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: 15-1306 Peri od: Worksheet S From 01/01/2020 Parts I-III SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/14/2021 11: 21 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 7/14/2021 Time: 11: 21 am ] Manually prepared cost report use only ] 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.

(5) Amended PART II - CERTIFICATION

Contractor

use only

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.

(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.

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

]Cost Report Status

(3) Settled with Audit

(1) As Submitted

(4) Reopened

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH PAOLI HOSPITAL (15-1306) for the cost reporting period beginning 01/01/2020 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) MI CHAEL CRAIG

Officer or Administrator of Provider(s)

10. NPR Date:

11. Contractor's Vendor Code:

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 Hospi tal	0	230, 941	-266, 952	0	0	1.00
2.00 Subprovi der - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	83, 309	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200. 00 Total	0	314, 250	-266, 952	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it 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 LU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-1306 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/14/2021 11: 21 am 2.00 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 642 WEST HOSPITAL ROAD 1.00 PO Box: 1.00 State: IN Zip Code: 47454 2.00 City: PAOLI County: ORANGE 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 IU HEALTH PAOLI HOSPITAL151306 99915 07/01/2001 N 0 3.00 Hospi tal 4.00 4.00 Subprovider - IPF 5.00 Subprovider - IRF 5.00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF Swing Beds - NF 7.00 UHP SWING BEDS 15Z306 99915 07/01/2001 N 0 N 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14 00 Hospi tal -Based Hospi ce 14 00 n 15.00 Hospital-Based Health Clinic - RHC IU HEALTH PAOLI FAMILY 99915 12/07/2020 0 158557 Ν 15.00 AND INTERNAL 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From To: 1 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 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 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost Ν Ν 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) 22.02 Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural N Ν 22.03 Ν 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 In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d Medi cai d State State HMO days paid days Medi cai d Medi cai d eligible days unpaid days paid days el i gi bl e npaid day 1.00 2.00 3.00 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.

JSPLL <i>P</i>	<u>Financial Systems</u> AL AND HOSPITAL HEALTH CARE COMPLEX IDEN <sup>-</sup>	<u>IU HEALTH</u> TIFICATION DA		OSPITAL Provider CO	CN: 15-1306	Peri od:	In Lieu	Worksh	eet S-2	
						From 01	/01/2020 /31/2020	Part I Date/T		epare
		11	n-State	In-State	Out-of	Out-of	Medi ca		)ther	21 a
		Me	edi cai d	Medi cai d	State	State	HMO da		di cai d	
		pa	aid days	eligible	Medi cai d	Medi cai d			days	
			4	inpaid days	paid days	eligible				
		-	1.00	2. 00	3. 00	unpai d day 4.00	/s 5.00	)	6. 00	1
5. 00 li	If this provider is an IRF, enter the in-	-state Medica		2.00			0	0	0. 00	25.
	paid days in column 1, the in-state Medic									
	unpaid days in column 2, out-of-state Med	9								
	column 3, out-of-state Medicaid eligible		in							
	column 4, Medicaid HMO paid and eligible	but unpaid								
C	days in column 5.					Urhan/	Rural St	Date of	Geogra	3
							. 00		00	1
	Enter your standard geographic classific			us at the I	oegi nni ng	of the cos	t 2			26.
	reporting period. Enter "1" for urban or					ļ				
	Enter your standard geographic classific						2			27.
	reporting period. Enter in column 1, "1"				appl i cabl e	e, enter				
	the effective date of the geographic rec If this is a sole community hospital (SCI				SCH ctatus	offoo	+ 0			35.
	in the cost reporting period.	i), enter the	nulliber (	or perrous	30H Status	s ill errec	. 0			35.
	The cost reporting perrou.					Beai	nni ng:	Endi	i na:	
							. 00		00	
00 E	Enter applicable beginning and ending da	tes of SCH sta	atus. Sul	oscript li	ne 36 for r	number of				36.
	periods in excess of one and enter subse					ļ				ļ
	If this is a Medicare dependent hospital	(MDH), enter	the numb	per of peri	ods MDH st	:atu sisi	n 0			37.
	effect in the cost reporting period.	ملت من حک ما ما اسا	a MDII dan			.				27
	Is this hospital a former MDH that is eli accordance with FY 2016 OPPS final rule?						、 I			37.
	If line 37 is 1, enter the beginning and						,			38.
	than 1, subscript this line for the number									00.
	dates.									
							//N		/N	
							. 00		00	-
	Does this facility qualify for the inpat						N "	ı	V	39.
	hospitals in accordance with 42 CFR §412									
	for yes or "N" for no. Does the facility $CFR 412.101(b)(2)(i), (ii), or (iii)? En$						۷			
	instructions)	ici ili cordilli	2 1 10	or yes or	101 110.	(300				
	Is this hospital subject to the HAC progr	ram reduction	adjustm	ent? Enter	"Y" for ye	es or "N"	N	1	V	40.
f	for no in column 1, for discharges prior	to October 1	. Enter '	'Y" for yes	s or "N" fo	rnoin				
	column 2, for discharges on or after Oct	ober 1. (see	<u>instructi</u>	ons)				_		
							V	XVIII	XIX	4
le le	Description Description (DDC) Conital						1.00	2.00	3. 00	-
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Ca	anital navmon	t for dia	enroportio	nato charo	in accord	anch wilt	h N	T N	45.
	42 CFR Section §412.320? (see instruction		t for urs	spi opoi ti oi	late share	TIT accord	ance win t	11 11	IN	45.
	Is this facility eligible for additional		ntion for	r extraordi	nary circu	ımstances	purkuaMt	N	N	46.
	to 42 CFR §412.348(f)? If yes, complete									
	Is this a new hospital under 42 CFR §412							N	N	47.
. 00 <u>l</u>	ls the facility electing full federal ca	oital payment	? Enter	"Y" for ye	es or "N" f	or no.	N	N	N	48.
	Teaching Hospitals								_	ļ
	Is this a hospital involved in training							"		56.
	for no in column 1. If column 1 is "Y", a payment reduction? Enter "Y" for yes or				r subsequer	IT CR), MA	GME			
	If line 56 is yes, is this the first cos				resi dents	in annrov	ed GME	•		57.
	programs trained at this facility? Enter									0,
	did residents start training in the firs									
	"N" for no in column 2. If column 2 is '			et E-4. If	column 2 i	s "N", co	mplete			
	Nkst. D, Parts III & IV and D-2, Pt. II,									
	If line 56 is yes, did this facility elec			for physic	cians' serv	rices as d	efined i	n		58.
	CMS Pub. 15-1, chapter 21, §2148? If yes. Are costs claimed on line 100 of Workshe			ta Wkst D	_2 D+ I		N		1	59.
00 P	THE COSES CHAIRMEN OIL TITLE TOO OF WOLKSHEE	, A: II yes	, compre	WEST. D	NAHE 413.	85 Works	sheet A	Pass_T	hrough	59.
					Y/N				i cati on	
					.,				on Code	
					1. 00	2	. 00	3.	00	
			(NAUE) O	for o						60.
	Are you claiming nursing and allied heal					l l				
ķ	programs that meet the criteria under 42	CFR 413.85?	(see ins	structions	)					
F E	orograms that meet the criteria under 42 Enter "Y" for yes or "N" for no in colum	CFR 413.85? n 1. If colu	(see ins	structions 'Y", are y	) pu					
F E i	programs that meet the criteria under 42	CFR 413.85? n 1. If colu	(see ins	structions 'Y", are y	) pu					

Health Financial Systems IU HEAL	TH PAOL	_I HOSPITAL		In Lieu	of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION I	DATA	Provi der Co	CN: 15-1306 PG	eriod: rom 01/01/2020	Worksheet S-2	
			T			
	Y/N	I ME	Direct GME	I ME	Direct GME	ZT alli
	1 00	2.00	2.00	4.00	F 00	1
61.00 Did your hospital receive FTE slots under ACA section	1.00 on N	2. 00	3. 00	4. 00 0. 00	5. 00 0. 00	61.00
, , , , , , , , , , , , , , , , , , ,	(see					
<pre>instructions) 61.01 Enter the average number of unweighted primary care</pre>						61. 01
FTEs from the hospital's 3 most recent cost reports						
ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care						61. 02
FTE count (excluding OB/GYN, general surgery FTEs,	and					
primary care FTEs added under section 5503 of ACA). (see instructions)						
61.03 Enter the base line FTE count for primary care and/	pr					61. 03
general surgery residents, which is used for determining compliance with the 75% test. (see						
instructions)						
61.04 Enter the number of unweighted primary care/or surg						61. 04
allopathic and/or osteopathic FTEs in the current coreporting period. (see instructions).	υSτ					
61.05 Enter the difference between the baseline primary	i i					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)						
61.06 Enter the amount of ACA §5503 award that is being u						61.06
for cap relief and/or FTEs that are nonprimary care general surgery. (see instructions)	Or.					
	Pro	ogram Name	Program Code	Unweighted IME		
				FTE Count	Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents	for			0.00	0. 00	61. 10
each new program. (see instructions) Enter in colum						
the program name. Enter in column 2, the program co						
Enter in column 3, the IME FTE unweighted count. En in column 4, the direct GME FTE unweighted count.	tei					
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	СТС					
unweighted count. Enter in column 4, the direct GME unweighted count.	FIE					
					1 00	
ACA Provisions Affecting the Health Resources and S	ervi ces	s Administrati	on (HRSA)		1. 00	
62.00 Enter the number of FTE residents that your hospita	l trair			eriod for whic	h your 0.00	62. 00
hospital received HRSA PCRE funding (see instructio 62.01 Enter the number of FTE residents that rotated from		ching Health C	enter (THC) in	to your hosnit	al 0.00	62. 01
during in this cost reporting period of HRSA THC pr	ogram.	(see instruct	, ,	To your nospi t	0.00	02.01
Teaching Hospitals that Claim Residents in Nonprovi 63.00 Has your facility trained residents in nonprovider			oost reportin	a port od? Enta	r "Y" N	42.00
for yes or "N" for no in column 1. If yes, complete					I Y IN	63. 00
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	·		
Section 5504 of the ACA Base Year FTE Residents in	Nonnroy	/ider Settings	1.00 sThis base ve	2.00	3.00	
reporting period that begins on or after July 1, 20	09 and	before June 3	0, 2010.		J (	
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- FTEs attributable to rotations occurring in all non			I Enter			
in column 2 the number of unweighted non-primary ca	re resi	dent FTEs tha	t			
trained in your hospital. Enter in column 3 the rat by (column 1 + column 2)). (see instructions)	io of (	column 1 divi	ded			
μος (33. a.m 301 amin 2/). (300 math dott 0113)			1	ı	ı	ı

In Lieu of Form CMS-2552-10 Health Financial Systems LU HEALTH PAOLI HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-1306 Peri od: Worksheet S-2 From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7<u>/14/2021 11:21 am</u> 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)

Health Financial Systems IU HEALTH PAOLI HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15		Worksheet S Part I	
		7/14/2021	
		1.00	$\dashv$
Long Term Care Hospital PPS			
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cosfor yes and "N" for no.		ter "Y" N	80. 00 81. 00
TEFRA Providers  85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter '86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 Enter "Y" for yes and "N" for no.			85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital classified und Enter "Y" for yes or "N" for no.	der section 1886(d)(1)(	B)(vi)?N	87. 00
Effect 1 Tol yes of N Tol 110.	V	XIX	
Title V and VIV Convince	1.00	2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter	er "Y" for yes on	Y	90.00
"N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report of	either in full omN	N	91. 00
in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification	n)? (see	N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and )	XIX? Enter "Y" N	N	93. 00
for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no i	in the applicableN	N	94. 00
column. 95.00   fline 94 is "Y", enter the reduction percentage in the applicable column. 96.00   Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no i	0.00 in the applicableN	0. 00 N	95. 00 96. 00
column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and reside		0. 00 Y	97. 00 98. 00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charge. Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column.	ges on Wkst. C, N	Y	98. 01
XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of obscosts on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in colu		Y	98. 02
V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hosp reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no		N	98. 03
title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and		N	98. 04
title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disal C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, a		Y	98. 05
for title XIX.  98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for V through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in title XIX.		Y	98. 06
Rural Providers	l y		105 00
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method outpatient services? (see instructions)	1 .		105. 00 106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement training programs? Enter "Y" for yes or "N" for no in column 1. (see instru Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs i medical education program in the CAH's excluded IPF and/or IRF unit(s)? En	uctions) in an approved		107. 00
or "N" for no in column 2. (see instructions) 108.00Is this a rural hospital qualifying for an exception to the CRNA fee schedul Section §412.113(c). Enter "Y" for yes or "N" for no.			108. 00
Physical Occ	supational Speech	Respirator	У
1.00  109.00 If this hospital qualifies as a CAH or a cost provider, are N therapy services provided by outside supplier? Enter "Y" for	2.00 3.00 N N	4.00 N	109. 00

