and Hosp		13	3, 470	30, 370.00	ı	1.00
	days) (see instructions for col. 2 for the	i ce				1	
	portion of LDP room available beds)					I	
2. 00	l' ,					1	2.00
3. 00	HMO And other (see instructions)					I	3.00
	HMO IPF Subprovider					I	
4.00	HMO IRF Subprovider					0	4. 00 5. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF					0	
	Hospital Adults & Peds. Swing Bed NF		15	E 400	20 574 00		•
7. 00	Total Adults and Peds. (exclude observation		15	5, 490	30, 576. 00	I	7. 00
0 00	beds) (see instructions)					I	0.00
8. 00	I NTENSI VE CARE UNI T					I	8.00
9.00	CORONARY CARE UNIT					I	9.00
10.00	BURN INTENSIVE CARE UNIT					I	10.00
11.00	SURGICAL INTENSIVE CARE UNIT					I	11.00
	OTHER SPECIAL CARE (SPECIFY)					I	12.00
13.00	NURSERY					1	13. 00
	Total (see instructions)		15	5, 490	30, 576. 00		•
15.00	CAH visits					0	
16.00	SUBPROVIDER - I PF					I	16. 00
17.00	SUBPROVIDER - IRF					I	17. 00
	SUBPROVI DER					I	18. 00
19.00	SKILLED NURSING FACILITY					I	19. 00
	NURSING FACILITY					I	20.00
21. 00	OTHER LONG TERM CARE					I	21. 00
	HOME HEALTH AGENCY					I	22. 00
	AMBULATORY SURGICAL CENTER (D. P. )					I	23. 00
	HOSPI CE					I	24. 00
	HOSPICE (non-distinct part)	30. 00				I	24. 10
	CMHC - CMHC					1	25. 00
26. 00	RURAL HEALTH CLINIC (RHC)	88. 00				0	
	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
	Total (sum of lines 14-26)		15			I	27. 00
	Observation Bed Days					0	
29. 00	The state of the s					I	29. 00
	Employee discount days (see instruction)					I	30. 00
	Employee discount days - IRF					1	31. 00
	Labor & delivery days (see instructions)		0	C		Ì	32. 00
32. 01	Total ancillary labor & delivery room					İ	32. 01
	outpatient days (see instructions)					İ	
	LTCH non-covered days					İ	33. 00
33. 01	LTCH site neutral days and discharges			l		i	33. 01

Provi der CCN: 15-1302

			'	0 12/31/2020	7/15/2021 1:0	
	I/P Days	/ O/P Visits	/ Tri ps	Full Time	Equi val ents	,
Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
			Pati ents	& Residents	Payrol I	
	6. 00	7. 00	8. 00	9. 00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and	d 8 663	0	1, 274			1.00
exclude Swing Bed, Observation Bed and Hosp	i ce					
days) (see instructions for col. 2 for the						
portion of LDP room available beds)						
2.00 HMO and other (see instructions)	353	92				2. 00
3.00 HMO IPF Subprovider	0	0				3. 00
4.00 HMO IRF Subprovider	0	0				4. 00
5.00 Hospital Adults & Peds. Swing Bed SNF	588	0	588			5. 00
6.00 Hospital Adults & Peds. Swing Bed NF		0	365			6. 00
7.00 Total Adults and Peds. (exclude observation	1, 251	0	2, 227			7. 00
beds) (see instructions)						
8.00 INTENSIVE CARE UNIT						8. 00
9. 00 CORONARY CARE UNIT						9. 00
10.00 BURN INTENSIVE CARE UNIT						10.00
11. 00 SURGI CAL INTENSI VE CARE UNI T						11. 00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00 NURSERY						13.00
14.00 Total (see instructions)	1, 251	0	2, 227	0. 00	94. 59	
15.00 CAH visits	0	0	C			15.00
16. 00 SUBPROVI DER - I PF						16.00
17. 00 SUBPROVI DER - I RF						17.00
18. 00 SUBPROVI DER						18.00
19.00 SKILLED NURSING FACILITY						19. 00 20. 00
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE				1		20.00
22. 00 HOME HEALTH AGENCY				•		22.00
23. 00 AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00 HOSPICE						24. 00
24.10 HOSPICE (non-distinct part)			10			24. 10
25. 00 CMHC - CMHC			10			25. 00
26.00 RURAL HEALTH CLINIC (RHC)	0	0	C	0.00	0.00	26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER	O O	Ö	Ö			
27.00 Total (sum of lines 14-26)	J	Ĭ	Č	0.00		
28.00 Observation Bed Days		2	338		71.07	28. 00
29.00 Ambul ance Trips	0	-	000			29. 00
30.00 Employee discount days (see instruction)	i		C			30.00
31.00 Employee discount days - IRF			C			31.00
32.00 Labor & delivery days (see instructions)	0	0	C			32.00
32.01 Total ancillary labor & delivery room		آ ا	C			32. 01
outpatient days (see instructions)			_			
33.00 LTCH non-covered days	0					33. 00
33.01 LTCH site neutral days and discharges	0					33. 01

Period: Worksheet S-3
From 01/01/2020 Part I Provi der CCN: 15-1302

				Ť.	0 12/31/2020	Date/Time Pre 7/15/2021 1:0	
		Full Time		Di sch	arges	77 137 2021 1.0	5 piii
		Equi val ents					
	Component	onpaid Workers	Title V	Title XVIII	Title XIX	Total All	
		11.00	12.00	12.00	14.00	Pati ents	
1. 00	Illeanital Adulta O Dada (aslumna 5 / 7 an	11.00	12. 00	13. 00 186	14. 00	15. 00 344	1. 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 ar exclude Swing Bed, Observation Bed and Hosp		Ü	180	U	344	1.00
	days) (see instructions for col. 2 for the	n ce					
	portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			82	24		2. 00
3. 00	HMO IPF Subprovider			02	0		3.00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				U		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)	1					7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
	OTHER SPECIAL CARE (SPECIFY)						12. 00
	NURSERY						13. 00
	Total (see instructions)	0.00	0	186	О	344	14. 00
	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
	HOSPI CE						24.00
	HOSPICE (non-distinct part)						24. 10
	CMHC - CMHC			,			25. 00
	RURAL HEALTH CLINIC (RHC)	0.00					26.00
	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
	Total (sum of lines 14-26)	0. 00					27. 00
	Observation Bed Days						28. 00
	Ambul ance Tri ps						29. 00
	Employee discount days (see instruction)						30.00
	Employee discount days - IRF						31.00
	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22 00
	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges	1 1		0	l l	l	33. 01

Heal th	Financial Systems IU HEALTH BLACKFOR	D HOSPITAL		In Lieu	ı of Form CMS-2	2552-10		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC		Peri od:	Worksheet S-1	10		
				From 01/01/2020 To 12/31/2020	Date/Time Pre	epared:		
					7/15/2021 1:0			
				ŀ	1. 00			
	Uncompensated and indigent care cost computation				11 00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	divided by I	ine 202 col	umn 8)	0. 438814	1. 00		
0.00	Medicaid (see instructions for each line)				710 011			
2. 00 3. 00	Net revenue from Medicaid				712, 814 N	2. 00 3. 00		
4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplem	ental navmer	nts from Med	cai d2	IV	4.00		
5. 00								
6.00	Medi cai d charges				7, 793, 607	6.00		
7.00	Medicaid cost (line 1 times line 6)				3, 419, 944			
8. 00	Difference between net revenue and costs for Medicaid progra	m (line 7 mi	nus sum of	ines 2 and 5;	f < 2,707,130	8. 00		
	zero then enter zero)	for each Li	no)			ļ		
9. 00	Children's Health Insurance Program (CHIP) (see instructions Net revenue from stand-alone CHIP	TOT Each II	ne)		0	9. 00		
	Stand-alone CHIP charges				0			
	Stand-alone CHIP cost (line 1 times line 10)				0			
12.00	Difference between net revenue and costs for stand-alone CHI	P (line 11 m	minus line 9	if < zero the	n enter 0	12.00		
	zero)							
10.00	Other state or local government indigent care program (see instructions for each line)							
	0 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 2,903 13.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 22,705 14.00							
15. 00	State or local indigent care program cost (line 1 times line		(NOT THE UU	ed III IIIles 6 0		15. 00		
	Difference between net revenue and costs for state or local		re program (	ine 15 minus I	· ·	•		
	if < zero then enter zero)							
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care							
17 00	<pre>programs (see instructions for each line) Private grants, donations, or endowment income restricted to</pre>	funding ob	ari tu ooro		0	17. 00		
	Government grants, appropriations or transfers for support o				0			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Lo			ams (sum of lin	-			
	and 16)			. `				
			Uni nsured	Insured	Total (col. 1			
			patients 1.00	pati ents 2.00	+ col . 2) 3.00			
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00			
20.00	Charity care charges and uninsured discounts for the entire	facility (se	ee 890, 81	0 55, 268	946, 078	20. 00		
	instructions)							
21. 00	Cost of patients approved for charity care and uninsured dis	counts (see	390, 90	0 55, 268	446, 168	21. 00		
22 00	instructions) Payments received from patients for amounts previously writt	on off as			0	22. 00		
22.00	charity care	en on as		9	U	22.00		
23.00	Cost of charity care (line 21 minus line 22)	İ	390, 90	0 55, 268	446, 168	23. 00		
	· · · · · · · · · · · · · · · · · · ·							
					1.00			
24.00	Does the amount on line 20 column 2, include charges for pat		eyond a Leng	th of stay limi	t N	24. 00		
25 00	imposed on patients covered by Medicaid or other indigent ca If line 24 is yes, enter the charges for patient days beyond		nt care prod	ram's Lanath of	stay 0	25. 00		
23.00	llimit	the Thanger	it care prog	am 3 rength of	Stay 0	25.00		
26.00		i nstructi ons	s)	j	1, 535, 689	26. 00		
	Medicare reimbursable bad debts for the entire hospital comp	lex (see ins	structions)	ļ	168, 925	27. 00		
	Medicare allowable bad debts for the entire hospital complex	(see instru	ucti ons)		259, 884	•		
	Non-Medicare bad debt expense (see instructions)	ovnonce (ee	a inoterrati-		1, 275, 805	•		
	Cost of non-Medicare and non-reimbursable Medicare bad debt Cost of uncompensated care (line 23 column 3 plus line 29)	expense (See	z mstructio	15)	650, 800 1, 096, 968			
	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)		ļ	3, 811, 158			
		,				•		

Health Financial Systems I	U HEALTH BLACKFO	ORD HOSPITAL		In Lieu	of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co	CN: 15-1302	eri od:	Worksheet A	·
				rom 01/01/2020 o 12/31/2020	Date/Time Pre	enared.
					7/15/2021 1:0	
Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassified	
			+ 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	2.00	0.00	1.00	0.00	
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT		5, 732	5, 732	753, 545	759, 277	1. 00
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP		0	C	0	0	2.00
3.00 00300 OTHER CAPITAL RELATED COSTS		0	C	0	0	3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	72, 503	72, 503		1, 167, 592	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	686, 225	4, 544, 834	5, 231, 059		4, 994, 100	
7. 00   00700   0PERATI ON OF PLANT 9. 00   00900   HOUSEKEEPI NG	225, 697	1, 453, 206	1, 678, 903		1, 193, 348	7.00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	169, 225 219, 133	198, 908 259, 702	368, 133 478, 835		292, 564 231, 484	9. 00 10. 00
11. 00  01100  CAFETERI A	219, 133	239, 702	470,033	162, 926	162, 926	
13. 00 01300 NURSING ADMINISTRATION	196, 291	79, 517	275, 808		243, 098	
14. 00 01400 CENTRAL SERVI CES & SUPPLY	170, 271	-334	-334		186, 071	14. 00
15. 00 01500 PHARMACY	0	1, 618, 354	1, 618, 354		924, 130	
INPATIENT ROUTINE SERVICE COST CENTERS		170107001	., 0.0, 00.	3717221	72 17 100	10.00
30. 00 03000 ADULTS & PEDIATRICS	1, 871, 801	615, 395	2, 487, 196	-444, 811	2, 042, 385	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	175, 921	147, 310	323, 231	-53, 671	269, 560	
53. 00 05300 ANESTHESI OLOGY	0	209, 666	209, 666		224, 300	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	577, 419	1, 085, 486	1, 662, 905	-369, 491	1, 293, 414	
57. 00 05700 CT SCAN	0	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	58. 00 59. 00
60. 00 06000 LABORATORY	0	1, 191, 851	1, 191, 851	0	1, 191, 851	60.00
60. 01   06001   BLOOD   LABORATORY		1, 171, 031	1, 171, 031	0	1, 171, 031	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	Ö	0	ď	Ö	0	62.00
65. 00 06500 RESPIRATORY THERAPY	457, 155	73, 181	530, 336	-45, 176	485, 160	
65. 01 06501 SLEEP LAB	0	0	C	0	0	65. 01
66.00 06600 PHYSI CAL THERAPY	347, 017	41, 726	388, 743	-18, 595	370, 148	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	78, 079	0	78, 079	15, 370	93, 449	67. 00
68.00 06800 SPEECH PATHOLOGY	8, 675	0	8, 675		8, 675	
69. 00 06900 ELECTROCARDI OLOGY	10, 962	861	11, 823		10, 962	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	O	18, 239	18, 239	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	14, 761	14, 761	
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03140   CARDI OLOGY	0	0	0	713, 433	713, 433	73. 00 76. 00
76. 00   03140  CARDI OLOGT 76. 97   07697  CARDI AC REHABI LI TATI ON	29, 892	7, 748	37, 640	-5, 794	31, 846	
OUTPATIENT SERVICE COST CENTERS	27, 072	7, 740	37,040	-5, 774	31,040	70. 77
88.00 08800 RURAL HEALTH CLINIC (RHC)	147, 670	39, 103	186, 773	0	186, 773	88. 00
90. 00 09000 CLINIC	29, 423	34, 282	63, 705		57, 447	90.00
91. 00 09100 EMERGENCY	704, 298	2, 044, 655	2, 748, 953	-257, 376	2, 491, 577	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS		اء		1		
113. 00 11300   NTEREST EXPENSE	5 004 000	0	10 (50 5(0	0		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 934, 883	13, 723, 686	19, 658, 569	]	19, 658, 570	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	595	595	-1	504	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0	373	0		192.00
200. 00 TOTAL (SUM OF LINES 118 through 199)	5, 934, 883	13, 724, 281	19, 659, 164		19, 659, 164	
, ,				•		•

 
 Health Financial
 Systems
 IU HEALTH BLACK

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Peri od: Worksheet A From 01/01/2020 To 12/31/2020 Date/Time Prepared: Provi der CCN: 15-1302

				To 12/31/2020 Date/Time 7/15/2021	Prepared:
	Cost Center Description	Adjustments	Net Expenses	[ 77 137 202 1	1.03 piii
	oost deliter bescription		For Allocation		
		6.00	7. 00	i	
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	160, 968	920, 245	;	1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3. 00	00300 OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	205, 272	1, 372, 864		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-118, 741	4, 875, 359		5. 00
7.00	00700 OPERATION OF PLANT	45, 014	1, 238, 362		7. 00
9.00	00900 HOUSEKEEPI NG	-6, 160			9. 00
10.00	01000 DI ETARY	10, 767	242, 251		10.00
11.00	01100 CAFETERI A	-50, 519	112, 407		11. 00
13.00	01300 NURSING ADMINISTRATION	173, 169	416, 267	<u>'</u>	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	186, 071		14. 00
15.00	01500 PHARMACY	-100, 162	823, 968	3	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	2, 042, 385		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-13, 668	255, 892		50. 00
53.00	05300 ANESTHESI OLOGY	-224, 258	42		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-28, 462	1, 264, 952		54.00
	05700 CT SCAN	0	0		57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58. 00
59.00	05900 CARDIAC CATHETERIZATION	0	0		59. 00
60.00	06000 LABORATORY	0	1, 191, 851		60.00
	06001 BLOOD LABORATORY	0	0		60. 01
		0	0		62. 00
65.00	06500 RESPI RATORY THERAPY	927	486, 087	1	65. 00
	06501 SLEEP LAB	0	0		65. 01
66.00	06600 PHYSI CAL THERAPY	31, 443	401, 591		66. 00
	06700 OCCUPATI ONAL THERAPY	0	93, 449		67. 00
	06800 SPEECH PATHOLOGY	0	8, 675		68. 00
	06900 ELECTROCARDI OLOGY	40, 372	51, 334		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18, 239		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	14, 761		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	713, 433		73. 00
	03140 CARDI OLOGY	0	0		76. 00
/6.9/	07697 CARDI AC REHABI LI TATI ON	4, 978	36, 824		76. 97
	OUTPATIENT SERVICE COST CENTERS	10/ 770		ı	
88. 00	08800 RURAL HEALTH CLINIC (RHC)	-186, 773	0		88. 00
90.00	09000 CLINIC	0	57, 447		90.00
91.00	l	-1, 186, 278	1, 305, 299	' <u> </u>	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
110 0	SPECIAL PURPOSE COST CENTERS	<u></u>	^	i	110.00
	11300 I NTEREST EXPENSE	1 242 111	10 41/ 450		113.00
118. 00		-1, 242, 111	18, 416, 459	<u>′I</u>	118. 00
100.00	NONREI MBURSABLE COST CENTERS	۵	504	T	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	594		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1 242 111	10 417 052		192.00
200. 00	TOTAL (SUM OF LINES 118 through 199)	-1, 242, 111	18, 417, 053	PI	200. 00

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-1302 Period: From 01/01/2020 Worksheet A-6

12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Increases Cost Center Line # 0ther Sal arv 2.00 3.00 4.00 5.00 CAFETERI A 1.00 CAFETERI A 11.00 90, 521 72, 405 1.00 90, 521 72, 405 B - MEDICAL SUPPLIES 1.00 CENTRAL SERVICES & SUPPLY 14.00 186, 405 1.00 MEDICAL SUPPLIES CHARGED TO 18, 239 2.00 71.00 2.00 PATI ENTS 3.00 IMPL. DEV. CHARGED TO PATIENT 72.00 14, 761 3.00 4.00 EMPLOYEE BENEFITS DEPARTMEN 4.00 886 4.00 OPERATION OF PLANT 7.00 5.00 1,562 5.00 6 00 NURSING ADMINISTRATION 13 00 2, 488 6 00 7.00 ANESTHESI OLOGY 53.00 14,634 7.00 8.00 0.00 8.00 9.00 0.00 9.00 10.00 10.00 0.00 11.00 0.00 11.00 12.00 0.00 12.00 13 00 0.00 13 00 238, 975 DRUGS CHARGED TO PATIENTS 1.00 PHARMACY 15.00 20, 215 1.00 2.00 0 DRUGS CHARGED TO PATIENTS 73.00 713, 433 2.00 3.00 0.00 3.00 4.00 0.00 4.00 5.00 0.00 5.00 6.00 0.00 6.00 7.00 0.00 7.00 8.00 0.00 8.00 9.00 0.00 9.00 10.00 0.00 10.00 11.00 0.00 11.00 733, 648 - EMPLOYEE BENEFITS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 968, 596 1.00 2.00 0.00 2.00 3.00 0.00 0 3.00 4.00 0.00 4.00 5.00 0.00 5.00 6.00 0.00 6.00 0.00 7.00 7.00 8.00 0.00 8.00 9.00 0.00 9.00 10.00 0.00 10.00 11.00 0.00 11.00 968, 596 - DEPRECIATION 1.00 NEW CAP REL COSTS-BLDG & FIX 1. 00 0 740, 480 1.00 2.00 0.00 2.00 3.00 0.00 3.00 4.00 0.00 4.00 0.00 5 00 5 00 6.00 0.00 6.00 7.00 0.00 7.00 8.00 0.00 8.00 9 00 0.00 9 00 10.00 0.00 10.00 11.00 0.00 11.00 12.00 0.00 12.00 13.00 0.00 13 00 14.00 0.00 14.00 740, 480 - OUTPATIENT THERAPY 1.00 67.00 1<u>5, 2</u>31 15, 231 OCCUPATI ONAL THERAPY 139 1.00 139 H - AUTO & PROPERTY INSURANC 1.00 NEW CAP REL COSTS-BLDG & FIX 1.00 1.00 1<u>3, 0</u>65 13, 065 J - RURAL HEALTH CLINIC 1.00 RURAL HEALTH CLINIC (RHC) 88. 00 147, 670 1.00 147, 670 TOTALS K - ACCRUED PTO 4. 00 1.00 <u>EMPLOYEE BENEFITS DEPARTMEN</u> 126 108 1.00 TOTALS 126, 108 500.00 Grand Total: Increases 2, 914, 978 231,860 500.00 Provi der CCN: 15-1302 