Health Financial Systems IU HEALTH PAOLI HOSPITAL	N 45 4007 T		of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	[ ]	Period: From 01/01/2020 Fo 12/31/2020	Date/Time Pr	repared:
			7/14/2021 11	1:21 am
110.00 Did this hospital participate in the Rural Community Hospital Demonstrate Demonstration) for the current cost reporting period? Enter "Y" for yes of Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200	or "N <sup>"</sup> for no	. If yes, compl		110. 00
		1. 00	2. 00	
111.00 f this facility qualifies as a CAH, did it participate in the Frontier Integration Project (FCHIP) demonstration for this cost reporting period or "N" for no in column 1. If the response to column 1 is Y, enter the i the FCHIP demo in which this CAH is participating in column 2. Enter all 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
112.00Did this hospital participate in the Pennsylvania Rural Health Model	1. 00 N	2. 00	3. 00	112. 00
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	ter			112.00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no column 1. If column 1 is yes, enter the method used (A, B, or E only) is 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.	the			0115.00
116.00 s this facility classified as a referral center? Enter "Y" for yes or for no.				116. 00
117.00 s 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.	1 if	1		118. 00
	Premi ums	Losses	Insurance	
118 Ollist amounts of mal practice premiums and paid losses	1.00	2.00	3. 00	0118 01
118.01 List amounts of mal practice premiums and paid losses:	1. 00 40, 72	4 0		0118. 01
118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing amounts contained therein.	40, 72 r than the	1. 00 N		0118. 01
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All Providers					1.00	2.00	
40.00 Are there any related organizati 10? Enter "Y" for yes or "N" for enter in column 2 the home offic	no in column 1. If yes	s, and home offic				15H059	140. 0
1. 00		2. 00			3. 00	•	
If this facility is part of a ch of the home office and enter the					ne and addr	ess	
41.00Name: INDIANA UNIVERSITY HEALTH					Number:0810	)1	141. C
42.OQStreet:340 WEST TENTH STREET 43.OQCity: INDIANAPOLIS	PO Box: State:	IN	Zip (	`odo:	4620	24	142. C
43. OQCITY: INDIANAPOLIS	State:	I IV	ΙΖΙ Ρ. (	Joue:	4020	1	143. C
						1. 00	
44.00 Are provider based physicians' c	osts included in Worksh	neet A?				Y	144. 0
					1. 00	2. 00	
45.00 If costs for renal services are							145. 0
services only? Enter "Y" for yes dialysis facility include Medica							
for yes or "N" for no in column		s cost reporting	perrour	Litter Y			
46.00 Has the cost allocation methodol	ogy changed from the pr					1	146.0
for yes or "N" for no in column		chapter 40, §402	0) If yes	s, enter	the		
approval date (mm/dd/yyyy) in co	runill Z.						
						1.00	
47.00 Was there a change in the statis		for yes or "N" f	or no.			N	147. C
	of allocation? Enter "\					NI	1/0 0
	of allocation? Enter "\ fied cost finding metho	/" for yes or "N"	for no.	N" for n	0.	N N	
49.00Was there a change to the simpli		Y" for yes or "N" od? Enter "Y" for Part A	for no. yes or " Part	В	Title V	N Title XIX	
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Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55. OdHospital  66. OdSubprovider - IPF  57. OdSubprovider - IRF  58. OdSUBPROVIDER  59. OdSNF  60. OdHOME HEALTH AGENCY  61. OdCMHC	fied cost finding metho	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption 1 r no for each com N N N	for no. yes or " Part 2.00 From the anponent for N N N N N	B applicati	Title V 3.00 on of the A and Part	N Title XIX 4.00 B. N N N	155. C 156. C 157. C 158. C 159. C 160. C
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  66.00Subprovider - IPF  58.00SUBPROVIDER  59.00SNF  60.00HOME HEALTH AGENCY	fied cost finding method vider that qualifies for "Y" for yes or "N" for yes or "number of the compus hospital that hat he	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N N N N N N N N N N N N N N	for no. yes or " Part 2.00 From the annonent for N N N N N N N N N N N N N N N N N N N	B D D D D D D D D D D D D D D D D D D D	Title V 3.00 on of the A and Part I  N N N N N N N N N N N N N N N N N N	N Title XIX 4.00  B.  N N N N N N N N N N Enter N	155. 0 156. 0 157. 0 158. 0 160. 0 161. 0
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  56.00Subprovider - IPF  57.00Subprovider - IRF  58.00SUBPROVIDER  59.00SNF  60.00HOME HEALTH AGENCY  61.00CMHC  Multicampus  65.00Is this hospital part of a Multi	ried cost finding method vider that qualifies for "Y" for yes or "N" for yes or "	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N Cas one or more ca	for no. yes or " Part 2.00 From the anponent for N N N N N S S S S S S S S S S S S S S S	B application Part A	Title V 3.00 on of the A and Part I N N N N N N N CBSAS?	N Title XIX 4.00  B.  N N N N N N Title XIX 1.00	155. C 156. C 157. C 158. C 160. C 161. C
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  66.00Subprovider - IPF  57.00Subprovider - IRF  58.00SUBPROVIDER  59.00SNF  60.00HOME HEALTH AGENCY  61.00CMHC  Multicampus  65.00 Is this hospital part of a Multi"Y" for yes or "N" for no.	vider that qualifies for "Y" for yes or "N" for yes	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N N N N N N N N N N N N N N	for no. yes or " Part 2.00 From the annonent for N N N N N N N N N N N N N N N N N N N	B D D D D D D D D D D D D D D D D D D D	Title V 3.00 on of the A and Part I  N N N N N N N N N N N N N N N N N N	N Title XIX 4.00  B.  N N N N N N Title XIX 1.00  FITE/Campus 5.00	155. C 156. C 157. C 158. C 159. C 160. C
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  66.00Subprovider - IPF  57.00Subprovider - IRF  58.00SUBPROVIDER  59.00SNF  60.00HOME HEALTH AGENCY  61.00CMHC  Multicampus  65.00  Multicampus  66.00If line 165 is yes, for each camenter the name in column 0, coun	campus hospital that ha	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N Cas one or more ca	for no. yes or " Part 2.00 From the anponent for N N N N N S S S S S S S S S S S S S S S	B application Part A	Title V 3.00 on of the A and Part I N N N N N N N CBSAS?	N Title XIX 4.00  B.  N N N N N N Title XIX 1.00  FITE/Campus 5.00	155. C 156. C 157. C 158. C 159. C 160. C
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  66.00Subprovider - IPF  57.00Subprovider - IRF  58.00SUBPROVIDER  59.00SNF  60.00HOME HEALTH AGENCY  61.00CMHC  Multicampus  65.00 Is this hospital part of a Multi"Y" for yes or "N" for no.	campus hospital that ha	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N Cas one or more ca	for no. yes or " Part 2.00 From the anponent for N N N N N S S S S S S S S S S S S S S S	B application Part A	Title V 3.00 on of the A and Part I N N N N N N N CBSAS?	N Title XIX 4.00  B.  N N N N N N Title XIX 1.00  FITE/Campus 5.00	155. ( 156. ( 157. ( 158. ( 159. ( 161. (
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  66.00Subprovider - IPF  67.00Subprovider - IRF  68.00SUBPROVIDER  69.00SNF  60.00HOME HEALTH AGENCY  61.00CMHC  Multicampus  65.00  Is this hospital part of a Multi "Y" for yes or "N" for no.  66.00If line 165 is yes, for each cam enter the name in column 0, coun in column 1, state in column 2, code in column 3, CBSA in column	campus hospital that ha	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N Cas one or more ca	for no. yes or " Part 2.00 From the anponent for N N N N N S S S S S S S S S S S S S S S	B application Part A	Title V 3.00 on of the A and Part I N N N N N N N CBSAS?	N Title XIX 4.00  B.  N N N N N N Title XIX 1.00  FITE/Campus 5.00	155. C 156. C 157. C 158. C 159. C 160. C
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  66.00Subprovider - IPF  57.00Subprovider - IRF  58.00SUBPROVIDER  59.00SNF  60.00HOME HEALTH AGENCY  61.00CMHC  Multicampus  65.00 Is this hospital part of a Multi"Y" for yes or "N" for no.	campus hospital that ha	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N Cas one or more ca	for no. yes or " Part 2.00 From the anponent for N N N N N S S S S S S S S S S S S S S S	B application Part A	Title V 3.00 on of the A and Part I N N N N N N N CBSAS?	N Title XIX 4.00  B.  N N N N N N Title XIX 1.00  FITE/Campus 5.00	155. C 156. C 157. C 158. C 159. C 160. C
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  66.00Subprovider - IPF  57.00Subprovider - IRF  58.00SUBPROVIDER  59.00SNF  60.00HOME HEALTH AGENCY  61.00CMHC  Multicampus  65.00Is this hospital part of a Multi "Y" for yes or "N" for no.  66.00If line 165 is yes, for each cam 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	campus hospital that ha	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N Cas one or more ca	for no. yes or " Part 2.00 From the anponent for N N N N N S S S S S S S S S S S S S S S	B application Part A	Title V 3.00 on of the A and Part I N N N N N N N CBSAS?	N Title XIX 4.00 B. N N N N N 1.00 Enter N FTE/Campus 5.00	155. C 156. C 157. C 158. C 159. C 160. C
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55. OOHospital  66. OOSubprovider - IPF  57. OOSubprovider - IRF  58. OOSUBPROVIDER  59. OOSNF  60. OOHOME HEALTH AGENCY  61. OOCMHC  Multicampus  65. OOI is this hospital part of a Multi"Y" for yes or "N" for no.  66. OOI f line 165 is yes, for each camenter 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)	campus hospital that has bus bus ty zip 4,	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N 1.00 as one or more ca  County 1.00	mpuses ir  State  2.00  And Reinv	B D D D D D D D D D D D D D D D D D D D	Title V 3.00 on of the A and Part I  N N N N N N CBSAS?  The CBSA	N Title XIX 4.00 B. N N N N N 1.00 Enter N FTE/Campus 5.00 O.0	155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00 Hospital  66.00 Subprovider - IPF  58.00 SUBPROVIDER  59.00 SNF  60.00 HOME HEALTH AGENCY  61.00 CMHC  Multicampus  65.00 Is this hospital part of a Multi "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each cam 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 (H  67.00 Is this provider a meaningful us	campus hospital that has a Name O Dus Ty Zip 4,	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N N N O T T T T T T T T T T T	mpuses ir  State  2.00  And Reimor "N" for	B polication Part A differe Zip Cod 3.00	Title V 3.00 on of the A and Part I  N N N N N N N CBSAS?  Be CBSA 4.00  Act	N Title XIX 4.00 B. N N N N N 1.00 Enter N FTE/Campus 5.00	149. 0 155. 0 156. 0 157. 0 158. 0 160. 0 161. 0 165. 0
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00 Hospital  66.00 Subprovider - IPF  57.00 Subprovider - IRF  58.00 SUBPROVIDER  59.00 SNF  60.00 HOME HEALTH AGENCY  61.00 CMHC  Multicampus  65.00 Is this hospital part of a Multi "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each cam 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 (H  67.00 Is this provider a meaningful us 68.00 If this provider is a CAH (line	campus hospital that has a sign of the cost finding method vider that qualifies for "Y" for yes or "N" for yes	/" for yes or "N"  od? Enter "Y" for  Part A  1.00  or an exemption for no for each com  N N N N N N N N O The second of the sec	mpuses ir  State  2.00  And Reimor "N" for	B polication Part A differe Zip Cod 3.00	Title V 3.00 on of the A and Part I  N N N N N N N CBSAS?  Be CBSA 4.00  Act	N Title XIX 4.00 B. N N N N N 1.00 Enter N FTE/Campus 5.00 O.0	148. 00 149. 0  155. 00 156. 00 157. 00 160. 00 161. 00  165. 00  167. 00 168. 00
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00 Hospital  66.00 Subprovider - IPF  58.00 SUBPROVIDER  59.00 SNF  60.00 HOME HEALTH AGENCY  61.00 CMHC  Multicampus  65.00 Is this hospital part of a Multi "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each cam 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 (H  67.00 Is this provider a meaningful us	campus hospital that has a me hospital same o pus ty zip 4,  IT) incentive in the Arer under §1886(n)? End 105 is "Y") and is a me HIT assets (see instru	/" for yes or "N"  od? Enter "Y" for  Part A  1.00  or an exemption of r no for each com  N N N N N N N N N O  cas one or more ca  County 1.00  merican Recovery ter "Y" for yes coeaningful user (I user (I user))	mpuses ir  State  2.00  And Reimbor "N" for ine 167 i	B p) application Part A differe Zip Cod 3.00	Title V 3.00 on of the A and Part I N N N N N N N A The CBSAS? The CBSA Act The CBS	N Title XIX 4.00 B. N N N N N N 1.00 Enter N FTE/Campus 5.00 0.0	149. 0 155. 0 156. 0 157. 0 158. 0 160. 0 161. 0
Does this facility contain a pro lower of costs or charges? Enter (See 42 CFR §413.13)  55.00Hospital  66.00Subprovider - IPF  67.00Subprovider - IRF  68.00SUBPROVIDER  69.00SNF  60.00HOME HEALTH AGENCY  61.00CMHC  Multicampus  65.00Is this hospital part of a Multi "Y" for yes or "N" for no.  Modern 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 (H  67.00Is this provider a meaningful us 68.00If this provider is a CAH (line reasonable cost incurred for the	campus hospital that has a subject to the subject of the subject o	/" for yes or "N" od? Enter "Y" for Part A 1.00 or an exemption for no for each com N N N N N N N N Ode as one or more can County 1.00  merican Recovery ter "Y" for yes of caningful user (I uctions) does this province (see instructions) of the contraction of the canonic of th	mponent for N N N N N N N N N N N N N N N N N N N	B D application Part A difference Zip Cod 3.00	Title V 3.00 on of the A and Part I N N N N N N A O  CBSAS?  CBSA Act  Enter the hardship 6	N Title XIX 4.00 B. N N N N N 1.00 Enter N FTE/Campus 5.00 0.0	149. 0 155. 0 156. 0 157. 0 158. 0 161. 0 165. 0