					То	12/31/2020 Date/Time F 7/15/2021 1	
	Cost Center	Decreases	Salary	Other	Nket A 7 Dof		
	6. 00	Li ne # 7.00	Sal ary 8.00	9. 00	Wkst. A-7 Ref. 10.00		
	A - CAFETERIA						
1. 00	DI ETARY	10. 00	90, 521	7 <u>2, 405</u>	9		1. 00
	U B - MEDICAL SUPPLIES		90, 521	72, 405			-
1. 00	ADMINISTRATIVE & GENERAL	5. 00	O	2, 823	0		1.00
2.00	HOUSEKEEPI NG	9. 00	0	11, 892	0		2. 00
3.00	DIETARY	10. 00	0	559	0		3. 00
4. 00 5. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	4, 922 69, 931	0		4. 00 5. 00
6. 00	OPERATING ROOM	50. 00 50. 00	0	1, 281	0		6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	30, 595	Ö		7. 00
8.00	RESPI RATORY THERAPY	65. 00	0	33, 533	0		8. 00
9. 00	PHYSI CAL THERAPY	66. 00	0	1, 869	0		9. 00
10. 00 11. 00	CARDIAC REHABILITATION CLINIC	76. 97 90. 00	0	631	0		10.00
12.00	EMERGENCY	90.00 91.00	0	3, 161 77, 777	0		11. 00 12. 00
13.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	Ö	1	Ö		13. 00
	CANTEEN						
	0		0	238, 975			_
1. 00	C - DRUGS CHARGED TO PATIENT PHARMACY	15. 00	ol	690, 188	0		1.00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	501	0		2.00
3. 00	ADMINISTRATIVE & GENERAL	5. 00	Ō	3	Ö		3. 00
4.00	DI ETARY	10. 00	0	432	0		4. 00
5.00	ADULTS & PEDIATRICS	30. 00	0	10, 199	0		5. 00
6. 00 7. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	O	266 23, 220	0		6. 00 7. 00
8. 00	RESPIRATORY THERAPY	65. 00	0	23, 220 160	0		8. 00
9. 00	ELECTROCARDI OLOGY	69. 00	Ō	861	Ō		9. 00
10.00	CLINIC	90. 00	0	818	0		10. 00
11. 00	EMERGENCY	91.00	위	<u>7, 000</u>	<u> </u>		11. 00
	E - EMPLOYEE BENEFITS		UU	733, 648			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	78, 975	0		1.00
2.00	OPERATION OF PLANT	7. 00	0	55, 303	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	62, 413	0		3.00
4. 00 5. 00	DIETARY NURSING ADMINISTRATION	10. 00 13. 00	0	74, 527 33, 060	0		4. 00 5. 00
6. 00	ADULTS & PEDIATRICS	30. 00	0	344, 330	0		6.00
7. 00	OPERATING ROOM	50. 00	0	42, 874	O		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	136, 456	0		8. 00
9. 00	CARDI AC REHABI LI TATI ON	76. 97	0	34	0		9.00
10. 00 11. 00	CLINIC EMERGENCY	90. 00 91. 00	0	1, 207 139, 417	0		10. 00 11. 00
11.00	0	71.00	- — <del> </del>	968, 596			11.00
	F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 985	9		1.00
2. 00 3. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	431, 814 1, 264	0		2. 00 3. 00
4. 00	DI ETARY	10. 00	0	8, 907	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	Ō	2, 138	Ō		5. 00
6.00	PHARMACY	15. 00	0	19, 329	0		6. 00
7. 00	ADULTS & PEDIATRICS OPERATING ROOM	30.00	0	20, 351	0		7.00
8. 00 9. 00	RADI OLOGY-DI AGNOSTI C	50. 00 54. 00	0	9, 250 179, 220	0		8. 00 9. 00
10.00	RESPIRATORY THERAPY	65. 00	Ö	11, 483	Ö		10.00
11.00	PHYSI CAL THERAPY	66. 00	0	1, 356	0		11. 00
12.00	CARDI AC REHABI LI TATI ON	76. 97	0	5, 129	0		12.00
13. 00 14. 00	CLI NI C EMERGENCY	90. 00 91. 00	O	1, 072 33, 182	0		13. 00 14. 00
14.00	0	91.00	<del> </del>	740, 480	<u> </u>		14.00
	G - OUTPATIENT THERAPY						
1. 00	PHYSICAL THERAPY	66. 00	<u>15, 2</u> 31	<u> </u>	0		1.00
	O		15, 231	139			_
1. 00	<u>H - AUTO &amp; PROPERTY INSURANC</u> ADMINISTRATIVE & GENERAL	5. 00	٥	13, 065	12		1 00
1.00	0 σENERAL	5.00	위	1 <u>3, 065</u> 13, 065	12		1.00
	J - RURAL HEALTH CLINIC			. 3, 833			
1.00	RURAL HEALTH CLINIC (RHC)	88. 00	<u>147, 6</u> 70	0	0		1.00
	TOTALS		147, 670	0			4
1. 00	K - ACCRUED PTO ADMINISTRATIVE & GENERAL	5. 00	126, 108	O	O		1.00
1.00	TOTALS		126, 108	— — —	<u> </u>		1.00
500. 00	Grand Total: Decreases		379, 530	2, 767, 308			500.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-1302	Period: Worksheet A-7

12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 190, 324 0 1.00 259, 436 2.00 Land Improvements 0 2.00 15, 007, 745 3.00 Buildings and Fixtures 3.00 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 5.00 0 6.00 Movable Equipment 6.00 4, 530, 274 69, 114 69, 114 285, 105 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 19, 987, 779 69, 114 285, 105 69, 114 8.00 9.00 Reconciling Items 9.00 0 19, 987, 779 69, 114 285, 105 Total (line 8 minus line 9) 69, 114 10.00 10.00 Endi ng Bal ance Ful I y Depreciáted Assets 6.00 7.00 PART CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 190, 324 1.00 259, 436 2.00 2.00 Land Improvements 224, 509 3.00 Buildings and Fixtures 15, 007, 745 3, 042, 298 3.00 4.00 Building Improvements 4.00 5.00 5.00 Fixed Equipment 2,091,770 6.00 Movable Equipment 4, 314, 283 6.00 7.00 HIT designated Assets 7.00 Subtotal (sum of lines 1-7) Reconciling Items 8.00 19, 771, 788 5, 358, 577 8.00 9.00 9.00 10.00 Total (line 8 minus line 9) 19, 771, 788 5, 358, 577 10.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2020 To 12/31/2020		pared:
		SU	MMARY OF CAPI	TAL		
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			and 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	5, 732	0		0	0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00 Total (sum of lines 1-2)	5, 732	0		0 0	0	3. 00
	SUMMARY C	F CAPITAL				
Cost Center Description	0ther	Total (1) (sum				
	Capi tal -Rel ate	d of cols. 9				
	Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COL	UMN 2, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	5, 732				1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00 Total (sum of lines 1-2)	0	5, 732	l			3. 00

Heal th	n Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lieu	of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1302 P	eriod: rom 01/01/2020	Worksheet A-7 Part III	
						Date/Time Pre	pared:
		I COME	 PUTATION OF RA	TLOC	ALLOCATION OF	7/15/2021 1: 0	3 pm
		COMP	PUTATION OF RA	1105	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
		1. 00	2.00	2) 3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS		2.00	3.00	4.00	3.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	19, 771, 788	0	19, 771, 788	1. 000000	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0. 000000		2. 00
3.00	Total (sum of lines 1-2)	19, 771, 788		19, 771, 788			3. 00
		ALLOCAT	TION OF OTHER	CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate				
			d Costs	through 7)			
	DADT III DESCRIPTION OF CARLEY COOTS	6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS NEW CAP REL COSTS-BLDG & FIXT	CENTERS		ı o	964, 678	0	1. 00
2. 00	NEW CAP REL COSTS-BLDG & FIXT		0		904, 078	0	2.00
3. 00	Total (sum of lines 1-2)		0		964, 678	0	3. 00
	J		SL	JMMARY OF CAPIT			
	Coot Conton Bosonintian	Interest		Taura (222	Other	Tatal (2) (a	
	Cost Center Description	Interest	Insurance (see		Capi tal -Relate	Total (2) (sum of cols. 9	
			i iisti ucti olis)	l listi de ti olis)	d Costs (see	through 14)	
					instructions)	em ough 11)	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-57, 498	13, 065	0	0	920, 245	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	12.045	0	0	020 245	2.00
3. 00	Total (sum of lines 1-2)	-57, 498	13, 065	· · · · · · · · · · · · · · · · · · ·	미	920, 245	3. 00

	Financial Systems MENTS TO EXPENSES	10	HEALIH BLACK		eriod: com 01/01/2020	Worksheet A-8	
				To		Date/Time Pre	epared: 03 pm
				Expense Classification on To/From Which the Amount is			
					,		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref. 5.00	
	Investment income - NEW CAP R	1. 00 EL B	2. 00 -57, 498	3.00 NEW CAP REL COSTS-BLDG & FIX	4. 00 (T 1. 00	5.00	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - NEW CAP R	EL	0	NEW CAP REL COSTS-MVBLE EQUI	P 2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4.00
	discounts (chapter 8) Refunds and rebates of expens		0				
	(chapter 8)	85	0		0. 00		
	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6.00
	Telephone services (pay stations excluded) (chapter 2	1)	0		0. 00	0	7.00
	Tel evi si on and radi o servi ce (chapter 21)		0		0. 00	0	8. 00
	Parking Lot (chapter 21) Provider-based physician	A 0 2	1 411 104		0. 00		
	adjustment	A-8-2	-1, 411, 186			0	
	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11.00
	Related organization transactions (chapter 10)	A-8-1	2, 181, 112			0	12. 00
	Laundry and linen service Cafeteria-employees and guest	s B	-50 519	CAFETERI A	0. 00 11. 00	0	
15.00	Rental of quarters to employe and others		0	ON ETENIA	0. 00	0	
16.00	Sale of medical and surgical		0		0. 00	0	16. 00
17. 00	supplies to other than patien Sale of drugs to other than	ts	0		0. 00	0	17. 00
	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19.00
	education (tuition, fees,		· ·		0.00	Ç	17.00
20.00	books, etc.) Vending machines	В	0	DI ETARY	10. 00		
	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings trepay Medicare overpayments	Þ					
	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)			DUVOLOAL TUEDADV			0.4.00
	Adjustment for physical thera costs in excess of limitation	by A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	(chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIX	(T 1.00	0	26. 00
27. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE EQUI	P 2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech patholo		0	SPEECH PATHOLOGY	68. 00		31. 00
	costs in excess of limitation (chapter 14)						
	CAH HIT Adjustment for Depreciation and Interest	А	-2	NEW CAP REL COSTS-BLDG & FIX	(T 1.00	9	32.00
	CHARLTY CONTRIBUTIONS	Α	-10	ADMINISTRATIVE & GENERAL	5. 00	0	33.00

Health Financial Systems IU HEALTH BLAG				KFORD HOSPITAL	of Form CMS-2	2552-10	
ADJUSTMENTS TO EXPENSES					eri od:	Worksheet A-8	3
					rom 01/01/2020 o 12/31/2020	Date/Time Pre 7/15/2021 1:0	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 01 M	NISCELLANEOUS INCOME	В	-32, 002	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33.02 M	MISCELLANEOUS INCOME	В	-6, 160	HOUSEKEEPI NG	9. 00	0	33. 02
33.03 M	NISCELLANEOUS INCOME	В	-470	EMERGENCY	91. 00	0	33. 03
33.04 M	MARKETING/ADVERTISING COSTS	A	-1, 944	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05 E	EMPLOYEE BENEFITS	Α	-968, 596	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	33. 05
33.06 H	HOSPITAL ASSESSMENT FEES	Α	-708, 063	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07 R	RURAL HEALTH CLINIC	Α	-186, 773	RURAL HEALTH CLINIC (RHC)	88. 00	0	33. 07
50.00 T	OTAL (sum of lines 1 thru 49	)	-1, 242, 111				50.00
(	(Transfer to Worksheet A,						
C	column 6, line 200.)						

- Description all chapter references in this column pertain to CMS Pub. 15-1.
   Basis for adjustment (see instructions).
- A. Costs if cost, including applicable overhead, can be determined.
- B. Amount Received if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1302 OFFICE COSTS

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepare

OTTTCL	00313			To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
	Line No.	Cost Center	Expense Items	Amount of A	mount Included	<u> </u>
				Allowable Cost		
					column 5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT C	OF TRANSACTIONS WITH RELATED	ORGANI ZATI ONS	OR	
	CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	218, 468	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1, 174, 506	638	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3, 269, 523	2, 704, 227	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	811, 663	753, 681	4.00
4. 01	7.00	OPERATION OF PLANT	RELATED PARTY	274, 280	229, 266	4.01
4. 02	10.00	DI ETARY	RELATED PARTY	10, 767	0	4.02
4.03	13.00	NURSING ADMINISTRATION	RELATED PARTY	184, 426	11, 257	4.03
4.04	15.00	PHARMACY	RELATED PARTY	248, 320	348, 482	4.04
4. 05	50.00	OPERATING ROOM	RELATED PARTY	0	13, 668	4.05
4.06	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	126, 499	154, 961	4.06
4. 07	65.00	RESPI RATORY THERAPY	RELATED PARTY	25, 578	24, 651	4.07
4. 08	66.00	PHYSI CAL THERAPY	RELATED PARTY	66, 473	35, 030	4.08
4. 09	69.00	ELECTROCARDI OLOGY	RELATED PARTY	40, 372	0	4.09
4. 10	76. 97	CARDIAC REHABILITATION	RELATED PARTY	6, 098	0	4. 10
4. 11	4. 00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	20, 455	20, 455	4. 11
4. 12	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY	260, 143	260, 143	4. 12
4. 13	7. 00	OPERATION OF PLANT	RELATED PARTY	210, 504	210, 504	4. 13
4. 14	10.00	DI ETARY	RELATED PARTY	36, 517	36, 517	4. 14
4. 15	13. 00	NURSING ADMINISTRATION	RELATED PARTY	193	193	4. 15
4. 16	15. 00	PHARMACY	RELATED PARTY	532, 658	532, 658	4. 16
4. 17	30.00	ADULTS & PEDIATRICS	RELATED PARTY	5, 671	5, 671	4. 17
4. 18	50.00	OPERATING ROOM	RELATED PARTY	4, 901	4, 901	4. 18
4. 19	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	384, 888	384, 888	4. 19
4. 20	60.00	LABORATORY	RELATED PARTY	1, 142, 609	1, 142, 609	4. 20
4. 21	65.00	RESPI RATORY THERAPY	RELATED PARTY	459, 201	459, 201	4. 21
4. 22	66.00	PHYSI CAL THERAPY	RELATED PARTY	347, 870	347, 870	4. 22
4. 23	67.00	OCCUPATIONAL THERAPY	RELATED PARTY	78, 079	78, 079	4. 23
4. 24	68.00	SPEECH PATHOLOGY	RELATED PARTY	8, 675	8, 675	4. 24
4. 25	69.00	ELECTROCARDI OLOGY	RELATED PARTY	10, 962	10, 962	4. 25
4. 26	76. 97	CARDIAC REHABILITATION	RELATED PARTY	29, 242	29, 242	4. 26
4. 27			RELATED PARTY	25, 778	25, 778	4. 27
4. 28	91.00	EMERGENCY	RELATED PARTY	1, 724, 563	1, 724, 563	4. 28
5. 00	0		0	11, 739, 882	9, 558, 770	5. 00
* Tho	amounts on lines 1-4 (and su	pecripte as appropriate) are	transformed in detail to W	orkshoot A col	ump 4 lines a	_

\* 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 look been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	·		Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of	1			
		Ownershi p		Ownershi p				
1. 00	2.00	3. 00	4. 00	5. 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 XVIII.

6. 00	В	0. 00 I U HEALTH 100. 00	6. 00
7. 00	В	0.00 BALL HOSPITAL 100.00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10.00		0.00	10. 00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

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4. 25

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4.28

5.00

F	Related Organization(s) and/o	r	
	Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	NTED 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	HOSPI TAL		6.00
7. 00 8. 00 9. 00 10. 00	HOSPI TAL		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00		]	100.00

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

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2, 181, 112

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5.00

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

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

					-	Го 12/31/202	Date/Time Pr 7/15/2021 1:	epared: 03 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	hysi ci an/Provi	
		l denti fi er	Remuneration	Component	Component		der Component	
							Hours	
4 4 4	1.00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	1, 800		1, 800			
2.00		ANESTHESI OLOGY	224, 258			C	0	00
3. 00 4. 00		RADI OLOGY-DI AGNOSTI C CARDI AC REHABI LI TATI ON	150, 000 1, 120		150, 000		0	3. 00 4. 00
5. 00		EMERGENCY	1, 602, 877				0	5. 00
6. 00	0.00		1,002,077	1, 165, 606	417,009			6.00
7. 00	0.00			0	0		0	
8. 00	0.00			0	0		0	8.00
9. 00	0.00		0	1 0	0	Č	0	
10. 00			0	0	0	Ċ	Ö	
200. 0			1, 980, 055	1, 411, 186	568, 869		Ö	
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldentifier	Limit	Unadjusted RCE	Memberships &@		of Malpractice	
				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		ADMINISTRATIVE & GENERAL	0	0	0	C	_	
2.00		ANESTHESI OLOGY	0	0	0	C	0	
3.00		RADI OLOGY-DI AGNOSTI C	0	0	0		0	3.00
4.00		CARDIAC REHABILITATION EMERGENCY	0	0	0		0	
5. 00 6. 00	0.00			0	0		0	
7. 00	0.00						0	
8. 00	0.00			0				8. 00
9. 00	0.00			0	0		Ö	
10.00			0	l 0	0	Č	ő	
200. 0			l o	Ö	Ö	Ċ	Ö	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fier	component Share	Limit	Di sal I owance			
			of col. 14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADMINISTRATIVE & GENERAL	0	0	0	C	I .	1.00
2.00		ANESTHESI OLOGY	0	0	0	224, 258		2.00
3.00		RADI OLOGY-DI AGNOSTI C	0	0	0	1 100		3.00
4.00		CARDIAC REHABILITATION	0	0	0	1, 120		4.00
5. 00		EMERGENCY		0		1, 185, 808		5. 00
6. 00 7. 00	0. 00 0. 00			0				6. 00 7. 00
7. 00 8. 00	0.00						}	8.00
9. 00	0.00						1	9.00
10.00	0.00		1	1 0	1		1	7.00
	0.00		0	0	0	(	i	10.00

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lieu	u of Form CMS-2	<u> 2552-10</u>
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	F	reriod: rom 01/01/2020 o 12/31/2020		
		CAPITAL REL				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	col. 7)	1.00	2. 00	4. 00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	920, 245	920, 245				1. 00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0		C	1		2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL	1, 372, 864	117 211	0	1, 372, 864		4.00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	4, 875, 359 1, 238, 362	117, 211 174, 569		135, 833 54, 733	5, 128, 403 1, 467, 664	•
9. 00   00900  HOUSEKEEPI NG	286, 404	19, 204		41, 038	346, 646	•
10. 00 01000 DI ETARY	242, 251	37, 772		31, 189	311, 212	
11. 00 01100 CAFETERI A	112, 407	26, 565	C	21, 952	160, 924	•
13.00 01300 NURSING ADMINISTRATION	416, 267	3, 897	C	47, 602	467, 766	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	186, 071	20, 503	C	0	206, 574	14. 00
15. 00 01500 PHARMACY	823, 968	13, 932	C	0	837, 900	15. 00
I NPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS	2, 042, 385	150 144	C	452,020	2 (4/ 450	20.00
ANCI LLARY SERVI CE COST CENTERS	2, 042, 383	150, 144	U	453, 929	2, 646, 458	30.00
50. 00 05000 OPERATING ROOM	255, 892	80, 357	C	42, 662	378, 911	50.00
53. 00 05300 ANESTHESI OLOGY	42	0	C	0	42	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 264, 952	73, 353	C	140, 029	1, 478, 334	54.00
57.00 05700 CT SCAN	0	0	C	0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1 101 051	20.140	0	0	1 220 020	
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	1, 191, 851	28, 169		0	1, 220, 020 0	60. 00 60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	•
65. 00 06500 RESPIRATORY THERAPY	486, 087	10, 672	Ö	110, 864	607, 623	•
65. 01 06501 SLEEP LAB	0	0	C	. 0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	401, 591	50, 328	C	80, 461	532, 380	•
67. 00 06700 OCCUPATI ONAL THERAPY	93, 449	4, 432	C	22, 628	120, 509	•
68. 00 06800 SPEECH PATHOLOGY	8, 675	76	0	2, 104	10, 855	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	51, 334 18, 239	0		2, 658	53, 992 18, 239	•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	14, 761	0		0	14, 761	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	713, 433	Ö	Ö	ő	713, 433	
76. 00 03140 CARDI OLOGY	0	0	C	0	0	76. 00
76. 97 O7697 CARDIAC REHABILITATION	36, 824	3, 591	C	7, 249	47, 664	76. 97
OUTPATIENT SERVICE COST CENTERS		-1			-	
88. 00 08800 RURAL HEALTH CLINIC (RHC)	0	17.000	O		0	
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	57, 447 1, 305, 299	17, 982 80, 815		,		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 303, 244	00, 013		170, 790		92.00
SPECIAL PURPOSE COST CENTERS						72.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	18, 416, 459	913, 572	C	1, 372, 864	18, 409, 786	118. 00
NONREI MBURSABLE COST CENTERS				1		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	594	6, 673	0	0		190.00
192.0019200 PHYSICIANS' PRIVATE OFFICES 200.00 Cross Foot Adjustments	0	O	C			192. 00 200. 00
201.00 Negative Cost Centers		Ω	n	n		200.00
202.00 TOTAL (sum lines 118 through 201)	18, 417, 053	920, 245	Ö	1, 372, 864		
		• • •	•			•

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-1302	Period: Worksheet B From 01/01/2020 Part I

				To	12/31/2020	Date/Time Pre 7/15/2021 1:0	epared:
	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPI NG	DI ETARY	CAFETERI A	) piii
		5. 00	7. 00	9. 00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	7, 00	10.00	111.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 128, 403					5. 00
7.00	00700 OPERATION OF PLANT	566, 407	2, 034, 071				7. 00
9.00	00900 HOUSEKEEPI NG	133, 779	62, 156	542, 581			9.00
10.00	01000 DI ETARY	120, 104	122, 250	33, 638	587, 204		10.00
11.00	01100 CAFETERI A	62, 104	85, 979	23, 658	0	332, 665	11. 00
13.00	01300 NURSING ADMINISTRATION	180, 522	12, 612	3, 470	0	8, 428	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	79, 722	66, 360	18, 259	0	0	14. 00
15.00	01500 PHARMACY	323, 366	45, 092	12, 407	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 021, 325	485, 950	133, 710	587, 204	137, 749	30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	146, 231	260, 081	71, 562	0	11, 612	
53.00	05300 ANESTHESI OLOGY	16	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	570, 525	237, 411	65, 325	0	41, 905	•
57. 00	05700 CT SCAN	0	0	0	0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00	06000 LABORATORY	470, 835	91, 173	25, 087	0	39, 423	•
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
65.00	06500 RESPI RATORY THERAPY	234, 496	34, 540	9, 504	0	24, 019	•
65. 01	06501 SLEEP LAB	0	0	0	0	0	
66.00	06600 PHYSI CAL THERAPY	205, 458	· ·	44, 820	0	17, 183	•
67.00	06700 OCCUPATI ONAL THERAPY	46, 507	14, 344	3, 947	0	4, 354	•
68.00	06800 SPEECH PATHOLOGY	4, 189		68	0	328	
69.00	06900 ELECTROCARDI OLOGY	20, 837	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	7, 039	0	0	0	0	
72.00	· ·	5, 697	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS 03140 CARDI OLOGY	275, 331	0	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	18, 395	11, 623	3, 198	0	0	•
70.97	OUTPATIENT SERVICE COST CENTERS	10, 393	11,023	3, 190	<u> </u>		70.97
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88. 00
	09000 CLINIC	31, 863	58, 199	16, 014	ő	3, 137	
91.00	09100 EMERGENCY	600, 850			ō	44, 527	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1	,		,	92.00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 INTEREST EXPENSE						113. 00
118.00		5, 125, 598	2, 012, 473	536, 638	587, 204	332, 665	118. 00
	NONREI MBURSABLE COST CENTERS				-1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 805	21, 598	5, 943	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	O	O	0	192. 00
200. 00 201. 00	, ,	^	_			0	200. 00 201. 00
201.00		5, 128, 403	2, 034, 071	542, 581	587, 204	332, 665	
202.00	TIVIAL (Suil TITIES TIV LITIVUYIT 201)	5, 120, 403	2,034,071	1 342,301	307, 204	332,003	K02.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-1302	Period: Worksheet B From 01/01/2020 Part I

0031 7	ELECONTION GENERAL SERVICE 30373		Trovider o		rom 01/01/2020 o 12/31/2020		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	Subtotal	Intern &	)3 piii
	2001 2011 2000 pt. 611	ADMI NI STRATI ON	SERVICES &			Residents Cost	
			SUPPLY			& Post	
						Stepdown	
						Adjustments	
		13. 00	14. 00	15. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT			1			5. 00 7. 00
9. 00	00900 HOUSEKEEPI NG			ł			9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION	672, 798					13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	072,770	370, 915				14. 00
15. 00	01500 PHARMACY		8, 353				15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0, 333	1,227,110			13.00
30.00	03000 ADULTS & PEDIATRICS	442, 148	88, 488	17, 059	5, 560, 091	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	25, 404	0	445	894, 246	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	1 4	58	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	48, 737	2, 959	2, 445, 196	0	54. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	0	1, 846, 538	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	U 51 222	0	0(1.770	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	51, 323		961, 773	0	65. 00 65. 01
65. 01	06501 SLEEP LAB		0	,	045 503	0	
66. 00 67. 00	06600  PHYSI CAL THERAPY 06700  OCCUPATI ONAL THERAPY	0	2, 770 155	1	965, 502 189, 816	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		15, 687	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	1	74, 829	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27, 695		52, 973	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENT		22, 414		42, 872	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		22, 414		2, 182, 075	0	73.00
76. 00	03140 CARDI OLOGY	Ö	0		2, 102, 070	0	76.00
	07697 CARDI AC REHABI LI TATI ON	Ö	984	Ö	81, 864	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				·		
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88. 00
90.00	09000 CLI NI C	13, 508	4, 476	1, 368	211, 129	0	90.00
91.00	09100 EMERGENCY	191, 738	115, 517	11, 708	2, 854, 788	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
440.00	SPECIAL PURPOSE COST CENTERS			1			110 00
113.00	11300 INTEREST EXPENSE	672, 798	270 012	1 227 110	10 270 427		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0/2, /98	370, 912	1, 227, 118	18, 379, 437	U	118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	3	l o	37, 616	Ω	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	ő	0	ő	0.,010		192. 00
200. 00			· ·		o o		200.00
201. 00	, ,	0	0	О	o		201. 00
202.00	, , <u>,</u>	672, 798	370, 915	1, 227, 118	18, 417, 053		202. 00
		·					

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-1302	Peri od: From 01/01/2020	

		To 12/31/2020 Date/Time	
Cost Center Description	Total	7/15/2021	1: 03 pm
cost center bescription	26. 00		
GENERAL SERVICE COST CENTERS	20.00		
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT			1.00
2. 00 O0200 NEW CAP REL COSTS-MVBLE EQUIP			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00 00500 ADMINISTRATIVE & GENERAL			5. 00
7. 00 00700 OPERATION OF PLANT			7. 00
9. 00 00900 HOUSEKEEPI NG			9. 00
10. 00 01000 DI ETARY			10. 00
11. 00 01100 CAFETERI A			11. 00
13. 00 01300 NURSING ADMINISTRATION	1		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	1		14. 00
15. 00 01500 PHARMACY			15. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	5, 560, 091		30.00
ANCILLARY SERVICE COST CENTERS	27 2227 2		
50. 00 05000 OPERATI NG ROOM	894, 246		50.00
53. 00 05300 ANESTHESI OLOGY	58		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 445, 196		54.00
57. 00 05700 CT SCAN	2, 1.10, 1.70		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		59. 00
60. 00 06000 LABORATORY	1, 846, 538		60.00
60. 01 06001 BLOOD LABORATORY	0		60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o		62. 00
65.00 06500 RESPIRATORY THERAPY	961, 773		65. 00
65. 01 06501 SLEEP LAB	0		65. 01
66. 00 06600 PHYSI CAL THERAPY	965, 502		66. 00
67.00 06700 OCCUPATI ONAL THERAPY	189, 816		67. 00
68.00 06800 SPEECH PATHOLOGY	15, 687		68. 00
69. 00 06900 ELECTROCARDI OLOGY	74, 829		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	52, 973		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	42, 872		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 182, 075		73. 00
76. 00 03140 CARDI OLOGY	0		76. 00
76.97 07697 CARDIAC REHABILITATION	81, 864		76. 97
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC (RHC)	0		88. 00
90. 00 09000 CLINIC	211, 129		90. 00
91.00 09100 EMERGENCY	2, 854, 788		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
SPECIAL PURPOSE COST CENTERS			
113. 00 11300 I NTEREST EXPENSE			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 379, 437		118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37, 616		190. 00
192.0019200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
200.00 Cross Foot Adjustments	o		200. 00
201.00 Negative Cost Centers	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	18, 417, 053		202. 00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1302	Period: Worksheet B

					rom 01/01/2020 o 12/31/2020		epared:
			CAPI TAL REL	ATED COSTS		177 137 2021 1.0	Jo pili
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	FIXT	EQUI P	Subtotal	BENEFI TS	
	(	apital Related				DEPARTMENT	
		Costs					
ICEN	JEDAL CEDVICE COCT CENTERS	0	1. 00	2. 00	2A	4. 00	
	NERAL SERVICE COST CENTERS 100 NEW CAP REL COSTS-BLDG & FIXT				1		1.00
	200 NEW CAP REL COSTS-BEBG & TTXT				1		2.00
	400 EMPLOYEE BENEFITS DEPARTMENT	О	0	C	o	0	1
5.00 005	500 ADMINISTRATIVE & GENERAL	0	117, 211	C	117, 211	0	5.00
	700 OPERATION OF PLANT	0	174, 569	C	174, 569	0	
	900 HOUSEKEEPI NG	0	19, 204	C	19, 204	0	
	DOO DI ETARY	0	37, 772	0	37, 772	0	10.00
	100 CAFETERIA 300 NURSING ADMINISTRATION	0	26, 565 3, 897		26, 565 3, 897	0	
	400 CENTRAL SERVICES & SUPPLY	0	20, 503		20, 503	0	
	500 PHARMACY		13, 932	0	13, 932	0	•
	PATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	107 702		107 702		1
	DOO ADULTS & PEDIATRICS	0	150, 144	C	150, 144	0	30.00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATI NG ROOM	0	80, 357	C	80, 357	0	
	300 ANESTHESI OLOGY	0	72 252	0	72 252	0	53.00
	400 RADI OLOGY-DI AGNOSTI C 700 CT SCAN	0	73, 353 0		73, 353	0	
	BOO MAGNETIC RESONANCE IMAGING (MRI)		0			0	58. 00
	900 CARDI AC CATHETERI ZATI ON	Ö	Ö	Ö	Ö	0	59.00
	DOO LABORATORY	0	28, 169	C	28, 169	0	60.00
	DO1 BLOOD LABORATORY	0	0	C	0	0	60. 01
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62. 00
	500 RESPIRATORY THERAPY	0	10, 672	0	10, 672	0	65.00
	501 SLEEP LAB 500 PHYSI CAL THERAPY	0	50, 328	0	50, 328	0	65. 01 66. 00
	700 OCCUPATI ONAL THERAPY	0	4, 432	0	4, 432	0	67. 00
	BOO SPEECH PATHOLOGY	l ő	76	Ö	76	0	1
	900 ELECTROCARDI OLOGY	Ö	0	Ö	0	0	69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
	200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0	0	72. 00
	BOO DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
	140 CARDI OLOGY	0	2 501	0	2 501	0	
	697 CARDIAC REHABILITATION  TPATIENT SERVICE COST CENTERS	U U	3, 591	U	3, 591	0	76.97
	BOO RURAL HEALTH CLINIC (RHC)	0	o	C	l ol	0	88. 00
	DOO CLINIC	Ö	17, 982	Ö	17, 982	0	
91.00 091	100 EMERGENCY	0	80, 815	C	80, 815	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	ECIAL PURPOSE COST CENTERS						
113. 00113	300 INTEREST EXPENSE	0	012 570	_	012 570	0	113.00
	SUBTOTALS (SUM OF LINES 1 through 117)   NREIMBURSABLE COST CENTERS	<u> </u>	913, 572	C	913, 572	0	118. 00
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	6, 673	0	6, 673	n	190. 00
	200 PHYSI CI ANS' PRI VATE OFFI CES	ő	0, 0, 0	Ö	0,070		192.00
200. 00	Cross Foot Adjustments				0		200. 00
201. 00	Negative Cost Centers		0	C	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	920, 245	C	920, 245	0	202. 00

Peri od: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 7/15/2021 1: 03 pm Provi der CCN: 15-1302

Cost Center Description		ADMI NI STRATI VE	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	) Dill
		& GENERAL	PLANT				
		5. 00	7. 00	9. 00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	DO500 ADMINISTRATIVE & GENERAL	117, 211					5. 00
	00700 OPERATION OF PLANT	12, 945	187, 514				7. 00
	DO900 HOUSEKEEPI NG	3, 057	5, 730				9. 00
	D1000 DI ETARY	2, 745	11, 270		53, 522		10. 00
	D1100 CAFETERI A	1, 419			0	37, 130	
	01300 NURSING ADMINISTRATION	4, 126			0	941	
	01400 CENTRAL SERVICES & SUPPLY	1, 822	6, 117		0	0	
15.00	D1500 PHARMACY	7, 390	4, 157	640	0	0	15. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	23, 348	44, 798	6, 898	53, 522	15, 374	30. 00
4	ANCILLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM	3, 342	23, 976	1	0	1, 296	
	D5300 ANESTHESI OLOGY	0	0		0	0	
	D5400 RADI OLOGY-DI AGNOSTI C	13, 039	21, 886	3, 370	0	4, 677	
	D5700 CT SCAN	0	0	0	0	0	
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59.00	D5900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00	06000 LABORATORY	10, 761	8, 405	1	0	4, 400	
60. 01	06001 BLOOD LABORATORY	0	0	·	0	0	60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
	06500 RESPIRATORY THERAPY	5, 359	3, 184	490	0	2, 681	65.00
	D6501 SLEEP LAB	0	0	0	0	0	65. 01
	06600 PHYSI CAL THERAPY	4, 696	15, 016		0	1, 918	
	06700 OCCUPATI ONAL THERAPY	1, 063	1, 322		0	486	
	06800 SPEECH PATHOLOGY	96	23	1	0	37	68. 00
	06900 ELECTROCARDI OLOGY	476	0	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	161	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	130	0	0	0	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	6, 292	0	0	0	0	73. 00
76.00	03140 CARDI OLOGY	0	0	0	0	0	76. 00
/6.9/	07697 CARDI AC REHABI LI TATI ON	420	1, 072	165	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS							
	D8800 RURAL HEALTH CLINIC (RHC)	0	0	· ·	0	0	88. 00
	09000 CLI NI C	728	5, 365	1	0	350	
	09100 EMERGENCY	13, 732	24, 113	3, 713	0	4, 970	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS							
	11300 I NTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	117, 147	185, 523	27, 684	53, 522	37, 130	118.00
NONREI MBURSABLE COST CENTERS							
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	64	1, 991	1	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00	Cross Foot Adjustments		_				200.00
201.00	Negative Cost Centers	117 011	107.514	07 001	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	117, 211	187, 514	27, 991	53, 522	37, 130	K07.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1302	Period: Worksheet B		

From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Cost Center Description NURSI NG CENTRAL PHARMACY Subtotal Intern & ADMI NI STRATI ON SERVICES & Residents Cost SUPPLY & Post Stepdown Adjustments 13.00 14.00 15.00 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 OO1OO NEW CAP REL COSTS-BLDG & FIXT 1.00 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00900 HOUSEKEEPI NG 9.00 9.00 10 00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 10, 306 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 29, 384 14.00 01500 PHARMACY 26, 781 15.00 662 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 773 7, 010 372 308, 239 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 389 10 113,062 0 50.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 3,861 65 120, 251 54.00 0 57 00 05700 CT SCAN 0 57 00 0 58.00 O5800 MAGNETIC RESONANCE IMAGING (MRI) 0 C 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 60.00 06000 LABORATORY 0 53, 029 0 60.00 0 06001 BLOOD LABORATORY 60 01 C 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06500 RESPIRATORY THERAPY 0 65.00 4,066 26, 458 65.00 06501 SLEEP LAB 65.01 65.01 0 66.00 06600 PHYSI CAL THERAPY 219 74, 489 Ω 66.00 7, 519 67.00 06700 OCCUPATIONAL THERAPY 12 0 67.00 68.00 06800 SPEECH PATHOLOGY 236 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 476 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 355 71 00 2.194 0 71.00 1, 776 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1,906 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 26, 042 32, 334 0 73.00 03140 CARDI OLOGY 76.00 C 0 76.00 07697 CARDIAC REHABILITATION 76.97 78 5, 326 0 76.97 DUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 0 88.00 25, 843 90.00 lo9000l CLTNTC 207 355 30 Ω 90.00 91.00 09100 EMERGENCY 2, 937 9, 151 256 139, 687 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117 10, 306 29, 384 26, 781 911, 210 0 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 9,035 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201. 00 26, 781 202.00 10, 306 29, 384 920, 245 0 202. 00 TOTAL (sum lines 118 through 201)

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1302	Period: Worksheet B From 01/01/2020 Part II		