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lieu	of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	TIFICATION DATA		Peri od:	Worksheet S-	2
			From 01/01/2020 To 12/31/2020	Part    Date/Time Pro	enared:
			10 12/31/2020	7/14/2021 11	21 am
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginni	ng date and ending o	date for the reporting p	er <b>i</b> od		170. 00
respectively (mm/dd/yyyy)					
					4
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider h				12	171. 00
1876 Medicare cost plans reported on Wks					
"N" for no in column 1. If column 1 is y	es, enter the number	of section 1876 Medica	re days		
in column 2. (see instructions)					

Heal th	Financial Systems IU HEALTH PAO	LI HOSPITAL		In Lieu	ı of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1306	Peri od:	Worksheet S-	
				From 01/01/2020 To 12/31/2020	Date/Time Pr	
				Y/N	7/14/2021 11 Date	: 21 am
				1, 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO	responses. Er	nter all dates		
	the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					1
1.00	Has the provider changed ownership immediately prior to t	he beginning o	of the cost re	eportingN		1.00
	period? If yes, enter the date of the change in column 2.	(see instruc	tions) Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare					2. 00
	enter in column 2 the date of termination and in column 3 or "I" for involuntary.	, "V" FOR VOIL	intary			
3.00	Is the provider involved in business transactions, includ					3. 00
	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 r					
	i nstructi ons)		Y/N	Tuno	Doto	
			1.00	Type 2. 00	3.00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Ce Accountant? Column 2: If yes, enter "A" for Audited, "C"			A	02/25/2021	4. 00
	"R" for Reviewed. Submit complete copy or enter date avail					
	(see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues dif on the filed financial statements? If yes, submit reconci		iose N			5. 00
	on the fired financial statements: If yes, submit reconci	11411011.		Y/N	Legal Oper.	
	Account Educational Astrolation			1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2	: If ves. is	the provider	s the N		6.00
0.00	legal operator of the program?		т. б. б. б. б.			0.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see		uod during th	N N		7.00
8. 00	Were nursing school and/or allied health programs approve reporting period? If yes, see instructions.	u anuzor renev	wed durring the	e Cost N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approve		dical educatio	o <b>h</b> N		9. 00
10.00	program in the current cost report? If yes, see instructions an approved Intern and Resident GME program initiated		n the current	cost N		10.00
10.00	reporting period? If yes, see instructions.	or renewed in	the current	LOST IN		10.00
11. 00	Are GME cost directly assigned to cost centers other than	I & R in an A	Approved Teach	ning N		11. 00
	Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
10.00	Bad Debts				\ <u>'</u>	10.00
	Is the provider seeking reimbursement for bad debts? If y If line 12 is yes, did the provider's bad debt collection			cost reporting	Y period¶	12. 00 13. 00
	If yes, submit copy.	, , ,	Ü		po out	
14. 00	If line 12 is yes, were patient deductibles and/or co-pay Bed Complement	ments waived?	If yes, see i	nstructions.	N	14. 00
15. 00	Did total beds available change from the prior cost repor	ting period?	f yes, see in	nstructions.	N	15. 00
		Par	t A	Par	t B	
		Y/N 1.00	2. 00	Y/N 3.00	<u>Date</u> 4. 00	
	PS&R Data	1.00	2.00	3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only?			N		16. 00
	either column 1 or 3 is yes, enter the paid-through date the PS&R Report used in columns 2 and 4 .(see instruction					
17.00	Was the cost report prepared using the PS&R Report for to	tals Y	04/02/2021	Υ	04/02/2021	17. 00
	and the provider's records for allocation? If either colu or 3 is yes, enter the paid-through date in columns 2 and					
	or 3 is yes, enter the paid-through date in columns 2 and (see instructions)	4.				
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Re			N		18. 00
	data for additional claims that have been billed but are included on the PS&R Report used to file this cost report					
	yes, see instructions.	: 11				
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Re	port N		N		19. 00
	data for corrections of other PS&R Report information? If					
	yes, see instructions.		I	1		I

Heal th	Financial Systems IU HEALTH PAOLI	I HOSPITAL		In Lieu	of Form CMS	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (	CCN: 15-1306	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S Part II Date/Time F 7/14/2021	Prepared:
		Descr	i pti on	Y/N	Y/N	11.21 (111
			0	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Repudata for Other? Describe the other adjustments:	ort		N	N	20. 00
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
21.00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21. 00
	records? If yes, see instructions.					
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EDT CHILIDDEN	S HUSDITALS)		1. 00	
	Capital Related Cost	LFT CHILDKLIN	3 HOSFI TALS)			
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructio	ns		N	22. 00
	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			during the cost	N	23. 00
24.00	Were new leases and/or amendments to existing leases entergyes, see instructions	ed into duri	ng this cost	reporting perio	d?lf N	24. 00
25. 00	Have there been new capitalized leases entered into during	the cost re	porting perio	od? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the second sec	he cost repo	rting period <sup>°</sup>	? If yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost repor	ting period?	If yes, submit	copy. N	27. 00
28. 00	<u>Interest Expense</u> Were new loans, mortgage agreements or letters of credit en	ntered into	during the co	ost reporting pe	riod? INF	28. 00
29. 00	yes, see instructions. Did the provider have a funded depreciation account and/or		(Debt Service	e Reserve Fund)	treatedN	29. 00
20.00	as a funded depreciation account? If yes, see instructions				blana N	20.00
	Has existing debt been replaced prior to its scheduled matured Has debt been recalled before scheduled maturity without is					30. 00 31. 00
32.00	<u>Purchased Services</u> Have changes or new agreements occurred in patient care se		shed through	contractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instruction of Sec. 2135.2 appliers of Sec. 2135.2 appliers.		ning to compe	etitive bidding?	If no,	33.00
	see instructions. Provider-Based Physicians	•		-		
34.00	Are services furnished at the provider facility under an anyes, see instructions.	rrangement w	ith provider	-based physician	s? If Y	34.00
35.00	If line 34 is yes, were there new agreements or amended exi		ments with t	ne provi der-base	d Y	35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.	-	Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?	<del></del>		Υ		36. 00
37. 00	If line 36 is yes, has a home office cost statement been present yes, see instructions.	repared by t	he home offic	ce?If Y		37. 00
	If line 36 is yes, was the fiscal year end of the home of provider? If yes, enter in column 2 the fiscal year end of			of the N		38. 00
	If line 36 is yes, did the provider render services to other			yes, see N		39. 00
40. 00	instructions. If line 36 is yes, did the provider render services to the	home office	? If yes, se	ee N		40. 00
	i nstructi ons.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information	HONDA		LITTED		41 00
41.00	Enter the first name, last name and the title/position heRM by the cost report preparer in columns 1, 2, and 3,	<b>M</b> UNDA		UTTER		41.00
42 00	respectively.  Enter the employer/company name of the cost report preparel	MOLANA IINIVE	RSITY HEALTH			42. 00
43.00	Enter the telephone number and email address of the cost 3		NOTTE HEALIN	RUTTER@I UHEALT	H. ORG	43. 00
	report preparer in columns 1 and 2, respectively.			I		II

Heal th	Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lieu	of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der		Peri od: From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/14/2021 11:	
		_		3. 00	_		
	Cost Report Preparer Contact Information			0.00			
	Enter the first name, last name and the t		HRECTOR				41. 00
	by the cost report preparer in columns 1,	2, and 3,					
	respectively.						l.
	Enter the employer/company name of the co		r.				42. 00
	Enter the telephone number and email addr						43. 00
	report preparer in columns 1 and 2, respe	ecti vel y.					

Period: Worksheet S-3
From 01/01/2020 Part I Provi der CCN: 15-1306

				Τ̈́	o 12/31/2020	Date/Time Pre 7/14/2021 11:	
						// Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	No. of Bods	Avai I abl e	oran nour s	11 110 1	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 an		24			0	1. 00
	exclude Swing Bed, Observation Bed and Hosp			·			
	days)(see instructions for col. 2 for the						
	portion of LDP room available beds)						
2.00	HMO and other (see instructions)				1		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		24	8, 784	19, 200. 00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	0	C	0. 00	0	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	43. 00				0	
	Total (see instructions)		24	8, 784	19, 200. 00	0	14.00
15.00	CAH visits					0	15. 00
	SUBPROVIDER - I PF						16.00
	SUBPROVIDER - IRF						17. 00
	SUBPROVI DER				ł		18. 00
	SKILLED NURSING FACILITY NURSING FACILITY				ł		19. 00 20. 00
	OTHER LONG TERM CARE				1		20.00
	HOME HEALTH AGENCY	101. 00			ł	0	22. 00
	AMBULATORY SURGICAL CENTER (D. P. )	101.00				U	23. 00
	HOSPICE						24. 00
	HOSPICE (non-distinct part)	30. 00					24. 10
	CMHC - CMHC	30.00			1		25. 00
	RURAL HEALTH CLINIC	88. 00				0	26. 00
	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
	Total (sum of lines 14-26)	37. 33	24			· ·	27. 00
	Observation Bed Days					0	28. 00
	Ambulance Trips					-	29. 00
	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF				1		31. 00
	Labor & delivery days (see instructions)		0	C			32. 00
	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)				]		
	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges				1 1		33. 01

Provi der CCN: 15-1306

				0 12/31/2020	7/14/2021 11:	
	I/P Days	6 / 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		11	800			1. 00
exclude Swing Bed, Observation Bed and Ho						
days)(see instructions for col. 2 for the						
portion of LDP room available beds)						
2.00 HMO and other (see instructions)	137	222				2. 00
3.00 HMO IPF Subprovi der	0	0				3. 00
4.00 HMO I RF Subprovi der	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	163	0	163			5. 00
6.00 Hospital Adults & Peds. Swing Bed NF	400	0	100			6. 00
7.00 Total Adults and Peds. (exclude observation	on 498	11	1, 063	i		7. 00
beds) (see instructions)		0			•	0 00
8. 00 I NTENSI VE CARE UNI T	0	0	C	1		8.00
9. 00 CORONARY CARE UNIT						9.00
10. 00 BURN INTENSIVE CARE UNIT					•	10. 00 11. 00
11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY)					•	12.00
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY		25	129	ŀ	•	13.00
14.00 Total (see instructions)	498	36	1, 192		134. 83	•
15. 00 CAH visits	490	30	1, 192	0.00	134.03	15. 00
16. 00 SUBPROVIDER - IPF		U		Ί	•	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 NURSING FACILITY			•			20.00
21. 00 OTHER LONG TERM CARE			•			21. 00
22. 00 HOME HEALTH AGENCY	o	0	C	0.00	0.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23. 00
24. 00 HOSPI CE						24. 00
24.10 HOSPICE (non-distinct part)			30	)		24. 10
25. 00 CMHC - CMHC						25. 00
26.00 RURAL HEALTH CLINIC	0	0	C	0. 00	0.00	26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0. 00	0.00	26. 25
27.00 Total (sum of lines 14-26)				0. 00	134. 83	27. 00
28.00 Observation Bed Days		13	512			28. 00
29.00 Ambulance Trips	0					29. 00
30.00 Employee discount days (see instruction)			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			0	1		32. 01
outpatient days (see instructions)						
33.00 LTCH non-covered days	0					33. 00
33.01 LTCH site neutral days and discharges	<b>I</b> 0		l	I	I	33. 01