		To 12/31/2020 Date/ion	ne Prepared:
Cost Center Description	Total	//15/202	21 1:03 pm
cost center bescription	26. 00		
GENERAL SERVICE COST CENTERS	20. 00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	1		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	1		5. 00
7.00 00700 OPERATION OF PLANT			7. 00
9. 00 00900 HOUSEKEEPI NG			9. 00
10. 00 01000 DI ETARY			10.00
11. 00  01100  CAFETERI A			11. 00
13.00 01300 NURSING ADMINISTRATION			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00 01500 PHARMACY			15. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	308, 239		30.00
ANCILLARY SERVICE COST CENTERS			
50. 00   05000   OPERATI NG   ROOM	113, 062		50.00
53. 00 05300 ANESTHESI OLOGY	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	120, 251		54.00
57. 00 05700 CT SCAN	0		57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	F2 020		59.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	53, 029		60. 00 60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL	LS 0		62. 00
65. 00 06500 RESPIRATORY THERAPY			65. 00
65. 01 06501 SLEEP LAB	26, 458		65. 01
66. 00 06600 PHYSI CAL THERAPY	74, 489		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	7, 519		67. 00
68. 00 06800 SPEECH PATHOLOGY	236		68. 00
69. 00 06900 ELECTROCARDI OLOGY	476		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 906		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 334		73. 00
76. 00 03140 CARDI OLOGY	0		76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	5, 326		76. 97
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC (RHC)	0		88. 00
90. 00 09000 CLI NI C	25, 843		90.00
91. 00 09100 EMERGENCY	139, 687		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	RT)		92. 00
SPECIAL PURPOSE COST CENTERS			
113. 00 11300   NTEREST EXPENSE			113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through	<u>117)</u> 911, 210		118. 00
NONREI MBURSABLE COST CENTERS	N 0 005		100.66
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	1		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		192.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers			200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	920, 245		202. 00
202. 09   TOTAL (Suil Titles 110 till bugil 201)	720, 243		¥02.00

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Li eu	of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-1302 P	eriod: rom 01/01/2020	Worksheet B-1	
					Date/Time Pre	epared:
	CAPITAL REL	ATED_COSTS			7/15/2021 1:0	03 pm
	CALLIAL REL	LATED COSTS				
Cost Center Description	EW BLDG & FIX		EMPLOYEE	Reconci I i ati on		
	(SQUARE	EQUIP (DOLLAR VALUE)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	
	FEET)	(DOLLAR VALUE)	(GROSS		(ACCOM. COST)	
	Ĺ		SALARI ES)			
GENERAL SERVICE COST CENTERS	1. 00	2. 00	4.00	5A	5. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	36, 131					1.00
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP	_	0				2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	0 4, 602	0	5, 661, 105 560, 117		13, 288, 650	4. 00 5. 00
7. 00 00700 OPERATION OF PLANT	6, 854	0	225, 697		1, 467, 664	•
9. 00   00900 HOUSEKEEPI NG	754	0	169, 225		346, 646	•
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A	1, 483		128, 612		311, 212	•
13. 00   01100  CAPETERTA 13. 00   01300  NURSI NG ADMINI STRATI ON	1, 043 153		90, 521 196, 291		160, 924 467, 766	1
14.00 01400 CENTRAL SERVICES & SUPPLY	805		0		206, 574	14. 00
15. 00 01500 PHARMACY	547	0	0	0	837, 900	15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	5, 895	0	1, 871, 801	l ol	2, 646, 458	30.00
ANCILLARY SERVICE COST CENTERS	3,073	0	1, 671, 601	<u> </u>	2,040,430	30.00
50. 00 05000 OPERATING ROOM	3, 155		175, 921	0	378, 911	50.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0 2, 880	0	0 577, 419	0	42 1, 478, 334	•
57. 00 05700 CT SCAN	2, 880	0	377, 417	Ö	1, 470, 334	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	Ö	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	1 220 020	
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	1, 106 0	0		0	1, 220, 020 0	60. 00 60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	Ō	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	419	0	457, 155	1	607, 623	•
65. 01   06501   SLEEP LAB 66. 00   06600   PHYSI CAL THERAPY	0 1, 976	0	0 331, 786	· · · · · · · · · · · · · · · · · · ·	0 532, 380	
67. 00 06700 OCCUPATI ONAL THERAPY	174	0	93, 310		120, 509	
68. 00 06800 SPEECH PATHOLOGY	3	0	8, 675		10, 855	
69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10, 962	0	53, 992 18, 239	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	Ö	Ö	14, 761	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	713, 433	
76. 00   03140   CARDI OLOGY 76. 97   07697   CARDI AC   REHABI LI TATI ON	141	0	29, 892	0	0 47, 664	
OUTPATIENT SERVICE COST CENTERS	141	0	27, 072	<u> </u>	47,004	70. 77
88.00 08800 RURAL HEALTH CLINIC (RHC)	0			1	0	
90. 00   09000  CLI NI C 91. 00   09100  EMERGENCY	706				82, 564	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 173	U	704, 298	٥	1, 556, 912	91.00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300   NTEREST EXPENSE	25.040		F //1 10F	5 100 100	10 001 000	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	35, 869	0	5, 661, 105	-5, 128, 403	13, 281, 383	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	262	0	0	0	7, 267	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200. 00 201. 00
202.00   Cost to be allocated (per Wkst. B, Pai	t 920, 245	0	1, 372, 864		5, 128, 403	•
203.00 Unit cost multiplier (Wkst. B, Part I)		0. 000000	0. 242508		0. 385924	
204.00 Cost to be allocated (per Wkst. B, Pai	ηι I				117, 211	204.00
205.00 Unit cost multiplier (Wkst. B, Part II			0. 000000		0. 008820	205. 00
NAHE adjustment amount to be allocated	\$					206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						207.00
· · ·	•	•	•	· '		•

Health Financial Systems  IU HEALTH BLACKFORD HOSPITAL  In Lieu of Form CMS-2552- COST ALLOCATION - STATISTICAL BASIS  Provider CCN: 15-1302  Period: Worksheet B-1
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1302 Period: Worksheet B-1
From 01/01/2020 To 12/31/2020 Date/Time Prepare
7/15/2021 1:03 pm
Cost Center Description OPERATION OF HOUSEKEEPING DIETARY CAFETERIA NURSING
PLANT (SQUARE (TOTAL PATIENT (FTE'S) ADMINISTRATION (SQUARE FEET) DAYS) (FTE'S)
FEET) DATS) (FIE 3)
7.00 9.00 10.00 11.00 13.00
GENERAL SERVICE COST CENTERS
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.00
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUI P   2.1
4.00   OO400   EMPLOYEE BENEFITS DEPARTMENT   4.
5. 00   00500   ADMI NI STRATI VE & GENERAL   5. 00000    ADMI NI S
7. 00   00700   0PERATI ON OF PLANT   24, 675   7.4
9. 00   00900   HOUSEKEEPI NG   754   23, 921   9. 10. 00   01000   DI ETARY   1, 483   1, 483   1, 274   10.
11. 00   01100   DTETARY   1,463   1,463   1,274   10.1   11. 00   01100   CAFETERI A   1,043   1,043   0   7,105   11.
13. 00   01300   NURSI NG   ADMI NI STRATI ON   153   153   0   180   3, 337   13.
14. 00   01400   CENTRAL   SERVI CES & SUPPLY   805   805   0   0   0   14.
15. 00 01500 PHARMACY 547 0 0 15.

Health Financial Systems	U HEALTH BLACKI	FORD HOSPITAL		In Lieu	of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO	CN: 15-1302	Peri od:	Worksheet B-1	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
Cost Center Description	CENTRAL	PHARMACY		·	77 107 2021 1. 0	JO DIII
	SERVICES &	(COSTED				
	SUPPLY	REQUIS.)				
	(COSTED					
	REQUIS.)					
	14. 00	15. 00				
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT						5.00
9. 00   00900 HOUSEKEEPI NG						7. 00 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 SERVI CES & SUPPLY	244, 270					14. 00
15. 00 01500 PHARMACY	5, 501	733, 644				15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	5, 501	733, 044				13.00
30. 00 03000 ADULTS & PEDIATRICS	58, 275	10, 199				30.00
ANCI LLARY SERVI CE COST CENTERS	00,210	10, 177				00.00
50. 00 05000 OPERATI NG ROOM	0	266				50.00
53. 00   05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	32, 096	1, 769				54.00
57.00 05700 CT SCAN	0	0				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BL00D LABORATORY	0	0				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65.00 06500 RESPIRATORY THERAPY	33, 799	160				65. 00
65. 01 06501 SLEEP LAB	0	0				65. 01
66. 00   06600 PHYSI CAL THERAPY	1, 824	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	102	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	18, 239	0				71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENT 73.00 O7300 DRUGS CHARGED TO PATIENTS	14, 761 0	713, 432				72. 00 73. 00
73. 00 07300 DROGS CHARGED TO PATTENTS  76. 00 03140 CARDI OLOGY	0	713, 432				76.00
76. 97   07697 CARDI AC   REHABI LI TATI ON	648	0				76. 97
OUTPATIENT SERVICE COST CENTERS	040	<u> </u>				70. 77
88. 00 08800 RURAL HEALTH CLINIC (RHC)	0	o				88. 00
90. 00 09000 CLINIC	2, 948	818				90.00
91. 00 09100 EMERGENCY	76, 075	7, 000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	. 5, 576	., 500				92.00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	244, 268	733, 644				118. 00
NONREI MBURSABLE COST CENTERS						]
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2	0				190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0				192. 00
200.00 Cross Foot Adjustments						200. 00

370, 915

1. 518463

0. 120293

29, 384

1, 227, 118

1.672634

0.036504

26, 781

200.00

201.00 202. 00

203. 00

204. 00

205.00

206. 00

207. 00

200.00

201.00

202.00

203.00

204. 00

205.00

206.00

207.00

H)

Cross Foot Adjustments Negative Cost Centers

Parts III and IV)

Cost to be allocated (per Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B, Part

Unit cost multiplier (Wkst. B, Part II)

NAHE adjustment amount to be allocated (per Wkst. B-2)

NAHE unit cost multiplier (Wkst. D,

Health Financial Systems	IU HEALTH BLACKI	FORD HOSPITAL		In lieu	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	TO HEREIT BETOK	Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet C	epared:
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 560, 091		5, 560, 09	1 0	0	30. 00
ANCILLARY SERVICE COST CENTERS				•		
50.00 05000 OPERATING ROOM	894, 246		894, 24	6 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	58		5		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 445, 196		2, 445, 19	6 0	0	54.00
57.00 05700 CT SCAN	0		(	0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		(	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		(	0	0	
60. 00 06000 LABORATORY	1, 846, 538		1, 846, 53	8 0	0	
60. 01   06001   BLOOD   LABORATORY	0		(	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	_		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	961, 773	0	961, 77	3	0	65. 00
65. 01 06501 SLEEP LAB	0/5 500	0	0/5 50	0	0	
66. 00 06600 PHYSI CAL THERAPY	965, 502	0	965, 50		0	
67. 00 06700 OCCUPATI ONAL THERAPY	189, 816	0	189, 81		0	67.00
68. 00 06800 SPEECH PATHOLOGY	15, 687	0	15, 68		0	
69. 00 06900 ELECTROCARDI OLOGY	74, 829		74, 82		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	52, 973 42, 872		52, 97 42, 87		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 182, 075		2, 182, 07		0	73.00
76. 00 03140 CARDI OLOGY	2, 102, 075		2, 102, 07		0	
76. 97   07697   CARDI AC   REHABI LI TATI ON	81, 864		81, 86	-	0	
OUTPATIENT SERVICE COST CENTERS	01,004		01,00	<del>-</del> 1	0	70. 77
88. 00 08800 RURAL HEALTH CLINIC (RHC)	0			0	0	88. 00
90. 00 09000 CLINIC	211, 129		211, 12	9 0	0	
91. 00 09100 EMERGENCY	2, 854, 788		2, 854, 78		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	842, 066		842, 06		0	92.00
SPECIAL PURPOSE COST CENTERS				•		
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	19, 221, 503	0				200. 00
201.00 Less Observation Beds	842, 066		842, 06	6		201. 00
202.00 Total (see instructions)	18, 379, 437	0			0	202. 00

Health Financial Systems	U HEALTH BLACKI	FORD HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CN: 15-1302	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/15/2021 1:0	epared: 03 pm
		Title	: XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col . 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3, 373, 576		3, 373, 57	76		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	13, 816	2, 005, 891	2, 019, 70		0. 000000	50.00
53. 00   05300   ANESTHESI OLOGY	0	43, 257	43, 25	0. 001341	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	328, 881	6, 382, 676	6, 711, 55	0. 364326	0. 000000	54.00
57.00 05700 CT SCAN	0	0		0.000000	0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	59. 00
60. 00 06000 LABORATORY	670, 738	3, 108, 695	3, 779, 43		0. 000000	
60. 01 06001 BLOOD LABORATORY	0	0, 100, 010		0.000000	0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0.000000	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	395, 776	782, 073	1, 177, 84		0. 000000	
65. 01 06501 SLEEP LAB	0,0,7,0	.02,0.0	., ., .,	0.000000	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	248, 514	966, 437	1, 214, 95		0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	96, 947	53, 491			0. 000000	
68. 00 06800 SPEECH PATHOLOGY	7, 604	831			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	59, 408	348, 285			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 400	84, 839			0. 000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	68, 658			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 221, 230	4, 244, 935			0. 000000	
76. 00 03140 CARDI OLOGY	2, 221, 230	4, 244, 733	0,400,10	0. 000000	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	318, 028	318, 02		0. 000000	
OUTPATIENT SERVICE COST CENTERS	U <sub>I</sub>	310,020	310, 02	0. 237411	0.000000	70. 77
88. 00 08800 RURAL HEALTH CLINIC (RHC)	O	0	l	٥		88. 00
90. 00   09000   CLINIC	0	941, 829	941, 82	0. 224169	0. 000000	
91. 00 1091001 EMERGENCY	240, 282	12, 900, 407			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 950	1, 972, 289			0. 000000	
SPECIAL PURPOSE COST CENTERS	4, 930	1, 972, 209	1,911,23	0.423000	0.000000	92.00
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	7, 661, 722	34, 222, 621	41, 884, 34	12		200.00
201. 00 Less Observation Beds	7,001,722	34, 222, 021	41,004,34	+3		200.00
202.00 Total (see instructions)	7, 661, 722	34, 222, 621	41, 884, 34	12		201.00
202. 04   Total (See Histractions)	1,001,722	34, 222, 021	41,004,34	10		K02.00

Health Financial Systems I	U HEALTH BLACKFO	RD HOSPITAL	In lieu	of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	O HEALTH BENOTE O	Provi der CCN: 15-1302	Peri od:	Worksheet C	2002 10
			From 01/01/2020	Part I	
			To 12/31/2020	Date/Time Pr 7/15/2021 1:	03 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0.000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 57. 00   05700   CT   SCAN	0. 000000 0. 000000				54. 00 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00
59. 00 05900 CARDIAC CATHETERIZATION	0. 000000				59.00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65. 00
65. 01 06501 SLEEP LAB	0. 000000				65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
76. 00 03140 CARDI OLOGY	0. 000000				76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
OUTPATIENT SERVICE COST CENTERS	T T				- 00 00
88. 00   08800 RURAL HEALTH CLINIC (RHC) 90. 00   09000 CLINIC	0. 000000				88. 00 90. 00
91. 00   09100   EMERGENCY	0. 000000				90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				91.00
SPECIAL PURPOSE COST CENTERS	0.000000				72.00
113. 00 11300 I NTEREST EXPENSE					113. 00
200.00 Subtotal (see instructions)					200.00
201. 00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
•	•				•

Hoalth Eina	ncial Systems I	U HEALTH BLACK	ENDD HOSDITAL		In Liou	ı of Form CMS-2	2552 10
	N OF RATIO OF COSTS TO CHARGES	O HEALTH BLACK	Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet C	epared:
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,		RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS	5, 560, 091		5, 560, 09	1 0	5, 560, 091	30. 00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	894, 246		894, 24		894, 246	•
	O ANESTHESI OLOGY	58		5		58	
	O RADI OLOGY-DI AGNOSTI C	2, 445, 196		2, 445, 19	6 0	2, 445, 196	
	O CT SCAN	0			0	0	
	O MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	
	O CARDI AC CATHETERI ZATI ON	1 04/ 500		1 04/ 50	0	0	
	O LABORATORY	1, 846, 538		1, 846, 53	8	1, 846, 538	•
	1 BLOOD LABORATORY	0	1	1	0	0	
	O WHOLE BLOOD & PACKED RED BLOOD CELLS O RESPIRATORY THERAPY	961, 773		041 77	0	961, 773	
65. 01 0650		901,773	0	961, 77	3	901, 773	1
	O PHYSI CAL THERAPY	965, 502		965, 50	0	965, 502	
	O OCCUPATI ONAL THERAPY	189, 816		189, 81		189, 816	1
	O SPEECH PATHOLOGY	15, 687		15, 68		15, 687	
	O ELECTROCARDI OLOGY	74, 829		74, 82		74, 829	
	OMEDICAL SUPPLIES CHARGED TO PATIENTS	52, 973		52, 97		52, 973	
	OIMPL. DEV. CHARGED TO PATIENT	42, 872		42, 87		42, 872	
	O DRUGS CHARGED TO PATIENTS	2, 182, 075		2, 182, 07		2, 182, 075	
	O CARDI OLOGY	0	i		o o	0	
76. 97 0769 <sup>-</sup>	7 CARDIAC REHABILITATION	81, 864		81, 86	4 0	81, 864	76. 97
OUTP	ATIENT SERVICE COST CENTERS						
	O RURAL HEALTH CLINIC (RHC)	0	l .	L	0 0	0	00.00
	O CLINIC	211, 129		211, 12		211, 129	
91.00 0910		2, 854, 788		2, 854, 78		2, 854, 788	
	O OBSERVATION BEDS (NON-DISTINCT PART)	842, 066		842, 06	6	842, 066	92. 00
	IAL PURPOSE COST CENTERS	1	i	1	, ,		
	O INTEREST EXPENSE	10 001 500		10 001 50		10 001 500	113.00
200. 00	Subtotal (see instructions)	19, 221, 503		, , , , , , , , , , , , , , , , , , , ,		19, 221, 503	
201. 00 202. 00	Less Observation Beds Total (see instructions)	842, 066 18, 379, 437		842, 06 18, 379, 43		842, 066 18, 379, 437	
202. UY	Tiotal (see Histructions)	10,3/9,43/	0	10, 3/9, 43	7  0	10, 3/7, 43/	K05.00

Health Financial Systems	U HEALTH BLACKI	FORD HOSPITAL		In Lieu	of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-1302	Period: From 01/01/2020	Worksheet C Part I Date/Time Pre 7/15/2021 1:0	epared:
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpati ent	
					Ratio	
	6. 00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3, 373, 576		3, 373, 57	6		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	13, 816	2, 005, 891	2, 019, 70	0. 442760	0. 000000	50.00
53. 00   05300   ANESTHESI OLOGY	0	43, 257	43, 25	0. 001341	0. 000000	53. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	328, 881	6, 382, 676	6, 711, 55	0. 364326	0. 000000	54.00
57.00 05700 CT SCAN	0	0		0. 000000	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0.000000	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0.000000	0. 000000	59. 00
60. 00 06000 LABORATORY	670, 738	3, 108, 695	3, 779, 43	0. 488575	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0.000000	0. 000000	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0. 000000	0. 000000	62.00
65. 00 06500 RESPIRATORY THERAPY	395, 776	782, 073	1, 177, 84	9 0. 816550	0. 000000	65. 00
65. 01 06501 SLEEP LAB	0	0		0.000000	0. 000000	65. 01
66. 00 06600 PHYSI CAL THERAPY	248, 514	966, 437	1, 214, 95	0. 794684	0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	96, 947	53, 491	150, 43	8 1. 261756	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	7, 604	831	8, 43	1. 859751	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	59, 408	348, 285	407, 69	0. 183543	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84, 839	84, 83	0. 624394	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	68, 658	68, 65	0. 624428	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 221, 230	4, 244, 935	6, 466, 16	0. 337460	0.000000	73. 00
76. 00 03140 CARDI OLOGY	0	0		0.000000	0.000000	76.00
76.97 O7697 CARDIAC REHABILITATION	0	318, 028	318, 02	0. 257411	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC (RHC)	0	0		0. 000000	0. 000000	
90. 00 09000 CLINIC	0	941, 829	941, 82	9 0. 224169	0. 000000	90.00
91. 00 09100 EMERGENCY	240, 282	12, 900, 407			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 950	1, 972, 289	1, 977, 23	9 0. 425880	0. 000000	92. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	7, 661, 722	34, 222, 621	41, 884, 34	.3		200. 00
201.00 Less Observation Beds				_		201. 00
202.00 Total (see instructions)	7, 661, 722	34, 222, 621	41, 884, 34	3		202. 00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1302		Date/Time Pre 7/15/2021 1:0	
	I · · · · · · · · · · · · · · · · · ·	Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					4
D. 00 03000 ADULTS & PEDIATRICS					30.0
ANCILLARY SERVICE COST CENTERS					4
D. 00 05000 OPERATING ROOM	0. 000000				50.0
3. 00 05300 ANESTHESI OLOGY	0. 000000				53. (
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. (
7.00   05700   CT SCAN	0. 000000				57.
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.
9.00 05900 CARDIAC CATHETERIZATION	0. 000000				59.
). 00   06000   LABORATORY	0. 000000				60.
). 01  06001 BL00D LABORATORY	0. 000000				60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.
5.00 06500 RESPIRATORY THERAPY	0. 000000				65.
5. 01 06501 SLEEP LAB	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 PATIENTS	0. 000000				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
5. 00 03140 CARDI OLOGY	0. 000000				76.
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.
OUTPATIENT SERVICE COST CENTERS					1
3.00 08800 RURAL HEALTH CLINIC (RHC)	0. 000000				88.
D. 00 09000 CLINIC	0. 000000				90.
1.00 09100 EMERGENCY	0. 000000				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.
SPECIAL PURPOSE COST CENTERS					1
13. 00 11300 I NTEREST EXPENSE					113.
00.00 Subtotal (see instructions)	1				200.
11.00 Less Observation Beds					201.
D2.00 Total (see instructions)	1 1				202.

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C			Date/Time Pre 7/15/2021 1:0	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capital Related				Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
		Part I, col.		. Charges	column 4)	
	II, col. 26)	8)	2)			
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						1
50.00 05000 OPERATING ROOM	113, 062				400	
53. 00 05300 ANESTHESI OLOGY	0	43, 257			0	53. 00
54. 00  05400 RADI OLOGY-DI AGNOSTI C	120, 251	6, 711, 557		,	2, 176	•
57.00 05700 CT SCAN	0	0	0. 00000		0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59. 00
60. 00 06000 LABORATORY	53, 029	3, 779, 433			3, 382	•
60. 01 06001 BL00D LABORATORY	0	0	0. 00000		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000		0	
65. 00 06500 RESPIRATORY THERAPY	26, 458	1, 177, 849			3, 085	•
65. 01 06501 SLEEP LAB	0	0	0. 00000		0	
66. 00 06600 PHYSI CAL THERAPY	74, 489				1, 890	•
67. 00 06700 OCCUPATI ONAL THERAPY	7, 519				453	
68.00 06800 SPEECH PATHOLOGY	236				67	68. 00
69. 00 06900 ELECTROCARDI OLOGY	476	,			32	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 355				0	,
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 906				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 334	6, 466, 165			4, 153	•
76. 00 03140 CARDI OLOGY	0	0	0. 00000		0	, 0. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	5, 326	318, 028	0. 01674	.7 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC (RHC)	0	0	0.0000		0	
90. 00 09000 CLINIC	25, 843				0	
91. 00 09100 EMERGENCY	139, 687					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	46, 682				117	
200.00   Total (lines 50 through 199)	649, 653	38, 510, 767	l	1, 417, 374	15, 813	200.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ATTHROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1302	Peri od: Worksheet D From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 Prepared: 7/15/2021

			'	0 12/31/2020	7/15/2021 1:0	epareu: 03 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	lursi ng School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	0	0	0	50. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65. 01 06501 SLEEP LAB	0	0	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00 03140 CARDI OLOGY	0	0	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	-T		,	-1		
88.00 08800 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	00.00
90. 00 09000 CLINIC	0	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0	0	0	l o	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		0	92.00
200.00   Total (lines 50 through 199)	ı o	0	l O	ı o	0	200.00

	IU HEALTH BLACK			In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY STROUGH COSTS	SERVICE OTHER P	ASS Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	<b>(</b>			(col. 5 ÷ col.	
	Ludcati on cost	4)	col s. 2, 3,	8)	7)	
		")	and 4)		(see	
			una 1)		instructions)	
	4. 00	5, 00	6, 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 2, 019, 707	0. 000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 43, 257		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 6, 711, 557		54.00
57.00 05700 CT SCAN	0	0		0	0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0. 000000	59. 00
60. 00 06000 LABORATORY	0	0		0 3, 779, 433	0. 000000	60.00
60. 01 06001 BL00D LABORATORY	0	0		0 0	0. 000000	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0. 000000	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 1, 177, 849	0. 000000	65.00
65. 01 06501 SLEEP LAB	0	0		0	0. 000000	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 214, 951	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 150, 438	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 8, 435	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 407, 693		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 84, 839		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 68, 658	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 6, 466, 165		
76. 00 03140 CARDI OLOGY	0	0		0	0. 000000	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0 318, 028	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
00 OO OOOOO DUDAL HEALTH CLINIC (DHC)		l 0		0	0 000000	90 00

0 0 0 0.000000

0. 000000 0. 000000

0. 000000 92. 00 200. 00

941, 829 13, 140, 689 1, 977, 239 38, 510, 767 88.00

90. 00 91. 00

88. 00 | 08800 RURAL HEALTH CLINIC (RHC) 90. 00 | 09900 CLINIC 91. 00 | 09100 EMERGENCY 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50 through 199)

Health Financial Systems	U HEALTH BLACKFO	ORD HOSPITAL		In Lieu	of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	SERVICE OTHER PAS	S Provider C		From 01/01/2020	Worksheet D Part IV Date/Time Pre 7/15/2021 1:0	
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	

			'	0 12/31/2020	7/15/2021 1:0	epareu. Os pm
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	7, 152	0	0	0	50. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	121, 459	0	0	0	54. 00
57.00 05700 CT SCAN	0. 000000	0	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	0	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000	0	0	0	0	59. 00
60. 00   06000   LABORATORY	0. 000000	241, 022	0	0	0	60.00
60. 01  06001 BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	0	0	0	62. 00
65.00 06500 RESPIRATORY THERAPY	0. 000000	137, 330	0	0	0	65. 00
65. 01  06501   SLEEP LAB	0. 000000	0	0	0	0	65. 01
66. 00   06600 PHYSI CAL THERAPY	0. 000000	30, 835		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	9, 073		0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 409		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	27, 186	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	830, 531	0	0	0	73. 00
76. 00 03140 CARDI OLOGY	0. 000000	0	0	0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC (RHC)	0. 000000	0	0	0	0	00.00
90. 00  09000  CLI NI C	0. 000000	0	0	0	0	90. 00
91.00 09100 EMERGENCY	0. 000000	5, 427		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	4, 950	0	0	0	92. 00
200.00 Total (lines 50 through 199)		1, 417, 374	0	0	0	200. 00

Health Financial Systems	U HEALTH BLACK	KEORD HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A				Period: From 01/01/2020	Worksheet D	epared:
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not		
	Part I, col. 9	7	Subject To	Subj ect To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				_		
50.00   05000   OPERATING ROOM	0. 442760	0	497, 23	6 0	0	50.00
53. 00   05300   ANESTHESI OLOGY	0. 001341	0	5, 77	6 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 364326	0	1, 702, 50	3 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59.00
60. 00 06000 LABORATORY	0. 488575	0	733, 35	9 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0. 816550	0	217, 57	9 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 794684	0	329, 51	6 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1. 261756	0	12, 49	1 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	1. 859751	0	55	4 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 183543	0	151, 41	9 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 624394	0	15, 49	4 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 624428		19, 67	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 337460	0	2, 423, 82	7 116	0	73. 00
76. 00 03140 CARDI OLOGY	0. 000000	0		0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 257411	0	141, 53	5 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC (RHC)						88. 00
90. 00 09000 CLINIC	0. 224169	0	480, 55	8 0	0	90.00
01 00 00100 EMERGENCY	0.217248					91 00

0. 217248

0. 425880

480, 558 2, 727, 900 699, 132

10, 158, 555

10, 158, 555

178

294

0 91.00

0 92.00

0 200. 00 201. 00

0 202. 00

09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

91.00

200. 00 201. 00

202.00

Health Financial Systems II	U HEALTH BLACK	FORD HOSPITAL		In Lieu	of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		T Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V	epared:
			XVIII	Hospi tal	Cost	
·	Cost Reimbursed Services Jubject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not				
ANCILLADY SEDVICE COST CENTEDS	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS  50. 00  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  50.000  60.000  60.000  60.001  60.001  60.001  60.001  60.001  60.001  60.0000  60.0000  60.0000  6	220, 156  620, 266  0  0  358, 301  0  177, 664  0  261, 861  15, 761  1, 030  27, 792  9, 674  12, 286  817, 945  0  36, 433	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50. 00 53. 00 54. 00 57. 00 58. 00 59. 00 60. 01 62. 00 65. 01 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 00 76. 97
88.00   08800   RURAL HEALTH CLINIC (RHC)   90.00   09000   CLINIC   91.00   09100   EMERGENCY   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   200.00   Subtotal (see instructions)   Less PBP Clinic Lab. Services-Program   Only Charges   Net Charges (line 200 - line 201)	107, 726 592, 631 297, 746 3, 557, 280 0	39 0 78				88. 00 90. 00 91. 00 92. 00 200. 00 201. 00

Health Financial Systems	IU HEALTH BLACKF			of Form CMS-	
COMPUTATION OF INPATIENT OPERATING CO	ST	Provi der CCN: 15-1302	Peri od: From 01/01/2020	Worksheet D-	
			To 12/31/2020	Date/Time Pr 7/15/2021 1:	epared:
		Title XVIII	Hospi tal	Cost	OS PIII
Cost Center Description				1. 00	
PART I - ALL PROVIDER COMPONENT	S			1. 00	
1.00 Inpatient days (including priva	to room days and swing had	dave oveluding nowborn)		2, 565	1.00
2.00 Inpatient days (including priva				1, 612	
3.00 Private room days (excluding sv				ys, do (	3.00
not complete this line. 4.00 Semi-private room days (excludi	ng swing-bed and observation	on bed days)		1, 274	4 4.00
5.00 Total swing-bed SNF type inpati			mber 31 of the c		
reporting period  6.00 Total swing-bed SNF type inpati	ent days (including private	e room days) after Decemb	er 31 of the cos	t (	6.00
reporting period (if calendar y		e room days) arter becemb	er or the cos		0.00
7.00 Total swing-bed NF type inpatie	nt days (including private	room days) through Decem	ber 31 of the co	st 365	7.00
reporting period  8.00 Total swing-bed NF type inpation	nt days (including private	room days) after Decembe	r 31 of the cost	(	8.00
reporting period (if calendar y	year, enter 0 on this line)	•			
9.00 Total inpatient days including newborn days) (see instructions		le to the Program (exclud	ing swing-bed an	d 663	9.00
10.00 Swing-bed SNF type inpatient da	ys applicable to title XVII		e room days) thr	ough 588	10.00
December 31 of the cost reporti			a room dove) aft	o	11.00
11.00 Swing-bed SNF type inpatient da December 31 of the cost reporti			e room days) art	E1 (	11.00
12.00 Swing-bed NF type inpatient day	rs applicable to titles V or	r XIX only (including pri	vate room days)	through (	12. 00
December 31 of the cost reporti 13.00 Swing-bed NF type inpatient day		r XIX only (includina pri	vate room davs)	after (	13.00
December 31 of the cost reporti	ng period (if calendar year	r, enter 0 on this line)			
14.00 Medically necessary private roo 15.00 Total nursery days (title V or	m days applicable to the Pr	rogram (excluding swing-b	ed days)		14.00
16.00 Nursery days (title V or XIX or					16.00
SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF	sorvices applicable to see	ryicos through Docombor 2	1 of the cost re	porting	17. 00
peri od	services appricable to ser	TVICES till ough becember 3	i or the cost re	oor tring	17.00
18.00 Medicare rate for swing-bed SNF period	services applicable to ser	rvices after December 31	of the cost repo	rting	18. 00
19.00 Medicaid rate for swing-bed NF	services applicable to serv	vices through December 31	of the cost rep	orting 216.95	5 19.00
period 20.00 Medicaid rate for swing-bed NF	sorvices applicable to sorv	vices after December 21 o	f the cost repor	ting 0.00	20.00
peri od	services appricable to serv	vices arter becember 51 0	the cost repor	triig 0. oc	20.00
21.00 Total general inpatient routine 22.00 Swing-bed cost applicable to SN			arting pariod (	5, 560, 09	
line 17)	r type services through bed	cember 31 of the cost rep	biting period (i	ine s x (	22.00
23.00 Swing-bed cost applicable to SM	F type services after Decem	mber 31 of the cost repor	ting period (lin	e 6 x (	23. 00
line 18) 24.00   Swing-bed cost applicable to NF	type services through Dece	ember 31 of the cost repo	rting period (li	ne 7 x 79,18	7 24.00
line 19) 25.00 Swing-bed cost applicable to NF					
line 20)	type services after becenik	ber 31 of the cost report	ing period (ine	0 X	25.00
26.00 Total swing-bed cost (see instr	,		<b>,</b> ,	1, 544, 083	
27.00 General inpatient routine servi PRIVATE ROOM DIFFERENTIAL ADJUS		ost (fine 2) minus fine 2	5)	4, 016, 008	27.00
28.00 General inpatient routine servi		g-bed and observation bed	charges)		28.00
29.00 Private room charges (excluding 30.00 Semi-private room charges (excl					29.00
31.00 General inpatient routine servi		27 ÷ line 28)		0. 000000	
32.00 Average private room per diem o				0. 00	
33.00 Average semi-private room per o					33.00
34.00 Average per diem private room of 35.00 Average per diem private room of			ructions)		34.00
36.00 Private room cost differential					35.00
37.00 General inpatient routine servi			differential (I		
minus line 36)					_
PART II - HOSPITAL AND SUBPROVI		AD ILICTAENTO			
PROGRAM INPATIENT OPERATING COS				0.404.04	20 00
	ING SORVICE COST NOR diam i	(cap instructions)			
38.00 Adjusted general inpatient routi 39.00 Program general inpatient routi				2, 491. 32 1, 651, 745	
38.00 Adjusted general inpatient rout	ne service cost (line 9 x l m cost applicable to the Pr	line 38) rogram (line 14 x line 35	)	1, 651, 745	5 39.00 40.00

		U HEALTH BLACKI			In Lieu	of Form CMS-	
COMPUTAT	TION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2020	Worksheet D-	1
						Date/Time Pro 7/15/2021 1:0	
			Titl€	e XVIII	Hospi tal	Cost	os pili
	Cost Center Description	otal Inpatien		Average Per			
		Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	URSERY (title V & XIX only)						42. 00
	ntensive Care Type Inpatient Hospital Unit NTENSIVE CARE UNIT	:s I I		1	1		43. 00
	CORONARY CARE UNIT			İ			44. 00
	SURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			}			46. 00 47. 00
17100 0	Cost Center Description			•	•		17.00
48 00 P	Program inpatient ancillary service cost (V	Wkst D_3 col	3 line 200)			1. 00 606, 292	18.00
	otal Program inpatient costs (sum of lines			tions)		2, 258, 037	
	ASS THROUGH COST ADJUSTMENTS						1
	cass through costs applicable to Program in cass through costs applicable to Program in					and III)	
1.	V)		,	(	,		
	otal Program excludable cost (sum of lines otal Program inpatient operating cost excl		related non	nhysician and	ethatiet and m	edi cal 0	
	education costs (line 49 minus line 52)	uurng capitai l	rerateu, HOH-	priysi Craff affe	эшенэг, ани M	cui cai — U	33.00
TA	ARGET AMOUNT AND LIMIT COMPUTATION						1
	rogram discharges arget amount per discharge					0 00	54. 00 55. 00
	arget amount (line 54 x line 55)					0.00	1
	ifference between adjusted inpatient opera	ating cost and	target amount	(line 56 min	us line 53)	0	
	onus payment (see instructions) esser of lines 53/54 or 55 from the cost o	conorting porto	d onding 1006	undated and	compounded by	tho 0.00	58. 00 59. 00
	arket basket	eporting period	u enuring 1996	, upuateu anu	compounded by	trie 0.00	39.00
	esser of lines 53/54 or 55 from prior year						60.00
	f line 53/54 is less than the lower of line perating costs (line 53) are less than exp						61.00
	6), otherwise enter zero (see instructions		THES 54 X 00)	, 01 1% 01 111	e target amount	(TTHE	
	delief payment (see instructions)						62. 00
	Ilowable Inpatient cost plus incentive pay ROGRAM INPATIENT ROUTINE SWING BED COST	yment (see insti	ructi ons)			0	63. 00
	ledicare swing-bed SNF inpatient routine co	osts through Dec	cember 31 of	the cost repo	rting period (S	ee 1, 464, 896	64.00
	nstructions)(title XVIII only)	<del></del> D			:: (C		/ - 00
	ledicare swing-bed SNF inpatient routine constructions)(title XVIII only)	osts after Dece	mber 31 of th	e cost report	ing period (See	C	65. 00
	otal Medicare swing-bed SNF inpatient rou	tine costs (line	e 64 plus lin	e 65)(title X	VIII only). For	CAH 1, 464, 896	66. 00
	see instructions)		ul December 0	1 -6			(7.00
	itle V or XIX swing-bed NF inpatient routi 2 x line 19)	ne costs through	gn December 3	I OF the cost	reporting peri	bd (line 0	67. 00
	itle V or XIX swing-bed NF inpatient routi	ne costs after	December 31	of the cost r	eporting period	(line 0	68. 00
	3 x line 20) otal title V or XIX swing-bed NF inpatien	t routine costs	(line 67 ± 1	ine 68)		0	69.00
PA	ART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILI	ΓΥ, AND ICF/I	ID ONLY			
	killed nursing facility/other nursing faci				37)		70.00
	djusted general inpatient routine service Program routine service cost (line 9 x line		(TITE /U ÷ III	ne 2)			71. 00 72. 00
73.00 M	ledically necessary private room cost appli	cable to Progra	•				73. 00
	otal Program general inpatient routine ser	•			Part II colu	mp 26	74. 00 75. 00
	apital-related cost allocated to inpatient ine 45)	. Toutine SelVI	ce costs (IIO	m worksneet B	, rait II, COIU	III1 ∠U,	/3.00
76. 00 P	er diem capital-related costs (line 75 ÷ l	•					76. 00
	Program capital-related costs (line 9 x ling ropatient routine service cost (line 74 min						77. 00 78. 00
	ggregate charges to beneficiaries for exce		provider rec	ords)			79.00
80. 00 T	otal Program routine service costs for cor	mparison to the	•	,	minus line 79)		80.00
	npatient routine service cost per diem lir npatient routine service cost limitation		81)				81. 00 82. 00
	ripatient routine service cost rimitation ( Leasonable inpatient routine service costs	•					83. 00
84. 00 P	rogram inpatient ancillary services (see i	nstructions)					84. 00
	Itilization review - physician compensation						85. 00 86. 00
	<u>otal Program inpatient operating costs (su</u> ART IV - COMPUTATION OF OBSERVATION BED PA						00.00
87. 00 T	otal observation bed days (see instruction	ns)					87. 00
	djusted general inpatient routine cost per Ubservation bed cost (line 87 x line 88) (s					2, 491. 32 842, 066	
07. 00 <b>[</b> 0	baser various bed cost (TITIE O/ X TITIE 88) (S	see matructions	٠,		ļ	042,000	1 07.00

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 1:0	pared: 03 pm
	Title XVIII Hospital 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	308, 239	5, 560, 091	0. 05543	842, 066	46, 682	90.00
91.00 Nursing School cost	0	5, 560, 091	0. 00000	0 842, 066	0	91.00
92.00 Allied health cost	0	5, 560, 091	0. 00000	0 842, 066	0	92.00
93.00 All other Medical Education	0	5, 560, 091	0. 00000	0 842, 066	0	93.00