Period: Worksheet S-3
From 01/01/2020 Part I Provi der CCN: 15-1306

				Ţ	0 12/31/2020	Date/Time Pre 7/14/2021 11:	
		Full Time		Di sch	arges	77 147 2021 11.	Z i diii
	0	Equi val ents	T! +1 - 1/	T: +1 - \0/1   1	T: +1 - VIV	T-+-1 All	
	Component	onpaid Workers	Title V	Title XVIII	Title XIX	Total All	
		11. 00	12. 00	13. 00	14. 00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 an		12.00			292	1. 00
1.00	exclude Swing Bed, Observation Bed and Hosp		0	113	3	212	1.00
	days) (see instructions for col. 2 for the						
	portion of LDP room available beds)						
2.00	HMO and other (see instructions)			45	99		2. 00
3. 00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				Ö		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation	1					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	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13. 00
	Total (see instructions)	0.00	0	115	5	292	
15.00	CAH visits						15. 00
16. 00	SUBPROVIDER - IPF						16. 00
	SUBPROVIDER - IRF						17. 00
	SUBPROVI DER						18. 00
	SKILLED NURSING FACILITY						19. 00
	NURSING FACILITY						20.00
	OTHER LONG TERM CARE						21. 00
	HOME HEALTH AGENCY	0. 00					22. 00
	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
	HOSPICE						24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC						25. 00
	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
	Ambulance Trips						29. 00
	Employee discount days (see instruction)						30.00
	Employee discount days - IRF						31. 00
	Labor & delivery days (see instructions)						32. 00
	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	[ 1		0			33. 00
	LTCH site neutral days and discharges			0			33. 01

Heal th	Financial Systems IU HEALTH PAOLI HOS	PI TAL		In Lieu	ı of Form CMS-2	2552-10			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CO	CN: 15-1306	Peri od:	Worksheet S-1	0			
				From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:			
					7/14/2021 11:				
					1. 00				
	Uncompensated and indigent care cost computation								
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by	line 202 col	umn 8)	0. 406967	1. 00			
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				5, 913, 612	2 00			
2. 00 3. 00	Did you receive DSH or supplemental payments from Medicaid?				5, 913, 612 Y	2. 00 3. 00			
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payme	nts from Med	i cai d?	Ϋ́	4. 00			
5.00									
6.00	Medicaid charges				16, 485, 858				
7. 00 8. 00	Medicaid cost (line 1 times line 6)	lino 7 m	inus sum of	lines 2 and 5:	6, 709, 200 f < 795, 588	7. 00 8. 00			
8.00	O Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5;   f < 795,588   8.   zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions fo	r each I	i ne)						
9. 00	Net revenue from stand-alone CHIP				0	9. 00			
	Stand-alone CHIP charges				0	10. 00 11. 00			
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (	line 11	minus line 9	· if / zero the	-				
12.00	zero)	,1110 11	minus inic /	, II \ Zelo tile	T CITICI 0	12.00			
	Other state or local government indigent care program (see inst								
	Not revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  1, 104   13.0								
14.00	O Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 11,915 14. UState or local indigent care program cost (line 1 times line 14) 4,849 15.								
	0 Difference between net revenue and costs for state or local indigent care program (line 15 minus I) ne 13; 3,745 16								
	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 fu</pre>	ındi na .ch	ari ty caro		0	17. 00			
	Government grants, appropriations or transfers for support of h				0	18. 00			
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local			ams (sum of lin	es 8, 1 <b>2</b> 99, 333	19. 00			
	and 16)		Un! naveral	Lancon	T-+-1 (1 1				
			Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2)				
			1. 00	2. 00	3.00				
	Uncompensated Care (see instructions for each line)								
20. 00	Charity care charges and uninsured discounts for the entire factions instructions)	cility (\$	ee 1,447,11	7 51, 883	1, 499, 000	20. 00			
21.00	Cost of patients approved for charity care and uninsured discou	ints (see	588, 92	9 51, 883	640, 812	21 00			
21.00	instructions)		000, 72	01,000	010,012	21.00			
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00			
22.00	charity care		F00 00	F1 003	(40,010	22.00			
23. 00	Cost of charity care (line 21 minus line 22)		588, 92	.9 <b>.</b> 51, 883	640, 812	23.00			
					1. 00				
24.00	Does the amount on line 20 column 2, include charges for patier			th of stay limi	t N	24. 00			
05 00	imposed on patients covered by Medicaid or other indigent care					05.00			
25. 00	If line 24 is yes, enter the charges for patient days beyond th	ne indige	nt care prog	ram's length of	stay 0	25. 00			
26.00	Total bad debt expense for the entire hospital complex (see ins	struction	s)		2, 303, 771	26. 00			
	Medicare reimbursable bad debts for the entire hospital complex				83, 015				
	Medicare allowable bad debts for the entire hospital complex (s	see instr	ucti ons)		127, 716				
	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	oneo (co	o instructio	ne)	2, 176, 055 930, 284				
	Cost of inch-wedicare and non-reimbursable medicare bad debt exp Cost of uncompensated care (line 23 column 3 plus line 29)	ense (se	e matructio	113)	1, 571, 096				
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			2, 370, 429				

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C	CN: 15-1306	Peri od:	of Form CMS-2 Worksheet A	
		o. 2.11. 2.11.02.0	1.101.46.	j	From 01/01/2020 Fo 12/31/2020	Date/Time Pre 7/14/2021 11:	epared: 21 am
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Recl assi fi ed	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0		520, 655	520, 655	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0		1, 086, 242	1, 086, 242	•
3.00	00300 OTHER CAP REL COSTS	272 054	104 1/3	4/7 11	0	0	
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	272, 954 836, 056	194, 162 6, 671, 138	467, 110 7, 507, 19		2, 062, 823 7, 337, 862	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	411, 012	1, 270, 023	1, 681, 03	-718, 222	962, 813	7. 00
7. 01 8. 00	00701 UTILITIES 00800 LAUNDRY & LINEN SERVICE	0	0 38, 456	38, 45	375, 792	375, 792 38, 456	
9. 00	00900 HOUSEKEEPI NG	223, 861	208, 696	432, 55		337, 141	•
10.00	01000 DI ETARY	171, 739	220, 627	392, 36		143, 661	
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	605, 887	0 833, 226	1, 439, 11	172, 982 3 -267, 771	172, 982 1, 171, 342	•
13. 01	01301 HOUSE SUPERVI SORS	398, 793	99, 448	498, 24	-69, 916	428, 325	13. 01
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 268, 267	27, 550 1, 959, 218	27, 550 2, 227, 48!		192, 700 559, 014	
16. 00	01600 MEDICAL RECORDS & LIBRARY	200, 207	8, 127	8, 12		4, 588	
17.00	01700 SOCIAL SERVICE	0	7 010	255 225	0	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	348, 314	7, 018	355, 33:	22, 305	377, 637	19. 00
	03000 ADULTS & PEDI ATRI CS	1, 144, 466	1, 354, 771	2, 499, 23	-452, 410	2, 046, 827	30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	166, 633	0 17, 855	184, 48	0 3 -153, 268	0 31, 220	31. 00 43. 00
	ANCILLARY SERVICE COST CENTERS						1
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	450, 837 37, 488	279, 774 0	730, 61 37, 488		552, 134 224, 087	•
	05400 RADI OLOGY-DI AGNOSTI C	891, 703	1, 182, 891	2, 074, 59		1, 357, 343	
	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	74 022	1, 820, 685	1, 820, 68		1, 819, 252	
64. 00 65. 00	06500 RESPIRATORY THERAPY	76, 822 316, 657	45, 146 135, 224	121, 968 451, 88		96, 146 360, 467	•
66.00	06600 PHYSI CAL THERAPY	519, 913	329, 397	849, 310		421, 016	
68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		93, 243 59, 995	93, 243 59, 995	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0		23, 319	23, 319	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		10, 593 1, 588, 240	10, 593 1, 588, 240	
73. 01	07301 DRUGS CHARGED TO PATIENTS	Ö	0		0 1, 300, 240	1, 300, 240	1
	07400 RENAL DI ALYSI S	0	0		0	0	
	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION	0	0			0	
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	
90.00	09000 CLI NI C	37, 669	27, 407			63, 500	90.00
	09001 VISITING SPECIALTY CLINIC 09002 PAOLI PRIMARY CARE CLINIC	186, 842 414, 447	80, 502 261, 784			226, 049 544, 840	
91.00	09100 EMERGENCY	1, 271, 186	1, 632, 889			2, 475, 708	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	0	0	(	0	0	95. 00
101. 00	10100 HOME HEALTH AGENCY	0	0		0	0	101. 00
113. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	Т	0		0	0	113. 00
118. 00		9, 051, 546	18, 706, 014	27, 757, 560	8, 452	27, 766, 012	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		ol o	0	190. 00
190. 01	19001 VISITING SPECIALTY CLINIC	0	0		0	0	190. 01
	19002 OUTREACH 19003 FOUNDATI ON	15, 677	6, 423	22, 10	-3, 792		190. 02 190. 03
190. 04	19004 SPRING VALLEY FAMILY PRACTICE	Ö	0		o o	0	190. 04
	19005 PAOLI FAMILY PRACTICE	0	4, 147	4, 14			190. 05
	19006 OTHER PROPERTY 19100 RESEARCH	0	3, 886 0	3, 88	-3, 860 0 0		190. 06 191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		o o	0	192. 00
193. 00 200. 00	19300 NONPAID WORKERS TOTAL (SUM OF LINES 118 through 199)	0 9, 067, 223	0 18, 720, 470	27, 787, 69:	0 3	0 27, 787, 693	193. 00 200. 00
200.00	1 1.5 (55 5. 2.1425 115 till 54gil 177)	,,507,220	.5, .25, .70	2.,,0,,0,,	-ı	2.,,0,,070	

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/14/2021 11: 21 am

					1.0 12,01,2020	7/14/2021 11:	21 am
	Cost Center Description	Adiustments	Net Expenses		•		
	, , , , , , , , , , , , , , , , , , ,		For Allocation				
		6.00	7. 00	Ì			
	GENERAL SERVICE COST CENTERS	0.00	7,00	I			
1.00	00100 CAP REL COSTS-BLDG & FLXT	0	520, 655				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	0	1, 086, 242				2.00
3.00		0	1,080,242				3.00
	00300 OTHER CAP REL COSTS		_				•
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	150, 794					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	146, 288					5. 00
7. 00	00700 OPERATION OF PLANT	-22, 888	939, 925				7. 00
7. 01	00701 UTI LI TI ES	0	375, 792				7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	38, 456				8. 00
9.00	00900 HOUSEKEEPI NG	0	337, 141				9. 00
10.00	01000 DI ETARY	l o	143, 661				10.00
11.00	01100 CAFETERI A	-46, 020					11.00
	01300 NURSING ADMINISTRATION	-653, 793					13. 00
	•						
	01301 HOUSE SUPERVI SORS	0	,				13. 01
14.00	01400 CENTRAL SERVICES & SUPPLY	0	192, 700				14. 00
15. 00	01500 PHARMACY	-24, 199	534, 815				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-2, 928	1, 660				16. 00
	01700 SOCI AL SERVI CE	0	0				17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	-89, 698	287, 939				19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	-742, 314	1, 304, 513				30.00
	03100 INTENSIVE CARE UNIT	-742, 314		1			31.00
		•		•			•
43.00	04300 NURSERY	0	31, 220				43. 00
	ANCILLARY SERVICE COST CENTERS	_		ı			4
	05000 OPERATING ROOM	0	552, 134				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	224, 087				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-706					54.00
60.00	06000 LABORATORY	-43, 750	1, 775, 502				60.00
64.00	06400 I NTRAVENOUS THERAPY	0	96, 146				64.00
65.00	06500 RESPI RATORY THERAPY	ĺ	360, 467				65.00
	06600 PHYSI CAL THERAPY	236, 842	657, 858				66.00
	06700 OCCUPATI ONAL THERAPY	0	93, 243				67.00
	06800 SPEECH PATHOLOGY	0					68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23, 319				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	10, 593				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 588, 240				73. 00
73. 01	07301 DRUGS CHARGED TO PATIENTS	0	0				73. 01
	07400 RENAL DI ALYSI S	0	0				74. 00
	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
	07697 CARDI AC REHABI LI TATI ON	ĺ	0				76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U				10.77
00.00							1 00 00
	08800 RURAL HEALTH CLINIC	0					88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	_				89. 00
	09000 CLI NI C	6, 313					90.00
	09001 VISITING SPECIALTY CLINIC	-28	226, 021				90. 01
90.02	09002 PAOLI PRIMARY CARE CLINIC	-349, 776	195, 064				90. 02
91.00	09100 EMERGENCY	-54, 547	2, 421, 161				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		, , , ,				92.00
00	OTHER REIMBURSABLE COST CENTERS	•					1
05 00	09500 AMBULANCE SERVICES	0	<u> </u>	I			95. 00
	109300 AMBULANCE SERVICES 110100 HOME HEALTH AGENCY						101.00
101.00		<u> </u>	U				101.00
	SPECIAL PURPOSE COST CENTERS			1			4
	11300 I NTEREST EXPENSE	0					113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 490, 410	26, 275, 602				118. 00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19001 VISITING SPECIALTY CLINIC	0	0				190. 01
	19002 OUTREACH	l n	18, 308				190. 02
	19003 FOUNDATI ON	0	10, 300	1			190.02
	19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE						190. 03
190.04	117004 DAOL FAMILY DRACTICE	1	1 2				
	19005 PAOLI FAMILY PRACTICE	0	3, 347				190. 05
	19006 OTHER PROPERTY	0	26				190. 06
	19100 RESEARCH	0	0				191. 00
192. 00	19200 PHYSICIANS' PRIVATE OFFICES	0	0				192. 00
	19300 NONPALD WORKERS	0	n				193.00
200.00	•	_	_				200.00
_30.0	, , ,	., ., ., ., , , ,		1			,

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

Provi der CCN: 15-1306 Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared:

					7/14/2021 1	
	Cook Conton	Increases	Calami	Othora		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFITS	0.00		0.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 596, 510		1. 00
2.00		0. 00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0.00	0	0		5. 00
6. 00		0. 00	Ö	Ö		6. 00
7.00		0. 00	0	0		7. 00
8.00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	Ö		11.00
12.00		0. 00	0	O		12. 00
13.00		0. 00	0	0		13. 00
14.00		0.00	0	0		14.00
15. 00 16. 00	1	0. 00 0. 00	0	0		15. 00 16. 00
17. 00	i	0.00	o	Ö		17. 00
18.00		0. 00	0	O		18. 00
19.00		<u> </u>	9	9		19. 00
	O   B - BI LLABLE DRUGS		0	1, 596, 510		
1. 00	DRUGS CHARGED TO PATIENTS	73. 00		1, 588, 240		1.00
2. 00	OPERATING ROOM	50. 00		727		2. 00
3.00		0. 00	0	O		3. 00
4.00		0. 00	0	0		4.00
5. 00 6. 00	i	0. 00 0. 00	0	0		5. 00 6. 00
0.00			— — —	1, 588, 967		0.00
	C - BILLABLE SUPPLIES		٥,	1,000,707		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	23, 319		1. 00
2 00	PATI ENTS	0.00	0			2.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0. 00	Ö	o		4. 00
5.00		0. 00	0	0		5. 00
6.00		0. 00	0	0		6.00
7. 00 8. 00	1	0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10.00		0. 00	Ö	o		10.00
11. 00		0. 00	0	0		11. 00
12.00		0.00	9	0		12. 00
	D - IMPLANT SUPPLIES		0	23, 319		
1. 00	IMPL. DEV. CHARGED TO PATIEN	TS 72.00	0	10, 593		1.00
2.00		0. 00	0	0		2. 00
3.00		0.00	0	0		3.00
4. 00 5. 00	1	0. 00 0. 00	0	0		4. 00 5. 00
3.00	6 — — — — <del>-</del>		— —  —	10, 593		3.00
	E - NON-BILLABLE DRUGS					
1.00	PHARMACY	15. 00	0	31, 629		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00	i	0.00	o	ő		4.00
5. 00		0. 00	O	Ö		5. 00
6.00		0. 00	0	0		6. 00
7.00		0. 00 0. 00	0	0		7.00
8. 00 9. 00		0. 00	0	0		8. 00 9. 00
10.00		0. 00	Ö	o		10.00
11.00	1	0. 00	0	0		11. 00
12.00		0.00	•	0		12. 00
	O	TS .	0	31, 629		-
1. 00	CENTRAL SERVICES & SUPPLY	14. 00	1	167, 562		1.00
2. 00	OPERATION OF PLANT	7. 00		1, 489		2. 00
3. 00	NURSING ADMINISTRATION	13. 00		2, 297		3. 00
4.00	NONPHYSICIAN ANESTHETISTS	19. 00		53, 222		4. 00
5. 00 6. 00	OPERATING ROOM	50. 00 0. 00	o	133, 230 0		5. 00 6. 00
7. 00		0.00	Ö	ő		7. 00
8. 00		0. 00	0	0		8. 00
			· · · · · · · · · · · · · · · · · · ·	·		

Health Financial Systems RECLASSIFICATIONS IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-1306

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/14/2021 11:21 am

					7/14/2021 1	1:21 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
9. 00		0. 00	0	0		9. 00
10.00		0. 00	0	0		10. 00
11. 00		0. 00	0	0		11. 00
12.00		0. 00	0	0		12.00
13.00		0. 00	0	0		13.00
14.00		0. 00	0	0		14.00
15.00		0. 00	0_	0		15. 00
	0			357, 800		
	G - CAPITAL RELATED COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	350, 373		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1, 086, 242		2. 00
3.00		0. 00	0	O		3.00
4.00		0. 00	0	O		4.00
5.00		0. 00	0	0		5. 00
6.00		0. 00	o	o		6. 00
7. 00		0. 00	0	O		7. 00
8. 00		0. 00	ō	o		8. 00
9. 00		0. 00	o	o		9. 00
10.00		0. 00	ő	Ö		10. 00
11. 00		0. 00	ő	o	1	11. 00
12.00		0. 00	ő	Ö		12. 00
13. 00		0.00	o	o		13. 00
14. 00	1	0.00	0	0	1	14. 00
15. 00	ł	0.00	0	o		15. 00
16. 00		0.00	0			16. 00
			0	0		
17.00		0.00	U	0		17.00
18.00		0. 00	0	U		18.00
19.00		0.00	0	0		19.00
20.00		0. 00	0	0		20.00
21.00		0. 00	0	0		21. 00
22.00		<u>0.</u> 00	•	9		22. 00
	0		0	1, 436, 615		_
	H - LEASE EXPENSE		-1	.=		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	약	<u>170, 2</u> 82		1. 00
	0		0	170, 282		_
	I - COO/CNO					
1. 00	ADMINISTRATIVE & GENERAL	5. 00	<u>187, 0</u> 44	o		1. 00
	0		187, 044	0		_
	J - UTILITIES					
1. 00	UTILITIES	7. 01	0	375, 792		1. 00
2.00		0. 00	0_	0		2.00
	0		0	375, 792		
	L - OBSTETRICS					
1.00	NURSERY	43. 00	0	3, 331		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	145, 260	4 <u>1, 3</u> 39		2. 00
			145, 260	44, 670		1
	M - CAFETERIA			•		
1.00	CAFETERI A	11. 00	93, 821	79, 161		1.00
	0	— — <del> </del>	93, 821	79, 161		
	N - OT AND ST			,		1
1. 00	OCCUPATIONAL THERAPY	67. 00	84, 571	8, 672		1.00
2. 00	SPEECH PATHOLOGY	68. 00	5 <u>4, 4</u> 15	<u>5, 5</u> 80		2. 00
2.00	0	— — <del>55.</del> 00	138, 986	14, 252		2.00
	P - MALPRACTICE INSURANCE		130, 700	14, 252		1
1. 00	ADMINISTRATIVE & GENERAL	5. 00	O	3, 562		1.00
1.00	TOTALS		<del> </del>	3, 562		1.00
500.00	Grand Total: Increases		565, 111			500.00
500.00	oranu rotar: rncreases		303, 111	5, 733, 152		1500.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-o From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/14/2021 11: 21 am Provi der CCN: 15-1306

						7/14/2021 11	:21 am
		Decreases		0.11			
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
1. 00	A - EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	5. 00	T	02 020	٥		1.00
2. 00	OPERATION OF PLANT	7. 00		83, 029 85, 863	0		2.00
3. 00	HOUSEKEEPING	7. 00 9. 00		84, 550	0		3.00
4. 00	DI ETARY	10. 00		65, 820	0		4.00
5. 00	NURSING ADMINISTRATION	13. 00		77, 920	0		5. 00
6. 00	HOUSE SUPERVI SORS	13. 01		69, 916	Ö		6. 00
7. 00	PHARMACY	15. 00		61, 564	Ö		7. 00
8. 00	NONPHYSICIAN ANESTHETISTS	19. 00		27, 555	Ö		8.00
9. 00	ADULTS & PEDIATRICS	30. 00		278, 107	O		9. 00
10.00	OPERATING ROOM	50. 00		106, 420			10.00
11.00	RADI OLOGY-DI AGNOSTI C	54. 00		137, 635	0		11. 00
12.00	INTRAVENOUS THERAPY	64. 00		15, 726	0		12. 00
13.00	RESPI RATORY THERAPY	65. 00		45, 153	0		13. 00
14.00	PHYSI CAL THERAPY	66. 00		104, 096	0		14. 00
15.00	CLI NI C	90. 00		1, 576	0		15. 00
16.00	VISITING SPECIALTY CLINIC	90. 01		31, 910	0		16. 00
17.00	PAOLI PRIMARY CARE CLINIC	90. 02		59, 757	0		17. 00
18.00	EMERGENCY	91.00		256, 211	0		18.00
19. 00	OUTREACH	<u> </u>	— — <del>,</del>	3, 702	<u> </u>		19. 00
	B - BILLABLE DRUGS		<u> </u>	1, 596, 510			1
1. 00	DI ETARY	10.00		32	0		1.00
2. 00	PHARMACY	15. 00		1, 549, 540	0		2.00
3. 00	NURSERY	43. 00		1, 547, 546	Ö		3. 00
4. 00	RADI OLOGY-DI AGNOSTI C	54. 00		24, 191	0		4. 00
5. 00	VISITING SPECIALTY CLINIC	90. 01		2, 203	Ö		5. 00
6.00	PAOLI PRIMARY CARE CLINIC	90. 02		12, 995	O		6. 00
	0 — — — — — —		$$	1, 588, 967			
	C - BILLABLE SUPPLIES						]
1.00	NURSING ADMINISTRATION	13. 00		7	0		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00		310	0		2. 00
3.00	NONPHYSICIAN ANESTHETISTS	19. 00		13	0		3. 00
4. 00	ADULTS & PEDIATRICS	30. 00		1, 194	0		4. 00
5. 00	OPERATING ROOM	50. 00		15, 828	0		5.00
6. 00	RADI OLOGY-DI AGNOSTI C	54. 00		6	0		6.00
7.00	I NTRAVENOUS THERAPY	64. 00		51	0		7.00
8. 00	RESPI RATORY THERAPY	65. 00		247	0		8.00
9. 00 10. 00	PHYSICAL THERAPY VISITING SPECIALTY CLINIC	66. 00 90. 01		364 538	0		9. 00 10. 00
11.00	PAOLI PRIMARY CARE CLINIC	90.01		1, 812	0		10.00
12.00	EMERGENCY	91. 00		2, 949	0		12.00
12.00	0		— — n	23, 319	<u> </u>		12.00
	D - IMPLANT SUPPLIES		<u> </u>	20, 017			1
1.00	NURSERY	43. 00		8	0		1.00
2.00	OPERATING ROOM	50. 00		9, 904	0		2. 00
3.00	VISITING SPECIALTY CLINIC	90. 01		38	0		3. 00
4.00	PAOLI PRIMARY CARE CLINIC	90. 02		53	0		4.00
5.00	EMERGENCY	91.00		<u>5</u> 90	0		5. 00
	0		0	10, 593			4
4 00	E - NON-BILLABLE DRUGS	7 00	-				1
1.00	OPERATION OF PLANT	7. 00		3	0		1.00
2. 00 3. 00	CENTRAL SERVICES & SUPPLY NONPHYSICIAN ANESTHETISTS	14. 00 19. 00		172 351	0		2. 00 3. 00
4. 00	ADULTS & PEDIATRICS	30. 00		4, 335	0		4.00
5. 00	NURSERY	43. 00		136	0		5. 00
6. 00	OPERATING ROOM	50. 00		2, 488	Ö		6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54. 00		11, 930	Ö		7. 00
8.00	INTRAVENOUS THERAPY	64. 00		1, 337	0		8. 00
9.00	RESPI RATORY THERAPY	65. 00		206	0		9. 00
10.00	PHYSI CAL THERAPY	66. 00		13	0		10. 00
11.00	PAOLI PRIMARY CARE CLINIC	90. 02		7	0		11. 00
12.00	EMERGENCY	91. 00		1 <u>0, 6</u> 51	0		12. 00
	0		0	31, 629			1
	F - NON-BILLABLE MED SUPPLIE						4 .
1.00	ADMINISTRATIVE & GENERAL	5. 00		5, 755	0		1.00
2.00	HOUSEKEEPI NG	9. 00		10, 706	0		2.00
3.00	DIETARY	10.00		433	0		3.00
4.00	PHARMACY	15.00		27, 320	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00		10 59 064	0		5.00
6. 00 7. 00	ADULTS & PEDIATRICS NURSERY	30. 00 43. 00		58, 964 13, 488	0		6. 00 7. 00
7. 00 8. 00	RADI OLOGY-DI AGNOSTI C	54. 00		33, 300			8.00
9. 00	INTRAVENOUS THERAPY	64. 00		8, 708			9. 00
		2 30		2, . 00	<u> </u>		