	Financial Systems IU HEALTH BLACKFO ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1302	In Lieu Period:	u of Form CMS-: Worksheet D-	
			From 01/01/2020 To 12/31/2020		
		Title XIX		7/15/2021 1:0	
	Cost Center Description	I II LIE XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	I NPATI ENT DAYS			0.575	]
1. 00 2. 00	Inpatient days (including private room days and swing-bed of Inpatient days (including private room days, excluding swin			2, 565 1, 612	
3. 00	Private room days (excluding swing-bed and observation bed not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private		mber 31 of the c	1, 274 ost 588	•
6. 00	reporting period  Total swing-bed SNF type inpatient days (including private	3 ,			
0.00	reporting period (if calendar year, enter 0 on this line)	3 ,			0.00
7. 00	Total swing-bed NF type inpatient days (including private r reporting period	oom days) through Decem	ber 31 of the co	st 365	7. 00
8. 00	Total swing-bed NF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	room days) after Decembe	r 31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable newborn days) (see instructions)	e to the Program (exclud	ing swing-bed an	d 0	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (see instructions)		e room days) thr	ough 0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,	only (including privat	e room days) aft	er O	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or December 31 of the cost reporting period	XIX only (including pri	vate room days)	through 0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or December 31 of the cost reporting period (if calendar year,		vate room days)	after 0	13. 00
14.00	Medically necessary private room days applicable to the Pro	gram (excluding swing-b	ed days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0 0	
17. 00	<u>SWING BED ADJUSTMENT</u> Medicare rate for swing-bed SNF services applicable to serv	rices through December 3	1 of the cost re	porting	17. 00
18. 00	period Medicare rate for swing-bed SNF services applicable to serv	rices after December 31	of the cost repo	rting	18. 00
19. 00	period Medicaid rate for swing-bed NF services applicable to servi	ces through December 31	of the cost rep	orting 216.95	19. 00
20.00	period Medicaid rate for swing-bed NF services applicable to servi period	ces after December 31 o	f the cost repor	ti ng 0.00	20. 00
	Total general inpatient routine service cost (see instructi	,		5, 560, 091	•
22. 00	Swing-bed cost applicable to SNF type services through Dece line 17)	ember 31 of the cost rep	orting period (I	ine 5 x 0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after Decembline 18)	er 31 of the cost repor	ting period (lin	e 6 x 0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decemline 19)	ber 31 of the cost repo	rting period (li	ne 7 x 79,187	24. 00
25. 00	Swing-bed cost applicable to NF type services after Decembe line 20)	er 31 of the cost report	ing period (line	8 x 0	25. 00
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos	at (line 21 minus line 2	6)	1, 544, 083 4, 016, 008	•
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges)	bed and observation bed	charges)	0	•
	Semi -pri vate room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 2	.7 ÷ line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4				33.00
	Average per diem private room charge differential (line 32		ructions)	0. 00	•
	Average per diem private room cost differential (line 34 x	•		0. 00	•
	Private room cost differential adjustment (line 3 x line 35 General inpatient routine service cost net of swing-bed cos		differential (	0 ine 2 <b>4</b> 016 008	
37.00	minus line 36)	t and private room cost	urrerentiai (I	THE 24, 010, 000	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	D ILISTMENTS			1
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A Adjusted general inpatient routine service cost per diem (s			2, 491. 32	38. 00
	Program general inpatient routine service cost per diem (s			2, 491. 32	
	Medically necessary private room cost applicable to the Pro		)	0	
	Total Program general inpatient routine service cost (line		,		41. 00
		• ,	'		

Provider CON. 15-1302   Period   Provider CON. 15-1302   Provide
Cost Center Description
Title XIX   Mospital   Cost
Cost
1.00   2.00   3.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   6.00
A2.00   NUSSERY (ItTLe V a XIX only)
Intensive Care Type Inpatient Hospital Units
45.00 BURNI NTERSIVE CARE UNIT 46.00 SURGICAL INTERSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  68.00 Program inpati ent ancil lary service cost (Wst. D.3. col. 3. Line 200)  FOST Center Description  69.00 Total Program inpati ent ancil lary service cost (Wst. D.3. col. 3. Line 200)  FASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs appli cable to Program inpati ent ancil lary services (From Wkst. D. sum of Parts I and III)  50.00 Pass through costs appli cable to Program inpati ent ancil lary services (From Wkst. D. sum of Parts I and III)  50.00 Pass through costs appli cable to Program inpati ent ancil lary services (From Wkst. D. sum of Parts I and III)  50.00 Total Program excludable cost (sum of lines 50 and 51)  50.00 Total Program inpati ent ancil lary services (From Wkst. D. sum of Parts I and III)  50.00 Total Program inpati ent operating cost excluding capital related, non-physician anesthetist, and medical  50.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical  50.00 Target amount (I line 54 x line 55)  50.00 Target amount (I line 54 x line 55)  50.00 Difference between adjusted inpatient operating cost and target amount (I line 56 minus line 53)  50.00 Total program inpatient services (From Wkst. D. sum of Parts I and III)  50.00 Difference between adjusted inpatient operating cost and target amount (I line 56 minus line 53)  50.00 Difference between adjusted inpatient operating cost and target amount (I line 56 minus line 53)  50.00 Cost and the service of lines 53 services (From Wkst. D. sum of Parts I and III)  50.00 Difference between adjusted inpatient operating cost and target amount (I line 56 minus line 53)  50.00 Cost and the service of lines 53 services (From III)  50.00 Difference between adjusted inpatient operating cost and target amount (I line 50 minus lines 53)  50.00 Cost and target amount (I line 54 x line 51)  50.00 Cost and target amount (I line 54 x line 58)  50.00 Cost and target amou
46.00   SURGICAL INTENSIVE CARE UNIT
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)  48.00 Program inpatient costs (sum of lines 41 through 48)(see instructions)  59.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and III)  50.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and III)  50.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and III)  50.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and midcle 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 1 \$1.00 Pass III and 0 \$1.00 Pass III and 0 \$1.00 Pass III and 1 \$1.00 Pass III and 0 \$1
1.00   148.00   Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)   0   48.00   1014   Program inpatient costs (sum of lines 41 through 48) (see instructions)   0   48.00   0   49.00   0   45.00   45
49.00   PASS THROUGH COST ADJUSTMENTS   0.00   49.00   ADJUSTMENTS   0.00
PASS THROUGH COST ADJUSTMENTS  5.0.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts   1 and   0   51.00    7.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts   1 and   0   51.00    7.00 Total Program excludable cost (sum of lines 50 and 51)  8.00 Total Program excludable cost (sum of lines 50 and 51)  8.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  7.00 Education costs (line 49 minus line 52)  7.00 Education costs (line 49 minus line 52)  7.00 Education costs (line 48 minus line 52)  7.00 Education costs (line 48 minus line 52)  7.00 Education costs (line 48 minus line 52)  8.00 Program discharges  9.0 Education costs (line 48 minus line 52)  9.0 Education costs (line 48 minus line 53)  9.0 Education costs (line 48 minus line 53)  9.0 Education costs (line 48 minus line 53)  9.0 Education costs (line 53 minus line 53)  9.0 Education costs (line 53 minus line 53)  9.0 Education costs (line 53 minus line 53)  9.0 Education costs (line 53 minus line 53)  9.0 Education costs (line 53 minus line 53)  9.0 Education costs (line 53 minus line 53)  9.0 Education costs (line 53 minus line 53)  9.0 Education costs (line 53 minus line costs (line 54 minus line 53)  9.0 Education costs (line 53 minus line costs (line 54 minus line 53)  9.0 Education costs (line 54 minus line costs (line 54 minus line 53)  9.0 Education costs (line 54 minus line costs (line 54 minus line 65)  9.0 Education costs (line 40 minus line costs (line 64 plus line 65) (line 20 minus line minus line 65)  9.0 Education costs (line 64 minus line costs (line 64 plus line 65) (line 37)  9.0 Education costs (line 67 minus line costs (line 67 minus line 68)  9.0 Education costs (line 67 minus line costs (line 67 minus line 68)  9.0 Education costs (line 97 minus line costs (line 67 minus line 68)  9.0 Education costs (line 97 minus line costs (line 67 min
50.00   Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and III)
IV)   Sc. 00   Total Program excludable cost (sum of lines 50 and 51)   O   52.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and madical o   Sc. 00
52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical 0 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical 0 53.00 Total Program discharges 0 0 55.00 Total Program discharges 0 0 0 55.00 Total Program discharges 0 0 0 55.00 Total Program discharges 0 0 0 55.00 Total Program discharges 0 0 0 55.00 Total Medical Program discharge 0 0 0 55.00 Total Medical Program discharge 0 0 0 55.00 Total Medical Program discharges 0 0 0 55.00 Total Medical Program discharges 0 0 0 55.00 Total Medical Program discharges 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
education costs (line 49 minus line 52)
TARCET AMOUNT AND LIMIT COMPUTATION   54, 00   55, 00   17 graft and scharges   0   0, 00   55, 00   17 graft amount (line 54 x line 55)   0, 05   50, 00   55, 00   00   17 graft amount (line 54 x line 55)   0   05, 00   00   00   00   00   00
55.00 Target amount per discharge  56.00 Target amount (line 54 x line 55)  56.00 Target amount (line 54 x line 55)  56.00 Target amount (line 54 x line 55)  56.00 Target amount (line 56 minus line 53)  56.00 Target amount (line 56 minus line 53)  57.00  58.00 Bous payment (see instructions)  58.00 Bous payment (see instructions)  58.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the cost reporting period ending 1996, updated and compounded by the cost separation and the cost lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  61.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  62.01 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  63.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  64.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  65.00 Lesser of lines 53/54 or 55 from prior year cost report, updated and compounded by the cost reporting period (line 56), otherwise enter zero (see instructions)  66.00 Regard Inpatient cost plus incentive payment (see instructions)  67.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (litle XVIII only)  68.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  69.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line of 57.00 in 12 x line 19)  69.00 Depart III - SKILED NURSING FACILITY, OTHER NURSING FACILITY, NOI (FATID ONLY)  70.00 Skilled nursing facility/other nursing facility/iCf/IID routine service cost (line 37)  71.00 Program routine service cost (line 9 x line 76)  72.00 Program capital-related costs (line 9 x line 77)  73.00 Medicarly special chargest
56.00 Target amount (line \$4 x line \$5) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Bonus payment (see instructions) 59.00 Lesser of lines \$3/54 or \$5 from the cost reporting period ending 1996, updated and compounded by the 0.00 59.00 market basket 60.00 Lesser of lines \$3/54 or \$5 from the cost report, updated by the market basket 60.00 Lesser of lines \$3/54 is less than the lower of lines \$5, \$9 or 60 enter the lesser of \$50% of the amount by which operating costs (line \$3) are less than expected costs (lines \$4 x 60), or 1% of the target amount (line \$50), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 62.00 Relief payment (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Modulare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Modulare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Ine 67.00 listructions) (title XVIII only) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (Ine 67.00 listructions) (I
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 Boxno payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 59.00 market basket 0.00 lif lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 lif lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 63.00 Relief payment (see instructions) 0 63.00 Relief payment (see instructions) 0 63.00 Relief payment (see instructions) 0 63.00 Relief payment (see instructions) 0 63.00 Relief payment (see instructions) 0 64.00 Relief payment (see instructions) 0 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 0 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 0 66.00 Tall Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH 0 66.00 Tall Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH 0 66.00 Tall Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH 0 66.00 Tall Medicare swing-bed SNF inpatient routine costs (line 67 + line 68) 0 70 Tall title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 70 Tall title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 70 Tall title V or XIX swing-bed NF inpatient routine service cost (line 37) 70.00 Program routine service cost (line 9 x line 71) 71.00 72.00 Program couline service cost (line 9 x line 71) 71.00 72.00 Program couline service cost (line 9 x line 71) 71.00 72.00 Program couline service cost (line 75 + l
S9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 59.00 market basket 0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 1f line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.62.00 Relief payment (see instructions) 0.63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.63.00 PRORMM INPATIENT ROUTINE SWING BED COST 0.64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 0.65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 0.66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For (See Instructions) (title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 0.67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 0.67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 0.68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 67 + line 20) 0.00 Part III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 0.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 67 + line 20) 0.00 Part III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 0.00 Program routine service cost (line 9 x line 71) 0.00 Program routine service cost (line 75 + line 2) 0.00 Program capital related costs (
market basket  0.00 60.00 lf lines 53/54 or 55 from prior year cost report, updated by the market basket  0.00 60.00 lf lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount 56), otherwise enter zero (see Instructions)  0.00 Relief payment (see instructions
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  02.00 Relief payment (see instructions)  03.00 Allowable Inpatient cost plus incentive payment (see instructions)  043.00 PROGRAM INPATIENT ROUTINE SWING BED COST  05.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  05.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  06.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For (see instructions)  07.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  08.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  09.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  09.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICP/IID ONLY  17.00 Adjusted general inpatient routine service cost (line 70 + line 2)  17.00 Program routine service cost (line 9 x line 71)  17.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  17.00 Program capital-related costs (line 75 + line 2)  17.00 Program capital-related costs (line 75 + line 2)  17.00 Program capital-related costs (line 77 + line 70)  17.00 Aggregate charges to beneficiaries for excess costs (from provider records)  18.00 Inpatient routine service cost from comparison to the cost limitation (line 78 minus line 79)  18.00 Inpatient routine service cost from minus line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 line 10 li
operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 62.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (see instructions) (title XVIII only) (see instructions) (title XVIII only) (see instructions) (see instruction
62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 0 67.00 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 0 68.00 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 0 68.00 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Program routine service cost (line 9 x line 71)  70.00 Total Viction of the cost reporting period (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Ine 45)  76.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 75 + line 2)  77.00 Aggregate charges to benefic aries for excess costs (from provider records)  79.00 Aggregate charges to benefic aries for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation
Allowable Inpatient cost plus incentive payment (see instructions)  63.00  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH  67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH  68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, 175.00  75.00 Capital -related costs (line 75 + line 2)  76.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 76 minus line 77)  78.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Total Program routine service cost per diem limitation  79.00 Total Program routine service cost on the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation
PROGRAM IMPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 0 67.00 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 0 68.00 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Total Program general inpatient routine service costs (line 72 + line 73) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 81.00
instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH  0 (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line  0 67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line  0 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  0 70 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  0 80 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  0 70 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  0 80 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70 OB Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71 OD Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72 OD Program routine service cost (line 9 x line 71)  73 OD Medically necessary private room cost applicable to Program (line 14 x line 35)  74 OD Total Program general inpatient routine service costs (line 72 + line 73)  75 OD Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76 OD Per diem capital-related costs (line 75 ÷ line 2)  77 OD Program capital-related costs (line 74 minus line 77)  79 OD Aggregate charges to beneficiaries for excess costs (from provider records)  80 OD Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81 OD Inpatient routine service cost per diem limitation  81 OD Inpatient routine service cost per diem limitation
instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH  (see instructions)  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line  12 x line 19)  88.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line  13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 9 x line 76)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Silve the cost reporting period (line 78 minus line 79)  83.00 Total Program routine service cost per diem limitation  83.00 Silve the cost reporting period (line 78 minus line 79)  84.00 Silve the cost reporting period (line 78 minus line 79)  85.00 Silve the cost reporting period (line 78 minus line 79)  86.00 Silve the cost reporting period (line 78 minus line 79)  86.00 Silve the cost limitation (line 78 minus line 79)  87.00 Silve the cost limitation (line 78 minus line 79)
66.00 (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 0 67.00 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 0 68.00 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 0 68.00 13 x line 20) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, 75.00 11ne 45) 76.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 0 68.00 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  72.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost per diem limitation  81.00
12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 0 68.00 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 76.00 Program capital -related costs (line 74 minus line 77) 78.00 Raggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess cost (from provider records) 79.00 Inpatient routine service cost per diem limitation 81.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital -related costs (line 75 ÷ line 2)  77.00 Program capital -related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost per diem limitation  80.00 Inpatient routine service cost per diem limitation  81.00
69.00  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  70.00  Program routine service cost (line 9 x line 71)  71.00  Medically necessary private room cost applicable to Program (line 14 x line 35)  72.00  Total Program general inpatient routine service costs (line 72 + line 73)  73.00  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00  Per diem capital-related costs (line 75 ÷ line 2)  77.00  Program capital-related costs (line 9 x line 76)  Inpatient routine service cost (line 74 minus line 77)  79.00  Aggregate charges to beneficiaries for excess costs (from provider records)  80.00  Total Program routine service cost per diem limitation  81.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 81.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 81.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 7 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00
line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost per diem limitation  81.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00
81.00 Inpatient routine service cost per diem limitation 81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)
83.00 Reasonable inpatient routine service costs (see instructions) 83.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  338 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2,491.32 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 842,066 89.00

Health Financial Systems I	U HEALTH BLACK	FORD HOSPITAL		In Lieu	of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
		Ti tl	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 Capi tal -related cost	308, 239	5, 560, 091	0. 05543	8 842, 066	46, 682	90.00
91.00 Nursing School cost	0	5, 560, 091	0. 00000	0 842, 066	0	91.00
92.00 Allied health cost	0	5, 560, 091	0. 00000	0 842, 066	0	92.00
93.00 All other Medical Education	0	5, 560, 091	0. 00000	0 842, 066	0	93. 00

Health Fina	ncial Systems	IU HEALTH BLACKFORD HOSPITAL			In Lieu	ı of Form CMS-2	2552-10
	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1302	Per Fro To	iod: m 01/01/2020 12/31/2020	Worksheet D-3	B epared:
		Title	XVIII		Hospi tal	Cost	o piii
	Cost Center Description		Ratio of Cos		Inpatient	I npati ent	
	obst conton boodinption		To Charges			Program Costs	
			9			(col. 1 x col.	
					g	2)	
			1.00		2. 00	3. 00	
I NPAT	TIENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS				1, 262, 443		30.00
ANCI L	LARY SERVICE COST CENTERS						1
50.00 05000	OPERATING ROOM		0. 4427	60	7, 152	3, 167	50.00
53.00 05300	ANESTHESI OLOGY		0. 0013	41	0	0	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C		0. 3643	26	121, 459	44, 251	54.00
57.00 05700	CT SCAN		0. 0000	00	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)		0. 0000	00	0	0	58. 00
59.00 05900	CARDIAC CATHETERIZATION		0. 0000	00	0	0	59. 00
60.00 06000	LABORATORY		0. 4885	75	241, 022	117, 757	60.00
60. 01 06001	BLOOD LABORATORY		0. 0000	00	0	0	60. 01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	S	0. 0000	00	0	0	62. 00
65.00 06500	RESPIRATORY THERAPY		0. 8165	50	137, 330	112, 137	65.00
65. 01 06501	SLEEP LAB		0. 0000	00	0	0	65. 01
66.00 06600	PHYSI CAL THERAPY		0. 7946	84	30, 835	24, 504	66.00
67.00 06700	OCCUPATIONAL THERAPY		1. 2617	56	9, 073	11, 448	67.00
	SPEECH PATHOLOGY		1. 8597	51	2, 409	4, 480	68. 00
	ELECTROCARDI OLOGY		0. 1835		27, 186	4, 990	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	S	0. 6243	94	0	0	71. 00
	IMPL. DEV. CHARGED TO PATIENT		0. 6244		0	0	
	DRUGS CHARGED TO PATIENTS		0. 3374		830, 531	280, 271	
76.00 03140			0. 00000		0	0	
	CARDIAC REHABILITATION		0. 2574	11	0	0	76. 97
	ATIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC (RHC)		0. 00000			0	
90.00 09000			0. 2241		0	0	
91.00 09100		_	0. 2172		5, 427		91.00
	OBSERVATION BEDS (NON-DISTINCT PART		0. 4258	80	4, 950		92. 00
200. 00	Total (sum of lines 50 through 94 a				1, 417, 374		
201. 00	Less PBP Clinic Laboratory Services		P		0		201.00
202. 00	Net charges (line 200 minus line 20	1)	l	ı	1, 417, 374		202. 00

Health Financial Systems IU HEALTH   INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	BLACKFORD HOSPITAL	ON, 1E 1202 I	Peri od:	u of Form CMS-2	
INPATIENT ANCILLARY SERVICE CUST APPURTIUNMENT	Provi der C		Period: From 01/01/2020	Worksheet D-3	3
	'	CCN: 15-Z302	To 12/31/2020	Date/Time Pre 7/15/2021 1:0	epared: 03 pm
			Swing Beds - SNF	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					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
ANCILLARY SERVICE COST CENTERS		0.4407			
50. 00 05000 OPERATI NG ROOM		0. 44276		-	
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 00134		10 145	
54. 00   05400   RADI OLOGY - DI AGNOSTI C 57. 00   05700   CT   SCAN		0. 36432 0. 00000			•
58.00   05700 CT SCAN 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 00000		0	
59. 00   05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	
60. 00 1059001 CARDIAC CATHETERIZATION		0. 48857		-	
60. 01   06000  BL00D   LABORATORY		0. 00000		37, 704	•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000		0	•
65. 00 06500 RESPIRATORY THERAPY		0. 81655		-	
65. 01 06501 SLEEP LAB		0. 00000		0,,,,,2	1
66. 00 06600 PHYSI CAL THERAPY		0. 79468		88, 680	
67. 00 06700 OCCUPATI ONAL THERAPY		1. 26175			
68. 00 06800 SPEECH PATHOLOGY		1. 85975			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 18354	8, 157	1, 497	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 62439	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 62442	28 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 33746	368, 045	124, 200	73.00
76. 00   03140   CARDI OLOGY		0. 00000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 25741	1 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC (RHC)		0. 00000		0	
90. 00 09000 CLINIC		0. 22416		0	
91. 00 09100 EMERGENCY		0. 21724		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 42588		0	
Total (sum of lines 50 through 94 and 96 through			739, 509		
Less PBP Clinic Laboratory Services-Program onl	y charges (line 61	P	720 500		201.00
202.00 Net charges (line 200 minus line 201)			739, 509		202.00

Health Financial System	S	IU HEALTH BLACKFORD HOSPITAL			In Lieu	ı of Form CMS-2	2552-10
	RVICE COST APPORTIONMENT	Provi der C	CN: 15-1302	Period From C To 1		Worksheet D-3	epared:
		Titl	e XIX	Hos	spi tal	Cost	
Cost Center	Description		Ratio of Cos	t In	pati ent	I npati ent	
			To Charges	Р	rogram	Program Costs	
				CI	harges	(col. 1 x col.	
					, and the second	2)	
			1. 00		2.00	3. 00	
	E SERVICE COST CENTERS						
30.00 03000 ADULTS & PE					0		30.00
ANCILLARY SERVICE							
50.00 05000 OPERATING R			0. 44276	50	0	0	50.00
53. 00 05300 ANESTHESI OL			0. 00134		0	0	
54. 00 05400 RADI OLOGY-D	I AGNOSTI C		0. 36432		0	0	54.00
57.00 05700 CT SCAN			0. 00000		0	0	
58.00 05800 MAGNETIC RE			0. 00000		0	0	
59. 00 05900 CARDI AC CAT	HETERI ZATI ON		0. 00000		0	0	59. 00
60. 00 06000 LABORATORY			0. 48857		0	0	60.00
60. 01 06001 BL00D LABOR			0. 00000		0	0	
	& PACKED RED BLOOD CELLS	S	0. 00000		0	0	62.00
65. 00 06500 RESPI RATORY	THERAPY		0. 81655		0	0	65.00
65.01 06501 SLEEP LAB			0. 00000		0	0	65. 01
66. 00 06600 PHYSI CAL TH			0. 79468		0	0	
67. 00 06700 OCCUPATI ONA			1. 26175		0	0	67. 00
68.00 06800 SPEECH PATH			1. 85975		O	0	68. 00
69. 00 06900 ELECTROCARD			0. 18354		O	0	
	PLIES CHARGED TO PATIENT	S	0. 62439		0	0	
72. 00 07200 I MPL. DEV.			0. 62442		0	0	,
73. 00 07300 DRUGS CHARG	SED TO PATIENTS		0. 33746		0	0	73. 00
76. 00 03140 CARDI OLOGY			0. 00000		0	0	
76. 97 07697 CARDI AC REH			0. 25741	11	0	0	76. 97
OUTPATIENT SERVICE				, al			
88. 00 08800 RURAL HEALT	H CLINIC (RHC)		0. 00000		0	0	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY			0. 22416		0	0	
	L DEDC (NON DICTINGT DADT		0. 21724		0	0	
	BEDS (NON-DISTINCT PART)		0. 42588	30	0	0	
	of lines 50 through 94 a	nd 96 inrough 98) -Program only charges (line 61	Į.		0		200. 00 201. 00
	(line 200 minus line 20		ľ		0		201.00 202.00
202. 04   INEL CHarges	(Time 200 milius Time 20	'/	I	I	٠		K02.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1302 CCN: 15-Z302	Period: From 01/01/2020	Worksheet D-3	,
	·			7/15/2021 1:0	)3 pm
			Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	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		l	0		30. 00
ANCI LLARY SERVI CE COST CENTERS					30.00
50. 00 05000 OPERATI NG ROOM		0. 44276	0 0	0	50. 00
53. 00 05300 ANESTHESI OLOGY		0. 00134		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 36432		0	54. 00
57. 00 05700 CT SCAN		0. 00000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000	00	0	59. 00
60. 00 06000 LABORATORY		0. 48857	75 0	0	60.00
60. 01 06001 BL00D LABORATORY		0. 00000	00	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000	00	0	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 81655		0	65.00
65. 01  06501   SLEEP LAB		0. 00000		0	65. 01
66. 00 06600 PHYSI CAL THERAPY		0. 79468		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		1. 26175		0	67. 00
68. 00 06800 SPEECH PATHOLOGY		1. 85975		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 18354		0	69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 62439		0	
72.00   07200   MPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS		0. 62442 0. 33746		0	72. 00 73. 00
76. 00 03140 CARDI OLOGY		0. 00000		0	76.00
76. 00 03140 CARDI OLOGI 76. 97 07697 CARDI AC REHABI LI TATI ON		0. 25741		0	76. 00
OUTPATIENT SERVICE COST CENTERS		0. 2374	0	0	70. 77
88. 00 08800 RURAL HEALTH CLINIC (RHC)		0. 00000	00	0	88. 00
90. 00 09000 CLINIC		0. 22416		0	
91. 00 09100 EMERGENCY		0. 21724		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 42588		0	
200.00 Total (sum of lines 50 through 94 and	d 96 through 98)		0	0	200. 00
201.00 Less PBP Clinic Laboratory Services-F	Program only charges (line 61	)	0		201. 00
202.00 Net charges (line 200 minus line 201)	_		0		202. 00

Heal th	Financial Systems	IU HEALTH BLACKFOR	D HOSPITAL	In Lieu	of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1302	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Pre 7/15/2021 1:0	
			Title XVIII	Hospi tal	Cost	
					1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICE	S				
1.00	1.00 Medical and other services (see instructions)					1.00
2.00 Medical and other services reimbursed under OPPS (see instructions)				0	2. 00	
3.00	OPPS payments				0	3.00
4.00	Outlier payment (see instructions)				0	4.00

		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			3, 557, 358	1.00
2.00	Medical and other services reimbursed under OPPS (see instru	ıcti ons)		0	2. 00
3.00	OPPS payments			0	
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instr	ructions)		0.000	
6.00	Line 2 times line 5	,		0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	
8. 00	Transitional corridor payment (see instructions)	11/ 1 12 11 200		0	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	TV, COL. 13, TTNE 200		0	
	Total cost (sum of lines 1 and 10) (see instructions)			3, 557, 358	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
	Ancillary service charges	Line (0)		0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Total reasonable charges (sum of lines 12 and 13)	11 ne 69)		0	13. 00 14. 00
14.00	Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for	payment for services of	on a charge basi	s 0	15. 00
16.00	Amounts that would have been realized from patients liable 1	for payment for services	s on a chargebas	s had 0	16. 00
17 00	such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17 00
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000	18.00
	Excess of customary charges over reasonable cost (complete of	only if line 18 exceeds	line 11) (see	0	19. 00
	instructions)		, ,		
20.00	Excess of reasonable cost over customary charges (complete of	only if line 11 exceeds	line 18) (see	0	20. 00
21 00	<pre>instructions) Lesser of cost or charges (see instructions)</pre>			3, 592, 932	21 00
	Interns and residents (see instructions)			3, 592, 932	22.00
	Cost of physicians' services in a teaching hospital (see ins	structions)		0	23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			00.440	05 00
	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on Li		etructions)	38, 463 1, 793, 491	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)				
	instructions)	,		,	
	Direct graduate medical education payments (from Wkst. E-4,			0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36	b)		1 7/0 070	29.00
	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 760, 978 477	
	Subtotal (line 30 minus line 31)			1, 760, 501	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	(I CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			217, 280 141, 232	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		164, 803	*
	Subtotal (see instructions)	,		1, 901, 733	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>		0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration			0	39. 50 39. 97
	Partial or full credits received from manufacturers for repl		ructions)	0	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION	`	,	0	39. 99
	Subtotal (see instructions)			1, 901, 733	
40. 01	Sequestration adjustment (see instructions)			12, 551	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
	Interim payments			1, 912, 324	
	Interim payments-PARHM				41. 01
	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-23, 142	42. 01
43.00	Balance due provider/program-PARHM (see instructions)			-23, 142	43. 00
	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2	2, chapter 1, §1	15. 2 163, 126	1
	TO BE COMPLETED BY CONTRACTOR		;		
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94. 00

Health Financial Systems IU HEA	LTH BLACKFO	RD HOSPITAL		In Lieu	of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	D	Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part I Date/Time Pre 7/15/2021 1:0	pared:
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00 Total interim payments paid to provider			1, 825, 68	9	1, 912, 324	1.00
2.00 Interim payments payable on individual bills, ei submitted or to be submitted to the contractor f		5		0	0	2. 00

1.00			Inpatient	t Part A	Par	rt B	
1.00			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
Interim payments payable on Individual bills, either   Submitted or to be submitted to the contractor for servides   Payable on Individual bills, either   Submitted or to be submitted to the contractor for servides   Payable on Individual bills, either   Payable on Interim reaction to based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   Program to Provider   Program to Provider   Program to Provider   Program to Provider   Program to Provider   Program   Provider to Program   Provider   Program   Prov							
Submitted or to be submitted to the contractor for servides rendered in the cost reporting period. I frome, write "NONE" or enter a zero or enter a zero (1 ist separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If nond, write "NONE" or enter a zero. (1)   ADJUSTMENTS TO PROVIDER	1. 00	Total interim payments paid to provider		1, 825, 689		1, 912, 324	1. 00
rendered in the cost reporting period. If none, write "NONE" or enter a zero   List separately each retroactive lump sum adjustment amount   based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   DAJUSTMENTS TO PROVIDER   08/18/2020   168,600   0 3.01   3.02   3.03   3.04   0 0 0 3.03   3.04   0 0 0 3.03   3.04   0 0 0 3.03   3.04   0 0 0 3.04   3.05   3.05   3.05   DAJUSTMENTS TO PROGRAM   0 0 0 3.55   3.51   3.51   3.52   3.53   0 0 0 0 3.55   3.51   3.52   3.53   0 0 0 0 3.55   3.53   3.54   3.54   3.55	2.00	Interim payments payable on individual bills, either		0		0	2.00
Or enter a zero   Separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Or or or or or or or or or or or or or or		submitted or to be submitted to the contractor for service	es				
3.00   List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If nond, write "NONE" or enter a zero. (1)   Program To Provider		rendered in the cost reporting period. If none, write "M	ONE"				
based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		or enter a zero					
reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
Write "NONE" or enter a zero. (1)   Proyram to Provider   ADJUSTMENTS TO PROVIDER   OB/18/2020   168,600   O 3. 01   O 3. 02   O 0   O 3. 02   O 0   O 3. 02   O 0   O 3. 02   O 0   O 3. 03   O 0   O 3. 03   O 0   O 3. 04   O 0   O 3. 04   O 0   O 3. 04   O 0   O 3. 05							
Program to Provider			,				
ADJUSTMENTS TO PROVIDER							
3. 02   0   0   0   3. 02   3. 03   3. 04   0   0   0   3. 03   3. 04   0   0   0   3. 03   3. 04   0   0   0   3. 05   3. 0							
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 3.50-3.98) 4.00 Journal of Lines 3.01-3.49 minus sum of lines 3.50-3.99) Journal of Lines 1, 2, and 3.99) Journal of Lines 1, 2, and 3.99) Journal of Lines 1, 2, and 3.99) Journal of Lines 2, and 3.99) Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.09 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines 3.00 Journal of Lines 3.01-3.49 minus sum of lines		ADJUSTMENTS TO PROVIDER	08/18/2020	168, 600			
3. 04				0		-	
3.05				0		-	
Provider to Program   ADJUSTMENTS TO PROGRAM   O   O   O   O   O   O   O   O   O				~I		_	
3. 50   ADJUSTMENTS TO PROGRAM   0   0   3. 50     3. 51   3. 52   0   0   0   3. 51     3. 52   3. 53   0   0   0   3. 52     3. 53   3. 54   0   0   0   3. 53     3. 54   3. 99   Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98)   168,600   0   3. 59     4. 00   Total interim payments (sum of lines 1, 2, and 3. 99)   1, 994, 289   1, 912, 324   4. 00     (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR	3.05	Describer to Describe		U		0	3.05
3.51   0   0   3.51   3.52   3.53   0   0   0   3.53   3.53   3.54   0   0   0   3.53   3.54   3.59   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   1.994,289   1.912,324   4.00   1.00   1.994,289   1.912,324   4.00   1.994,289   1.912,324   4.00   1.994,289   1.912,324   4.00   1.994,289   1.994,289   1.912,324   4.00   1.994,289   1.99	2 50			٥			2 50
3.52   3.53   3.54   3.59   3.50   3.52   3.54   3.59   3.50   3.50   3.53   3.54   3.59   3.50		ADJUSTWENTS TO PROGRAW		~I		-	
3.53   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   168,600   0 3.50-3.98)   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,912,324   4.00   1,994,289   1,994,289   1,912,324   4.00   1,994,289				0		_	
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   168,600   0   3.54   3.99   3.50-3.98)   1,994,289   1,912,324   4.00   1,994,289			•	0		-	
3. 99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   1,994,289   1,912,324   4.00				0		-	
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   1,994,289   1,912,324   4.00		Subtotal (sum of lines 3 01-3 49 minus sum of lines		168, 600		-	
1,994,289   1,912,324   4.00				,		_	
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR   5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	4.00			1, 994, 289		1, 912, 324	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  5.01 TENTATIVE TO PROVIDER  0 0 5.01 5.02 5.03 Provider to Program  5.50 TENTATIVE TO PROGRAM  0 0 5.50 5.51 5.52 0 0 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Provider to Program 0 0 0 5.01 0 5.50 0 0 5.50 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
Or enter a zero. (1)   Program to Provider	5.00						5. 00
Program to Provider			ONE"				
TENTATI VE TO PROVIDER							
Solution   Contractor   Solution   Solutio	- 01	Program to Provider	-	ما			F 04
Solution   Section   Sec		TENTATIVE TO PROVIDER					
Provider to Program				-		-	
TENTATI VE TO PROGRAM	5. 03	Dravi dan ta Bragnam		U		0	5.03
5.51   0	5 50			0		0	5 50
5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 103, 609 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 23, 142 6. 02 7. 00 Total Medicare program liability (see instructions) 2, 097, 898 1, 889, 182 7. 00  Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00				-			
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 103,609 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 23,142 6.02 7.00 Total Medicare program liability (see instructions) 2,097,898 1,889,182 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				0		-	
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00		Subtotal (sum of lines 5 01-5 49 minus sum of lines		0		-	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 103,609 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 23,142 6.02 7.00 Total Medicare program liability (see instructions) 2,097,898 Contractor NPR Date (Mo/Day/Yr)  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	J. ,,			ĭ			0. ,,
Cost report. (1)   SETTLEMENT TO PROVIDER   103,609   0 6.01	6. 00		the	İ			6. 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00							
7.00 Total Medicare program Liability (see instructions)  2,097,898  1,889,182 7.00  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 01			103, 609		0	6. 01
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00	6. 02	SETTLEMENT TO PROGRAM	]	0		23, 142	6. 02
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total Medicare program liability (see instructions)		2, 097, 898			7.00
0 1.00 2.00							
8.00   Name of Contractor     8.00	2.21	In the second	0		1. 00	2. 00	2.25
	8.00	Name of Contractor	1	l			8.00

Heal tr	n Financial Systems IU HEALTH BLACK SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	ON: 15 1202 I	<u>In Lieu</u> Period:	u of Form CMS- Worksheet E-	
ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1302	From 01/01/2020	Part I	•
		<u>'</u>	CCN: 15-Z302	To 12/31/2020	Date/Time Pr 7/15/2021 1:	epared: 03 pm
				<u> Swing Beds – SNF</u>	Cost	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		1, 660, 19	4	C	1.00
2.00	Interim payments payable on individual bills, either		(	0	C	2.00
	submitted or to be submitted to the contractor for service					
	rendered in the cost reporting period. If none, write "N	ONE"				
3. 00	or enter a zero List separately each retroactive lump sum adjustment amou	n+				3.00
3.00	based on subsequent revision of the interim rate for the					3.00
	reporting period. Also show date of each payment. If none					
	write "NONE" or enter a zero. (1)	,				
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/18/2020	47, 20	0	C	0.0.
3. 02			(	0	C	0.02
3. 03			(	0	C	
3. 04				0	C	
3. 05	Provider to Program			<u>U</u>	C	3. 05
3. 50	ADJUSTMENTS TO PROGRAM			0	(	3. 50
3. 51	7.BOGGTINELITY OF THOOLIGHT			o	ď	
3. 52			(	0	C	3. 52
3. 53			(	0	C	3. 53
3.54			(	0	C	0.0.
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		47, 20	0	C	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 707, 39	4	(	4.00
4. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		1,707,37			7.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after o	esk				5. 00
	review. Also show date of each payment. If none, write "N	ONE"				
	or enter a zero. (1)					4
5. 01	Program to Provider TENTATIVE TO PROVIDER	1				5. 01
5. 01	ILIVIALIVE TO PROVIDER			0		
5. 03				ŏ		
	Provider to Program					1
5.50	TENTATI VE TO PROGRAM			0	C	0.00
5. 51			(	0	C	5. 51
E E 2						

5. 52 5. 99

6.00

6. 01

6. 02 7. 00

8. 00

0

0

NPR Date (Mo/Day/Yr)

145, 251

Contractor

Number 1.00

1, 852, 645

5. 51 5. 52 5. 99

6.00

6.01

6.02

7.00

Subtotal (sum of lines 5.01-5.49 minus sum of lines

Total Medicare program liability (see instructions)

cost report. (1)
SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Determined net settlement amount (balance due) based on the

Heal th	Financial Systems IU HEALTH BLACKFO	RD HOSPITAL	In Lieu	of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1302	Peri od: From 01/01/2020		
			To 12/31/2020	Date/Time Pr 7/15/2021 1:	
		Title XVIII	Hospi tal	Cost	
			ļ		
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI		1 14		1
1.00	Total hospital discharges as defined in AARA §4102 from Wks		ine 14		1.00
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	11 20			5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3		William C O Di	1.11	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of 168	certified HII technolo	gy WKST. 5-2, PT.	lline	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00 Other Adjustment (specify)					31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruct	i ons)		32. 00