Provi der CCN: 15-1306

Period: Worksheet A-6
From 01/01/2020
To 12/31/2020 Date/Time Prepared: 7/14/2021 11:21 am

						7/14/	2021 11: 21 am
		Decreases				1	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
10.00	RESPI RATORY THERAPY	65. 00		40, 539	0		10.00
11. 00	PHYSI CAL THERAPY	66. 00		15, 335	0		11. 00
12.00	VISITING SPECIALTY CLINIC	90. 01		4, 474	0		12. 00
13.00	PAOLI PRIMARY CARE CLINIC	90. 02		19, 207	0		13. 00
14.00	EMERGENCY	91. 00		119, 471	0		14. 00
15.00	OUTREACH	<u>190. 02</u>		90	0		15. 00
	0		0	357, 800			
	G - CAPITAL RELATED COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	803	9		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	100, 872	9		2. 00
3.00	OPERATION OF PLANT	7. 00	0	272, 753	0		3.00
4.00	HOUSEKEEPI NG	9. 00	0	160	0		4. 00
5.00	DI ETARY	10. 00	0	9, 438	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	0	5, 097	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14. 00	o	1, 930	0		7. 00
8.00	PHARMACY	15. 00	0	61, 676	0		8.00
9. 00	MEDICAL RECORDS & LIBRARY	16. 00	o	3, 529	Ö		9. 00
10.00	NONPHYSI CI AN ANESTHETI STS	19. 00	o	2, 998			10.00
11. 00	ADULTS & PEDIATRICS	30. 00	ol	61, 053	Ö		11.00
12.00	NURSERY	43. 00	ő	1, 788	Ö		12. 00
13. 00	OPERATING ROOM	50. 00	o	177, 794	ő		13.00
14. 00	RADI OLOGY-DI AGNOSTI C	54. 00	ol	510, 189	0		14.00
15. 00	LABORATORY	60.00	ol	1, 433	0		15. 00
16. 00	RESPIRATORY THERAPY	65. 00	o	5, 269	0		16.00
17. 00	PHYSI CAL THERAPY	66. 00	0	155, 248			17. 00
	VISITING SPECIALTY CLINIC	90. 01	O O		0		•
18.00			U	2, 132	U		18.00
19.00	PAOLI PRIMARY CARE CLINIC	90. 02	U	19, 298	U		19.00
20.00	EMERGENCY	91.00	0	38, 495	0		20.00
21.00	PAOLI FAMILY PRACTICE	190. 05	0	800	0		21.00
22. 00	OTHER PROPERTY	1 <u>90.</u> 06	의	3, 860	<u> —  —  Ч</u>		22. 00
	0		0	1, 436, 615			
4 00	H - LEASE EXPENSE	F 00		170 000	1.0		
1. 00	ADMI NI STRATI VE & GENERAL	5.00	•	17 <u>0, 2</u> 82	10		1.00
	0			170, 282			
4 00	I - COO/CNO	10.00	407.044				1 00
1. 00	NURSING ADMINISTRATION	13.00	187, 044	0			1. 00
	0		187, 044	0			
	J - UTILITIES						
1. 00	OPERATION OF PLANT	7. 00		361, 092	0		1.00
2.00	PAOLI PRIMARY CARE CLINIC	90. 02	+	1 <u>4, 7</u> 00	0		2. 00
	0		0	375, 792			
	L - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30. 00	4, 087	44, 670	0		1. 00
2.00	NURSERY	43. 00	<u>141, 1</u> 73	0	0		2. 00
	0		145, 260	44, 670			
	M - CAFETERIA						
1.00	DI ETARY	10. 00	93, 821	79, 161	0		1. 00
			93, 821	79, 161			
	N - OT AND ST						
1.00	PHYSI CAL THERAPY	66. 00	138, 986	14, 252	0		1.00
2.00		0. 00	0	0	o		2. 00
		— — <del></del> -*†	138, 986	14, 252	─		=: 55
	P - MALPRACTICE INSURANCE		.55, 750	, 202			
1. 00	PAOLI PRIMARY CARE CLINIC	90. 02	0	3, 562	0		1.00
1. 00	TOTALS	— <del>/ )  </del>	— — <del>ў</del>	$\frac{3,562}{3,562}$	$oxdot$ $$ $^{"}$		1.00
500 00	Grand Total: Decreases		565, 111	5, 733, 152			500.00
300.00	Jordina Total . Decl edaes	ļ	505, 111	5, 755, 152	1	1	1300.00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-130	Period: Worksheet A-7

12/31/2020 Date/Time Prepared: 7/14/2021 11:21 am Acqui si ti ons Begi nni ng Purchases Donati on Total Disposals 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 35, 505 35, 505 Land 148, 000 0 1.00 2.00 Land Improvements 438, 464 2.00 0 4, 741, 722 3.00 Buildings and Fixtures 3.00 4.00 Building Improvements 1, 939, 739 4.00 5.00 Fixed Equipment 5.00 6.00 Movable Equipment 11, 334, 654 6.00 288, 480 288, 480 471, 780 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 323, 985 323, 985 471, 780 18, 602, 579 8.00 9.00 Reconciling Items 9.00 0 18, 602, 579 323, 985 323, 985 471, 780 Total (line 8 minus line 9) 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 183, 505 1.00 2.00 0 2.00 Land Improvements 438, 464 3.00 Buildings and Fixtures 4, 741, 722 0 3.00 4.00 Building Improvements 1, 939, 739 4.00 0 5.00 5.00 Fixed Equipment 6.00 Movable Equipment 11, 151, 354 0 6.00 7.00 HIT designated Assets 7.00 Subtotal (sum of lines 1-7) Reconciling Items 8.00 18, 454, 784 0 8.00 0 9.00 9.00 10.00 Total (line 8 minus line 9) 18, 454, 784 10.00

Heal th	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet A-7 Part II Date/Time Pre 7/14/2021 11:	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	RKSHEET A, COL	UMN 2, LINES 1	and 2	_		
1. 00	CAP REL COSTS-BLDG & FIXT	0	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum	1			
	(	api tal -Rel ate	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	l and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3. 00	Total (sum of lines 1-2)	0	0	l			3. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lieu	of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1306 P	eriod: rom 01/01/2020	Worksheet A-7	
					Part III   Date/Time Pre	pared:
					7/14/2021 11:	
	COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
· ·		Leases	for Ratio	instructions)		
			(col. 1 - col.			
			2)			
	1.00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL CO						
1.00 CAP REL COSTS-BLDG & FIXT	7, 303, 430		7, 303, 430		0	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	11, 151, 354		11, 151, 354			2.00
3.00 Total (sum of lines 1-2)	18, 454, 784		18, 454, 784		0	3.00
	ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5	·		
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL CO	OSTS CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	503, 136	17, 519	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	1, 086, 242		2.00
3.00 Total (sum of lines 1-2)	0	0	0	1, 589, 378	17, 519	3. 00
		SU	MMARY OF CAPIT	AL		
Cost Center Description	Interest	nsurance (see	Taxes (see	Other	Total (2) (sum	
·		instructions)	instructions)	Capi tal -Relate	of cols. 9	
			·	d Costs (see	through 14)	
				instructions)	•	
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL CO	OSTS CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	0	520, 655	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1, 086, 242	2. 00
3.00 Total (sum of lines 1-2)	0	0	0	0	1, 606, 897	3.00

				T <sub>0</sub>	rom 01/01/2020 o 12/31/2020	Date/Time Pre	pared:
				Expense Classification on	Worksheet A	7/14/2021 11:	21 am
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00		1.00	2.00	3. 00	4. 00	5. 00	1 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-152, /63	CAP REL COSTS-BLDG & FIXT	1. 00	10	1. 00
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of expens (chapter 8)	es	0		0. 00	0	5. 00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
8. 00	stations excluded) (chapter 2 Television and radio service	1)	0		0. 00	0	8. 00
	(chapter 21)		0				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-3, 009, 050		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
	(chapter 23) Related organization	A-8-1	4, 307, 713			0	12. 00
	transactions (chapter 10)	A-0-1	4, 307, 713				
	Laundry and linen service Cafeteria-employees and guest	s B	-46 020	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employe	i i	0	on Etellin	0. 00	0	15. 00
16. 00	and others 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	
	abstracts		0				
19.00	Nursing and allied health education (tuition, fees,		Ü		0. 00	0	19. 00
20.00	books, etc.) Vending machines		0		0. 00	0	20. 00
	Income from imposition of		0		0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments	o 					
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical thera costs in excess of limitation		0	PHYSI CAL THERAPY	66. 00		24. 00
	(chapter 14)						
25.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
	COSTS-BLDG & FLXT						
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00		28. 00 29. 00
	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 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	gy A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for	А	0	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32. 00
33. 00	Depreciation and Interest MISCELLANEOUS INCOME	В	-401	ADMINISTRATIVE & GENERAL	5. 00	O	33. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				eri od:	Worksheet A-8	3
				rom 01/01/2020 o 12/31/2020	Date/Time Pre	norod.
				0 12/31/2020	7/14/2021 11:	
			Expense Classification on	Worksheet A	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			To/From Which the Amount is			
				•		
Cost Center Description			Cost Center		Wkst. A-7 Ref.	
	1. 00	2. 00	3. 00	4. 00	5. 00	
33.01 MISCELLANEOUS INCOME	В		NURSING ADMINISTRATION	13. 00		00.01
33. 02 MISCELLANEOUS INCOME	В		MEDICAL RECORDS & LIBRARY	16. 00		33. 02
33. 03 MISCELLANEOUS INCOME	В		PHYSI CAL THERAPY	66. 00		33. 03
33. 04 MISCELLANEOUS INCOME	В		VISITING SPECIALTY CLINIC	90. 01		33. 04
33. 05 HAF	A		ADMINISTRATIVE & GENERAL	5. 00		33. 05
33.06 RECRUITING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07 BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN			33. 07
33. 08 CRNA	A		NONPHYSICIAN ANESTHETISTS	19. 00		33. 08
33. 09 MARKETI NG	A		PAOLI PRIMARY CARE CLINIC	90. 02		33. 09
33.10 CLINIC START UP	A		PAOLI PRIMARY CARE CLINIC	90. 02		33. 10
33.11 CLINIC START UP AMORTIZIATION	l A	13, 810	PAOLI PRIMARY CARE CLINIC	90. 02	0	33. 11
33. 12 PENALTY	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
50.00 TOTAL (sum of lines 1 thru 49	)	-1, 490, 410				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						<u> </u>
(1) December 1 and 1 about 1 and 1 a						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

				7/14/2021 11:	21 am
Li ne No.	Cost Center	Expense Items	Amount of A	mount Included	
			Allowable Cost	in Wks. A,	
				column 5	
1.00	2.00	3. 00	4. 00	5. 00	
A. COSTS INCURRED AND ADJUST	TMENTS REQUIRED AS A RESULT (	OF TRANSACTIONS WITH RELATED	ORGANI ZATI ONS	OR	
CLAIMED HOME OFFICE COSTS:					
1.00	CAP REL COSTS-BLDG & FLXT	HOME OFFICE ALLOCATION	152, 763	0	1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1, 794, 391	0	2.00
5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4, 799, 794	4, 271, 492	3.00
5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	224, 934	0	3. 01
4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	83, 402	127, 279	3. 02
5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1, 083, 882	878, 620	3. 03
7.00	OPERATION OF PLANT	RELATED PARTY	0	22, 888	3. 04
13.00	NURSING ADMINISTRATION	RELATED PARTY	48, 425	702, 078	3. 05
15. 00	PHARMACY	RELATED PARTY	185, 549	209, 748	3. 06
66.00	PHYSI CAL THERAPY	RELATED PARTY	242, 692	0	3. 07
90.00	CLINIC	RELATED PARTY	29, 242	22, 929	3. 08
91.00	EMERGENCY	SIP ER ALLOCATION	2, 960, 590	1, 062, 917	3. 09
4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	2, 075	2, 075	3. 10
5. 00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	26, 088	26, 088	3. 11
10.00	DI ETARY	SHARED EMPLOYEES	8, 481	8, 481	3. 12
30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	39, 270	39, 270	3. 13
54.00	RADI OLOGY-DI AGNOSTI C	SHARED EMPLOYEES	706		3. 14
60.00	LABORATORY	SHARED EMPLOYEES	1, 710, 227	1, 710, 227	3. 15
65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES			4.00
TOTALS (sum of lines 1-4).			13, 401, 511	9, 093, 798	5. 00
	•				
12.					
	1.00  A. COSTS INCURRED AND ADJUST CLAIMED HOME OFFICE COSTS:  1.00 4.00 5.00 4.00 5.00 7.00 13.00 15.00 66.00 90.00 91.00 4.00 5.00 10.00 30.00 54.00 60.00	1.00 2.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT CLAIMED HOME OFFICE COSTS:  1.00 CAP REL COSTS-BLDG & FIXT 4.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 ADMINISTRATIVE & GENERAL 5.00 ADMINISTRATIVE & GENERAL 4.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 ADMINISTRATIVE & GENERAL 7.00 OPERATION OF PLANT 13.00 NURSING ADMINISTRATION 15.00 PHARMACY 66.00 PHYSICAL THERAPY 90.00 CLINIC 91.00 EMERGENCY 4.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 ADMINISTRATIVE & GENERAL 10.00 DIETARY 30.00 ADULTS & PEDIATRICS 54.00 RADIOLOGY-DIAGNOSTIC 60.00 LABORATORY 65.00 RESPIRATORY THERAPY TOTALS (sum of lines 1-4).  Transfer column 6, line 5 to Worksheet A-8, column 2, line	1.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED CLAIMED HOME OFFICE COSTS:  1.00 CAP REL COSTS-BLDG & FIXT	ALI LOWABLE COST  1.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS CLAIMED HOME OFFICE COSTS:  1.00 CAP REL COSTS-BLDG & FIXT 4.00 EMPLOYEE BENEFITS DEPARTMENTHOME OFFICE ALLOCATION 5.00 ADMINISTRATIVE & GENERAL 6.00 EMPLOYEE BENEFITS DEPARTMENTHOME OFFICE ALLOCATION 7.00 ADMINISTRATIVE & GENERAL 7.00 OPERATION OF PLANT 13.00 NURSING ADMINISTRATIVE & GENERAL 7.00 OPERATION OF PLANT 13.00 NURSING ADMINISTRATION 15.00 ADMINISTRATIVE & GENERAL 7.00 OPERATION OF PLANT 13.00 NURSING ADMINISTRATION 15.00 ADMINISTRATIVE & GENERAL 15.00 PHARMACY 16.00 PHARMACY 17.00 PHARMACY 18.425 19.00 PHARMACY 18.425 19.00 PHARMACY 19.00 PH	Line No.  Cost Center  Expense I tems  Amount of Amount Included Allowable Cost in Wks. A, column 5  1.00  2.00  3.00  4.00  5.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:  1.00 CAP REL COSTS-BLDG & FIXT HOME OFFICE ALLOCATION 1,794,391  6.00 ADMINISTRATIVE & GENERAL HOME OFFICE ALLOCATION 1,794,391  6.00 ADMINISTRATIVE & GENERAL HOME OFFICE ALLOCATION 2,4799,794  4.00 EMPLOYEE BENEFITS DEPARTMENT RELATED PARTY 83,402  7.00 OPERATION OF PLANT RELATED PARTY 83,402  7.00 OPERATION OF PLANT RELATED PARTY 1,083,882  13.00 NURSING ADMINISTRATION RELATED PARTY 48,425  70.00 OPERATION OF PLANT RELATED PARTY 48,425  13.00 PHARMACY RELATED PARTY 48,425  90.00 CLINIC RELATED PARTY 242,692  91.00 EMERGENCY SIP ER ALLOCATION 2,960,590  10.00 DI ETARY SOME EMPLOYEE BENEFITS DEPARTMENT SHARED EMPLOYEES 2,075  5.00 ADMINISTRATIVE & GENERAL SHARED EMPLOYEES 39,270  5.00 ADMINISTRATIVE & SHARED EMPLOYEES 39,270  5.00 ADMINISTRATIVE & SHARED EMPLOYEES 39,270  5.00 ADMINISTRATIVE & SHARED EMPLOYEES 9,000  70 ADDITION STRATIVE SHARED EMPLOYEES 9,000  90.00 LABORATORY SHARED EMPLOYEES 9,000  90.00 LABORATORY SHARED EMPLOYEES 9,000  90.00 CLOURD SHARED EMPLOYEES 9,000  90.00 SHARED EMPL

\* 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.

110	That been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be indicated in cordinar 4 or this part.								
					Related Organization(s) and/	or Home Office			
		Symbol (1)	Name	Percentage of	Name	Percentage of			
				Ownershi p		Ownershi p			
		1. 00	2.00	3. 00	4. 00	5. 00			
	B. INTERRELATIONSHIP TO 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	O. OO I U HEALTH BLOOM O. OC	6. 00
7. 00	В	O. OO I U HEALTH 100. OC	7. 00
8.00	С	0.00 IUH SLP 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-fi nanci al ) speci fy:		

- (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.
- $\hbox{E. Individual is director, of ficer, administrator, or key person of provider and related organization.}\\$
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syst	ems	IU HEALTH	I PAOLI H	OSPI TAL		In Lieu	of Form CMS-	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	M RELATED ORGANIZATIONS A	ND HOME F	Provi der C		Peri od:	Worksheet A-	3-1
OFFI CE	COSTS						From 01/01/2020 To 12/31/2020	Doto/Time Dr	onarad.
							To 12/31/2020	Date/Time Pro 7/14/2021 11	epareu: :21 am
1	let Adjustments	Wkst. A-7 Ref.							
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
			TMENTS REQUIRED AS A RESUI	LT OF TRA	NSACTI ONS	WITH RELATE	D ORGANIZATIONS (	OR	
	CLAIMED HOME C								
1. 00	152, 763	9							1. 00
2.00	1, 794, 391	9	9						2. 00
3. 00	528, 302								3. 00
3. 01	224, 934								3. 01
3. 02	-43, 877		2						3. 02
3. 03	205, 262								3. 03
3. 04	-22, 888								3. 04
3. 05	-653, 653								3. 05
3.06	-24, 199								3.06
3. 07	242, 692								3. 07
3. 08	6, 313								3. 08
3. 09	1, 897, 673	0							3. 09
3. 10	0	0							3. 10
3. 11	0	0							3. 11
3. 12	0	0							3. 12
3. 13	0	0	()						3. 13
3. 14		0							3. 14
3. 15 4. 00		0							3. 15 4. 00
	4 207 712	U	1						
5. 00	4, 307, 713		1						5. 00

\* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which look been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

not been posted to worksheet A, cor	Tullins I aliazor 2, the amount arrowable should be marcated in cordinir 4 or this part.	
Related Organization(s) and/o		
Home Office		
Type of Business	1	
6. 00		
B. INTERRELATIONSHIP TO RELA	ATED 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

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 HOSPITAL

7.00 HOME OFFICE

8.00 PHYSICIAN GROUP

costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control

6.00	HOSPI TAL	6.00
7.00	HOME OFFICE	7.00
8.00	PHYSICIAN GROUP	8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-1306 | Period: | Worksheet A-8-2 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

						To 12/31/202	Date/Time Pro 7/14/2021 11	
	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	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	116, 733			C		
2.00		ADULTS & PEDIATRICS	742, 314			C	-	
3.00		RADI OLOGY-DI AGNOSTI C	706				0	
4. 00		LABORATORY	43, 750				0	
5. 00 6. 00		PAOLI PRIMARY CARE CLINIC EMERGENCY	153, 327 2, 742, 679				0	5. 00 6. 00
7. 00	0.00	EWERGENCY	2, 742, 679	1, 952, 220	790, 459		0	7.00
8. 00	0.00		1		0			8.00
9. 00	0.00							9. 00
10.00	0.00		1 0		0	Č	o o	10.00
200. 00			3, 799, 509	3, 009, 050	790, 459	Ĭ	l ő	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &@	component Shar	of Mal practice	
				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	ĭ	0	C	_	
2.00		ADULTS & PEDIATRICS	0	0	0		0	
3.00		RADI OLOGY-DI AGNOSTI C	0		0		0	0.00
4. 00 5. 00		LABORATORY PAOLI PRIMARY CARE CLINIC	0		0		0	
6. 00		EMERGENCY	1		0		0	
7. 00	0.00	EMERGENCI	1 0		0		0	7.00
8. 00	0.00		1 0		0	Č	o o	8. 00
9. 00	0.00		0	Ö	Ö	C	Ō	•
10.00	0.00		0	O	0	C	O	•
200.00			0	C	0	C	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	¢omponent Shar	Limit	Di sal I owance			
	1 00		of col. 14	1/ 00	17.00	10.00	-	
1 00	1.00	2.00 ADMINISTRATIVE & GENERAL	15. 00	16.00	17. 00	18. 00		1 00
1. 00 2. 00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0		0	116, 733 742, 314		1. 00 2. 00
3. 00		RADI OLOGY-DI AGNOSTI C	0		0	742, 314		3.00
4. 00		LABORATORY			0	43, 750		4.00
5. 00		PAOLI PRIMARY CARE CLINIC				153, 327		5. 00
6. 00		EMERGENCY	1 0		n n	1, 952, 220		6. 00
7. 00	0.00		0	l o	o o	1, 752, 220		7. 00
8. 00	0.00		0	l o	n	l d	1	8.00
9. 00	0.00		l 0		Ö	l c		9. 00
10.00	0.00		0	0	0	C		10. 00
200. 00			0	0	0	3, 009, 050		200. 00