	Financial Systems IU HEALTH BLACKFOR			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provi der CCN: 15-1302	Period: From 01/01/2020	Worksheet E-2	2
		Component CCN: 15-Z302	To 12/31/2020	Date/Time Pre 7/15/2021 1:0	epared: 03 pm
		Title XVIII	Swing Beds - SNI	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient routine services - swing bed-SNF (see instructions		1, 479, 545	0	
	Inpatient routine services - swing bed-NF (see instructions)				2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Pa		D Part 394, 520	0	3.00
	V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-b	oed pass-through, see			
0.01	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)	hi ( it-		0.00	3.0
	Per diem cost for interns and residents not in approved tead	ining program (see insti		0. 00 0	•
5. 00 6. 00	Program days Interns and residents not in approved teaching program (see	instructions)	588	0	
	Utilization review - physician compensation - SNF optional r			0	7.00
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	lethod only	1, 874, 065	0	
9. 00	Primary payer payments (see instructions)		1, 074, 003	0	
	Subtotal (line 8 minus line 9)		1, 874, 065		
	Deductibles billed to program patients (exclude amounts appl	icable to physician	1,0,1,000	0	
11.00	professional services)	readire to physician	Ĭ	Ĭ	11.00
12.00	Subtotal (line 10 minus line 11)		1, 874, 065	0	12.00
	Coinsurance billed to program patients (from provider record	ls) (excl ude coi nsurance			•
	physici an professi onal services)	, ,			
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1, 864, 060	0	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
	Pioneer ACO demonstration payment adjustment (see instruction				16. 50
16. 55	Rural community hospital demonstration project (§410A Demons	stration) payment adjust	tm <b>e</b> nt O		16. 5!
	(see instructions)			_	
	Demonstration payment adjustment amount before sequestration	1	0	0	
	Allowable bad debts (see instructions)		1, 375		
	Adjusted reimbursable bad debts (see instructions)		894		17. 0
	Allowable bad debts for dual eligible beneficiaries (see instructions)	structions)	880 1, 864, 954		18. 00 19. 00
	Sequestration adjustment (see instructions)		12, 309		19.00
	Demonstration payment adjustment amount after sequestration)		12, 309		
	Sequestration adjustment-PARHM pass-throughs		ď	٥	19. 0
	Interim payments		1, 707, 394	0	
	Interim payments-PARHM		1,707,071	ĺ	20. 0
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)		1	1	21. 0
	Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	145, 251	0	
	Balance due provider/program-PARHM (see instructions)	•		1	22. 0
	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2	2, 61, 953	0	23.00
	chapter 1, §115.2		1		

Rufal Community hospital Demonstration Project (3410A Demonstration) Adjustment	
200.00 Is this the first year of the current 5-year demonstration period under the 21st Century	200. 00
Cures Act? Enter "Y" for yes or "N" for no.	
Cost Reimbursement	
201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66	201. 00
(title XVIII hospital))	
202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200	202. 00
(title XVIII swing-bed SNF))	
203.00 Total (sum of lines 201 and 202)	203. 00
204.00 Medicare swing-bed SNF discharges (see instructions)	204. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year	
demonstration period)	
205.00 Medicare swing-bed SNF target amount	205. 00

205.00 Medicare swing-bed SNF target amount		205. 00
206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)		206. 00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement		
207.00 Program reimbursement under the §410A Demonstration (see instructions)		207. 00
208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines	1 and	208. 00
3)		
209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)		209. 00
210. 00 Reserved for future use		210. 00
Comparision of PPS versus Cost Reimbursement		
215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see	)	215. 00
instructions)		
·	-	•

Health Financial Systems	IU HEALTH BLACKFOR	In Lieu	of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-1302	Peri od: From 01/01/2020	Worksheet E-2
		Component CCN: 15-Z302	To 12/31/2020	
		Title XIX	Swing Beds - SNF	Cost

		Component CCN: 15-Z302	To 12/31/2020	Date/Time Pr 7/15/2021 1:	repared:
		Title XIX	Swing Beds - SNF	Cost	US PIII
			Part A	Part B	
			1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES	-)			1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions Inpatient routine services - swing bed-NF (see instructions)		0	I	1.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Pa				3.00
3.00	V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-b		D Tart 0	I	3.00
	instructions)	sed pass till edgil, see		1	
3. 01	Nursing and allied health payment-PARHM (see instructions)			I	3. 01
4.00	Per diem cost for interns and residents not in approved tead	ching program (see inst	ructions) 0.00	I	4.00
5.00	Program days		0	I	5. 00
6. 00	Interns and residents not in approved teaching program (see		0	I	6. 00
7. 00	Utilization review - physician compensation - SNF optional r	nethod only	0	I	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	I	8.00
9.00	Primary payer payments (see instructions)		0	I	9.00
	Subtotal (line 8 minus line 9)	tradition des relevant at au	0	İ	10.00
11. 00	Deductibles billed to program patients (exclude amounts appl	icable to physician	0	I	11. 00
12 00	professional services) Subtotal (line 10 minus line 11)			İ	12. 00
	Coinsurance billed to program patients (from provider record	de) (evelude coi neurance	a for	I	13. 00
13.00	physician professional services)	day (exertide corristration	5   01	İ	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	I	14. 00
	Subtotal (see instructions)		Ö	I	15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	I	16. 00
	Pioneer ACO demonstration payment adjustment (see instruction	ons)		I	16. 50
16. 55	Rural community hospital demonstration project (§410A Demons	stration) payment adjus	tment	I	16. 55
	(see instructions)			I	
	Demonstration payment adjustment amount before sequestration	ו	0	I	16. 99
	Allowable bad debts (see instructions)		0	İ	17. 00
	Adjusted reimbursable bad debts (see instructions)		0	I	17. 01
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)	0	İ	18.00
	Total (see instructions) Sequestration adjustment (see instructions)		0	I	19. 00 19. 01
	Demonstration payment adjustment amount after sequestration)	1	0	I	19.01
	Sequestration adjustment-PARHM pass-throughs	,		I	19. 02
	Interim payments		0	I	20.00
	Interim payments-PARHM			İ	20. 01
21.00	Tentative settlement (for contractor use only)		0	İ	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			I	21. 01
	Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	0	I	22. 00
	Balance due provider/program-PARHM (see instructions)			I	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-3	2, 0	I	23. 00
	chapter 1, §115.2				_
200 00	Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration;		antum.		200 00
200.00	Cures Act? Enter "Y" for yes or "N" for no.	berrod under the 21st C	entury	1	200.00
	Cost Reimbursement				
201. 00	Medicare swing-bed SNF inpatient routine service costs (from	n Wkst. D-1. Pt. II. li	ne 66		201.00
	(title XVIII hospital))			İ	
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fr	rom Wkst. D-3, col. 3,	ine 200	I	202.00
	(title XVIII swing-bed SNF))			I	
203.00	Total (sum of lines 201 and 202)			I	203.00
204. 00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A i	n first year of the cu	rrent 5-year		
205 00	demonstration period) Medicare swing-bed SNF target amount		1		
		times line 204)		İ	205. 00 206. 00
200.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbu				200.00
207 00	Program reimbursement under the \$410A Demonstration (see ins				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E	,	es 1 and	I	208.00
200.00	[3]	2, 331. 1, 34 3. 111		İ	200.00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instr	ructions)		Ì	209. 00
	Reserved for future use			<u> </u>	210. 00
	Comparision of PPS versus Cost Reimbursement				
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line	e 209 plus line 210) (s	ee	1	215. 00
	i nstructi ons)		1	İ	l

Heal th	Financial Systems IU HEALTH BLACKFO	RD HOSPITAL	In Lieu	u of Form CMS-2	<u>2552-10</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1302	Peri od:	Worksheet E-3	3
			From 01/01/2020 To 12/31/2020		narod:
			10 12/31/2020	7/15/2021 1:0	og par eu. Da pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	<u>RE PART A SERVICES - C</u>	OST RETMBURSEMEN		1 00
1. 00 2. 00	Inpatient services Nursing and Allied Health Managed Care payment (see instruc	tions)		2, 258, 037 0	1.00 2.00
3. 00	Organ acquisition	tions)		0	
4. 00	Subtotal (sum of lines 1 through 3)			2, 258, 037	
5. 00	Primary payer payments			0	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 280, 617	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7. 00	Routine service charges			0	
8. 00 9. 00	Ancillary service charges			0	
	Organ acquisition charges, net of revenue Total reasonable charges			0	
10.00	Customary charges			0	10.00
11.00	Aggregate amount actually collected from patients liable fo	r payment for services	on a charge basi	s 0	11. 00
	Amounts that would have been realized from patients liable				12. 00
	such payment been made in accordance with 42 CFR 413.13(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	•
	Total customary charges (see instructions)			0	
15. 00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds	line 6) (see	0	15. 00
16. 00	instructions) Excess of reasonable cost over customary charges (complete	only if line 6 eveneds	line 14) (see	0	16. 00
10.00	linstructions)	only it time o exceeds	11110 14) (300	0	10.00
17.00	Cost of physicians' services in a teaching hospital (see in	structions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	·			1
	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	
	Cost of covered services (sum of lines 6, 17 and 18)			2, 280, 617	
	Deductibles (exclude professional component)			195, 580 0	•
	Excess reasonable cost (from line 16) Subtotal (line 19 minus line 20 and 21)			2, 085, 037	
	Coi nsurance			2,003,037	
	Subtotal (line 22 minus line 23)			2, 085, 037	
	Allowable bad debts (exclude bad debts for professional ser	vices) (see instruction	s)	41, 229	
26.00	Adjusted reimbursable bad debts (see instructions)		,	26, 799	26. 00
27.00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		29, 289	27. 00
	Subtotal (sum of lines 24 and 25, or line 26)			2, 111, 836	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructi			0	
	Demonstration payment adjustment amount before sequestration	n		0	
30. 00 30. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 111, 836 13, 938	
	Demonstration payment adjustment amount after sequestration			13, 936	
	Sequestration adjustment-PARHM			O	30. 03
	Interim payments			1, 994, 289	
31.01	Interim payments-PARHM				31. 01
	Tentative settlement (for contractor use only)			0	
	Tentative settlement-PARHM (for contractor use only)				32. 01
	Balance due provider/program (line 30 minus lines 30.01, 30		01 and 22 01)	103, 609	
	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, Protested amounts (nonallowable cost report items) in accor			15. 2 75, 338	33. 01
57.00	processes amounts (nonarrowable cost report riems) III accor	adiloc with old rub. 19-	z, chapter i, gi	p. 5. 2 75, 550	1 54.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-typevider CCN: 15-1302 accounting records, complete the General Fund column only)

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 1:02 pm

				0 12/31/2020	Date/IIme Pre   7/15/2021 1:0	
		General Fund	Speci fi c	Endowment Fund		р
		1.00	Purpose Fund	0.00	4 00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
	Cash on hand in banks	8, 560, 495	5 (	0	0	1. 00
2. 00	Temporary investments	0		o	0	2. 00
3. 00	Notes receivable	0		0	0	3. 00
	Accounts receivable	2, 243, 451	1	0	0	4. 00
	Other receivable	-1, 475, 429		0	0	5.00
	Allowances for uncollectible notes and accounts receivabl Inventory	e 0 307, 281		0	0	6. 00 7. 00
	Prepai d expenses	50, 102			0	8.00
	Other current assets	00, 102		ő	0	9. 00
	Due from other funds	0	) (	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	9, 685, 900	) (	0	0	11. 00
40.00	FI XED ASSETS	100.004		.l		40.00
12.00		190, 324	1	0	0	12.00
	Land improvements Accumulated depreciation	259, 436 -258, 466			0	13. 00 14. 00
	Buildings	15, 007, 745			0	15. 00
	Accumulated depreciation	-9, 772, 937		ő	0	16. 00
	Leasehold improvements	0		0	0	17. 00
	Accumulated depreciation	0	) (	0	0	18. 00
	Fixed equipment	0		0	0	19. 00
	Accumulated depreciation	0		0	0	20.00
	Automobiles and trucks Accumulated depreciation	0			0	21. 00 22. 00
	Major movable equipment	4, 314, 283			0	23. 00
	Accumulated depreciation	-3, 137, 751		o o	0	24. 00
25. 00	Minor equipment depreciable	0		0	0	25. 00
	Accumulated depreciation	0	0	0	0	26. 00
	HIT designated Assets	0		0	0	27. 00
	Accumulated depreciation Minor equipment-nondepreciable	0		0	0	28. 00 29. 00
	Total fixed assets (sum of lines 12-29)	6, 602, 634			0	30.00
	OTHER ASSETS	0,002,034		<u> </u>		30.00
	Investments	0	) (	0	0	31. 00
	Deposits on Leases	0	(	0	0	32. 00
	Due from owners/officers	0		0	0	33. 00
	Other assets	0		0	0	34.00
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	16, 288, 534			0	35. 00 36. 00
30.00	CURRENT LIABILITIES	10, 200, 334		<u> </u>	0	30.00
37. 00	Accounts payable	394, 017	' (	0	0	37. 00
	Sal ari es, wages, and fees payable	691, 132	2	0	0	38. 00
	Payroll taxes payable	29, 710		0	0	39. 00
	Notes and Loans payable (short term)	0		0	0	40.00
	Deferred income Accelerated payments	5, 663, 206		O <sub>1</sub>	0	41. 00 42. 00
	Due to other funds	3,003,200			0	43.00
	Other current liabilities	1, 444, 904		ő	0	
	Total current liabilities (sum of lines 37 thru 44)	8, 222, 969		0	0	45. 00
ļ	LONG TERM LIABILITIES					
	Mortgage payable	0		0	0	46. 00
	Notes payable	0		0	0	47. 00 48. 00
	Unsecured loans Other long term liabilities	16, 556			0	48.00
	Total long term liabilities (sum of lines 46 thru 49)	16, 556			0	50.00
	Total liabilities (sum of lines 45 and 50)	8, 239, 525	1	o	0	51. 00
ļ	CAPITAL ACCOUNTS					1
	General fund balance	8, 049, 009	1			52.00
	Specific purpose fund					53.00
	Donor created - endowment fund balance - restricted			0		54.00
	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance		1			55. 00 56. 00
	Plant fund balance - invested in plant				0	57. 00
	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	8, 049, 009	1	이	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	59) 16, 288, 534	H (	O <b>I</b> O	0	60. 00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES IU HEALTH BLACKFORD HOSPITAL

In Lieu of Form CMS-2552-10
Period: Worksheet G-1
From 01/01/2020 Provi der CCN: 15-1302

					o 12/31/202	0 Date/Time Pro 7/15/2021 1:0	
		General	Fund	Special Pu	irpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		9, 456, 301 -1, 407, 293			O	1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		8, 049, 008			o	3.00
4. 00	Additions (credit adjustments) (specify)	0	2, 2 , 2 2 2	C		0	
5.00	ROUNDI NG	1		C		0	
6. 00 7. 00		0				0 0	
8. 00		0				0	•
9. 00		0		C		0	
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		1 8, 049, 009			0	10. 00 11. 00
12.00	Deductions (debit adjustments) (specify)	0	8, 049, 009			0	
13.00		0		d		0	•
14.00		0		C		0	
15. 00 16. 00		0				0 0	
17. 00		0				0	•
	Total deductions (sum of lines 12-17)		0			o	18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8, 049, 009			O	19. 00
	Islieet (Title II IIIIIllus IIIle Io)	Endowment Fund	PI ant	Fund			
					]		
1. 00	Fund balances at beginning of period	6. 00	7. 00	8.00	<b>1</b>		1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	J			1		2.00
3.00	Total (sum of line 1 and line 2)	0		C			3. 00
4. 00 5. 00	Additions (credit adjustments) (specify) ROUNDING		0		-		4.00
6. 00	ROUNDING		0		1		5. 00 6. 00
7.00			0		İ		7. 00
8.00			0				8. 00
9. 00 10. 00	Total additions (sum of line 4-9)	0	0	(			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)	0		Č			11. 00
12.00	Deductions (debit adjustments) (specify)		0		l		12. 00
13. 00 14. 00			0		}		13. 00 14. 00
15. 00			0		1		15. 00
16.00			0				16. 00
17.00	Total deductions (sum of these 10.17)		0		J		17. 00
	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0		C			18. 00 19. 00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL		In Lieu	of Form CMS-2552-10
STATEMENT OF PATIENT REVENUES AND	OPERATI NG EXPENSES	Provider CCN: 15-1302		Worksheet G-2

From 01/01/2020 Parts I & II To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Cost Center Description I npati ent Outpati ent Total 1.00 2.00 3.00 PART I - PATIENT REVENUES <u>General Inpatient Routine Services</u> 1.00 Hospi tal 2, 540, 195 2, 540, 195 1.00 SUBPROVIDER - IPF 2.00 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 833, 381 833, 381 5.00 Swing bed - NF 6.00 6.00 7.00 SKILLED NURSING FACILITY 7.00 8.00 NURSING FACILITY 8.00 9.00 OTHER LONG TERM CARE 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 3, 373, 576 3, 373, 576 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13.00 13.00 14.00 SURGICAL INTENSIVE CARE UNIT 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 11-15) 16 00 0 16 00 3, 373, 576 3, 373, 576 17.00 Total inpatient routine care services (sum of lines 10 and 16) 17.00 18.00 Ancillary services 4, 042, 915 18, 408, 095 22, 451, 010 18.00 16, 059, 757 19.00 Outpatient services 245, 232 15, 814, 525 19.00 20.00 RURAL HEALTH CLINIC (RHC) 20 00 0 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULANCE SERVICES 23.00 24.00 CMHC 24 00 25.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 26.00 HOSPI CE 26.00 OTHER (SPECIFY) 27.00 27.00 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, 7, 661, 723 34, 222, 620 41, 884, 343 28.00 PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 19, 659, 164 29.00 30.00 ADD (SPECIFY) 30.00 31.00 31.00 32.00 32.00 33.00 33.00 34.00 34.00 35.00 35.00 Total additions (sum of lines 30-35) 36, 00 36,00 37.00 DEDUCT (SPECIFY) 37.00 38.00 38.00 39.00 39.00 40.00 40.00 41.00 41.00 Total deductions (sum of lines 37-41) 42.00 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to 19, 659, 164 43.00 Wkst. G-3, line 4)

Health Financial Systems IU HEALTH BLACKF	TORD HOSPITAL	In lieu	of Form CMS-2	2552_10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1302	Peri od:	Worksheet G-3	
		From 01/01/2020 To 12/31/2020	Date/Time Pre	narod
		10 12/31/2020	7/15/2021 1:0	
			1. 00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3,			41, 884, 343	
2.00 Less contractual allowances and discounts on patients' acc	counts		23, 980, 291	
3.00 Net patient revenues (line 1 minus line 2)			17, 904, 052	
4.00 Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		19, 659, 164	
5.00 Net income from service to patients (line 3 minus line 4)			-1, 755, 112	5. 00
OTHER I NCOME			0	4 00
6.00 Contributions, donations, bequests, etc 7.00 Income from investments			0	
8.00 Revenues from telephone and other miscellaneous communicat	tion sorvices		0	
9.00 Revenue from television and radio service	ITOH SELVICES		0	
10. 00 Purchase di scounts			0	
11.00 Rebates and refunds of expenses			0	
12.00 Parking Lot receipts			0	
13.00 Revenue from Laundry and Linen service			0	
14.00 Revenue from meals sold to employees and guests			0	14.00
15.00 Revenue from rental of living quarters			0	15. 00
16.00 Revenue from sale of medical and surgical supplies to other	er 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				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	
21.00 Rental of vending machines			0	
22.00 Rental of hospital space			0	
23.00 Governmental appropriations			0	_0.00
24. 00 MI SCELLANEOUS I NCOME			252, 545	
24. 50 COVI D-19 PHE Funding			95, 274	
25.00 Total other income (sum of lines 6-24)			347, 819	
26.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY)			-1, 407, 293 0	
28.00 Total other expenses (sum of line 27 and subscripts)			0	
29. 00 Net income (or loss) for the period (line 26 minus line 28	3)		-1, 407, 293	
27. 00 part modifie (or 1033) for the period (fine 20 millios fine 20	• /	I	1, 407, 275	27.00