Health Financial Systems	IU HEALTH PAOI				of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part I Date/Time Pre 7/14/2021 11:	epared: 21 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost Allocation			BENEFITS DEPARTMENT		
	(from Wkst A col. 7)					
	0	1. 00	2. 00	4. 00	4A	
GENERAL SERVICE COST CENTERS  1. 00   00100   CAP REL COSTS-BLDG & FLXT	520, 655	520, 655				1.00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP	1, 086, 242	320, 033	1, 086, 242			2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500 ADMINISTRATIVE & GENERAL	2, 213, 617 7, 484, 150	8, 588 32, 106		2, 241, 170 260, 731	7, 847, 888	4. 00 5. 00
7. 00 00700 OPERATION OF PLANT	939, 925	38, 913		104, 744	1, 169, 516	•
7. 01 00701 UTILITIES	375, 792	0	0	0	375, 792	7. 01
8.00   00800   LAUNDRY & LINEN SERVICE 9.00   00900   HOUSEKEEPING	38, 456 337, 141	2, 632 8, 272	5, 812 18, 268	0 57, 050	46, 900 420, 731	8. 00 9. 00
10. 00 01000 DI ETARY	143, 661	15, 860		19, 857	214, 402	•
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	126, 962	8, 816		23, 910	179, 157	
13. 00   01300   NURSI NG   ADMI NI STRATI ON 13. 01   01301   HOUSE   SUPERVI SORS	517, 549 428, 325	13, 571 0	29, 968 0	106, 740 101, 630	667, 828 529, 955	
14.00 01400 CENTRAL SERVICES & SUPPLY	192, 700	18, 351	40, 526	0	251, 577	14. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL   RECORDS & LI BRARY	534, 815 1, 660	10, 255 6, 605		68, 366 0	636, 082 22, 852	•
17. 00 01700 SOCIAL SERVICE	0	0, 003	14, 567	0	22, 832	1
19. 00 01900 NONPHYSICIAN ANESTHETISTS	287, 939	0	0	88, 766	376, 705	19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	1, 304, 513	64, 696	142, 868	290, 619	1, 802, 696	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	31, 220	2, 193	4, 843	6, 488	44, 744	43. 00
50. 00 05000 OPERATING ROOM	552, 134	52, 870	116, 755	114, 893	836, 652	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	224, 087	5, 237		46, 572	287, 461	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	1, 356, 637 1, 775, 502	51, 186 15, 421	113, 035 34, 056	227, 245 0	1, 748, 103 1, 824, 979	
64. 00 06400 I NTRAVENOUS THERAPY	96, 146	3, 947	8, 717	19, 578	128, 388	
65. 00 06500 RESPIRATORY THERAPY	360, 467	2, 895		80, 698	450, 453	
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	657, 858 93, 243	35, 948 7, 983	· ·	97, 077 21, 552	870, 269 140, 406	•
68. 00 06800 SPEECH PATHOLOGY	59, 995	5, 132	11, 333	13, 867	90, 327	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	23, 319 10, 593	0	0	0	23, 319 10, 593	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 588, 240	0	0	0	1, 588, 240	
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00   07400   RENAL DI ALYSIS 75.00   07500   ASC (NON-DI STINCT PART)	0	0		0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	O	0		Ö		76. 97
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC		0	0	٥	0	00 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 09000 CLINIC	69, 813	333		9, 600	80, 482	90.00
90.01 09001 VISITING SPECIALTY CLINIC 90.02 09002 PAOLI PRIMARY CARE CLINIC	226, 021 195, 064	30, 527 13, 658		47, 616 105, 619	371, 578 344, 503	
91. 00   09100   EMERGENCY	2, 421, 161	35, 887		323, 957	2, 860, 256	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
101.00 10100 HOME HEALTH AGENCY	Ō	0		Ō		101. 00
SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE	T					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	26, 275, 602	491, 882	1, 086, 242	2, 237, 175	26, 242, 834	
NONREI MBURSABLE COST CENTERS	1 0			٥		100.00
190.0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.0119001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 00 190. 01
190. 02 19002 OUTREACH	18, 308	3, 930	0	3, 995	26, 233	190. 02
190.03 19003 FOUNDATION 190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190. 03 190. 04
190. 05/19005 PAOLI FAMILY PRACTICE	3, 347	0	0	0	3, 347	190. 05
190. 06 19006 OTHER PROPERTY	26	24, 843	0	Ō	24, 869	190. 06
191. 00 19100 RESEARCH 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		191. 00 192. 00
193. 0019300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments		_	_			200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	26, 297, 283	0 520, 655	0 1, 086, 242	0 2, 241, 170		201. 00 202. 00
1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		323, 300	., 555, 2 12	_, , . , 0	, _,, _	,

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1306

				Į <sup>T</sup>	o 12/31/2020	Date/Time Pre 7/14/2021 11:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	Z I dili
	, , , , , , , , , , , , , , , , , , ,	& GENERAL	PLANT		LINEN SERVICE		
		5. 00	7. 00	7. 01	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS	1			-		1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT					1	1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP   OO400 EMPLOYEE BENEFITS DEPARTMENT					I	2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	7, 847, 888				I	5.00
7. 00	00700 OPERATION OF PLANT	497, 482	1, 666, 998			I	7. 00
7. 01	00701 UTI LI TI ES	159, 852	1, 000, 770	535, 644		I	7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	19, 950	12, 219	3, 225	82, 294	I	8. 00
9. 00	00900 HOUSEKEEPI NG	178, 968	38, 407	10, 137	0	648, 243	
10.00	01000 DI ETARY	91, 201	73, 638	19, 435	0	27, 293	
11.00	01100 CAFETERI A	76, 209	40, 933	10, 803	0	15, 171	11. 00
13.00	01300 NURSING ADMINISTRATION	284, 077	35, 516	16, 629	0	23, 353	13. 00
13. 01	01301 HOUSE SUPERVI SORS	225, 429	0	0	0	0	
	01400 CENTRAL SERVICES & SUPPLY	107, 014	85, 205	22, 488	0	0	14. 00
15.00	01500 PHARMACY	270, 573	47, 612	12, 566	0	0	15. 00
	01600 MEDI CAL RECORDS & LI BRARY	9, 721	30, 669	8, 094	0	11, 367	
17.00	01700 SOCIAL SERVICE	1/0 2/1	0	0	0	0	17.00
19. 00	01900 NONPHYSI CLAN ANESTHETLSTS I NPATLENT ROUTLNE SERVI CE COST CENTERS	160, 241	U	0	U	0	19. 00
30.00	03000 ADULTS & PEDIATRICS	766, 820	300, 377	79, 280	21, 953	111, 332	30.00
	03100 INTENSIVE CARE UNIT	700, 020	0 0	77, 200	21, 733	0	31. 00
43. 00	04300 NURSERY	19, 033	10, 182	2, 687	0	3, 774	43. 00
10.00	ANCILLARY SERVICE COST CENTERS	17,000	10, 102	2,007	o <sub>l</sub>	0,771	10.00
50.00	05000 OPERATING ROOM	355, 890	245, 474	64, 787	5, 959	90, 982	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	122, 278	24, 315	6, 417	1, 302	9, 012	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	743, 598	237, 654	62, 723	14, 618	88, 084	54.00
60.00	06000 LABORATORY	776, 299	71, 602	18, 897	0	26, 538	60.00
64.00	06400 I NTRAVENOUS THERAPY	54, 613	18, 328	4, 837	0	6, 793	64. 00
65.00	06500 RESPI RATORY THERAPY	191, 611	13, 441	3, 547	0	4, 982	1
66.00	06600 PHYSI CAL THERAPY	370, 190	5, 946	44, 051	2, 523		•
67.00	06700 OCCUPATI ONAL THERAPY	59, 725	1, 303	9, 782	559	13, 737	67.00
68.00	06800 SPEECH PATHOLOGY	38, 423	855	6, 288	360		•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 919	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 506	0	0	0	0	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 DRUGS CHARGED TO PATIENTS	675, 596 0	0	0	0	0	73. 00 73. 01
	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
, 0, , ,	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		9	J	70.77
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	Ö	0	89. 00
90.00	09000 CLINIC	34, 235	1, 548	408	0	574	90.00
90.01	09001 VISITING SPECIALTY CLINIC	158, 060	141, 737	37, 408	1, 037	52, 533	90. 01
90.02	09002 PAOLI PRIMARY CARE CLINIC	146, 543	63, 415	16, 737	0	23, 504	90. 02
91.00	09100 EMERGENCY	1, 216, 670	166, 622	43, 976	33, 983	61, 757	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					L	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS				ما		05 00
	09500 AMBULANCE SERVICES	0	0	0	0	0	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
112 00	SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE				ı		113. 00
118. 00		7, 824, 726	1, 666, 998	505, 202	82, 294	641, 480	•
110.00	NONREI MBURSABLE COST CENTERS	7,024,720	1,000, 990	505, 202	02, 274	041,400	1 10.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 01
	19002 OUTREACH	11, 159	0	Ö	ő		190. 02
	19003 FOUNDATI ON	0	0	0	Ö		190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190. 04
	19005 PAOLI FAMILY PRACTICE	1, 424	0	0	0		190. 05
	19006 OTHER PROPERTY	10, 579	0	30, 442	0		190. 06
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
200.00			_	_	_	_	200.00
201. 00		0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	7, 847, 888	1, 666, 998	535, 644	82, 294	648, 243	K07.00

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1306 Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

				įτ	0 12/31/2020	Date/Time Pre 7/14/2021 11:	epared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	HOUSE SUPERVI SORS	CENTRAL SERVICES & SUPPLY	Z I dili
		10. 00	11. 00	13. 00	13. 01	14. 00	
	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FLXT			1			1 00
2. 00 4. 00 5. 00 7. 00 7. 01	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 UTILITIES						1. 00 2. 00 4. 00 5. 00 7. 00 7. 01
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 H0USEKEEPI NG 01000 DI ETARY	425, 969					9. 00 10. 00
	01100 CAFETERI A	0	322, 273				11. 00
	01300 NURSING ADMINISTRATION	0	14, 949				13. 00
	01301 HOUSE SUPERVI SORS	0	14, 017	0	769, 401	4// 204	13. 01
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	12, 673	0	0	466, 284 35, 421	14. 00 15. 00
	01600 MEDI CAL RECORDS & LI BRARY	0	12, 073	0	0	13	
17.00	01700 SOCIAL SERVICE	O	0	Ō	0	0	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	5, 946	0	0	0	19. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	425, 969	E2 204	414, 625	204 050	72 642	20.00
	03100 INTENSIVE CARE UNIT	425, 969	52, 386 0		306, 050 0	73, 643 0	30. 00 31. 00
	04300 NURSERY	Ö	985	8, 157	6, 021	17, 152	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	17, 075		86, 198	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	7, 068 37, 814	,	43, 239 13, 109	0 42, 020	52. 00 54. 00
	06000 LABORATORY	ő	37, 535		0	42, 020	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	2, 717		16, 636	10, 812	64. 00
	06500 RESPI RATORY THERAPY	0	14, 266	1	0	48, 766	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	15, 759 3, 523	1	0	13, 653 3, 031	
	06800 SPEECH PATHOLOGY	0	2, 650		0	1, 950	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	0	Ö	Ö	27, 742	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12, 602	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07301 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0	73. 01 74. 00
	07500 ASC (NON-DISTINCT PART)	Ö	0	ő	0	0	75. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	.1			-1		
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900  FEDERALLY QUALIFIED HEALTH CENTER 09000  CLINIC	0	843		0	0	89. 00 90. 00
	09001 VISITING SPECIALTY CLINIC	o	14, 114	1	26, 769	5, 813	90. 01
	09002 PAOLI PRIMARY CARE CLINIC	0	10, 524	27, 540		23, 429	90. 02
	09100 EMERGENCY	0	56, 743	340, 112	251, 050	150, 126	
	09200 OBSERVATION BEDS (NON-DISTINCT PART   OTHER REIMBURSABLE COST CENTERS						92. 00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
101. 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS			1			
113. 00 118. 00	11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	425, 969	321, 587	1, 042, 352	769, 401	466, 173	113.00
118.00	NONREIMBURSABLE COST CENTERS	425, 969	321, 387	1,042,352	769, 401	400, 173	118.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 01
	19002 OUTREACH 19003 FOUNDATI ON	0	686	0	0		190. 02
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 03 190. 04
	19005 PAOLI FAMILY PRACTICE	ő	0	Ö	o O		190.04
190. 06	19006 OTHER PROPERTY	0	0	0	0		190. 06
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0	0	0		192. 00 193. 00
200. 00		٩	U	Ī	U		200. 00
201. 00		o	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	425, 969	322, 273	1, 042, 352	769, 401	466, 284	202. 00

Health Financial Systems IU HEALTH PAOLI HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1306

COST CONTO DESCRIPTION						o 12/31/2020	Date/Time Pre	epared:
SERION SERVICE COST CENTERS   1,00   16,00   17,00   19,00   24,00   1		Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE			21 am
1.00   10100 CAP REL COSTS-BLIC & FIXT			15. 00		17. 00	19. 00	24. 00	
2. 00					1			
11. 00   01100 CAFETER A   11. 00   13. 01   14. 00   1400 CENTRAL SERVICES & SUPPLY   1, 014. 927   15. 00   1500 PHARMACY   15. 00   15	2.00 (4.00 (5.00 (7.00 (7.01 (8.00 (9.00 (7.01 (	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 UTILITIES 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00
16. 00   01400   MEDICAL RECORDS & LIBRARY   0   82,716   0   0   0   543,112   17. 00   170   017	11. 00 ( 13. 00 ( 13. 01 ( 14. 00 (	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01301 HOUSE SUPERVISORS 01400 CENTRAL SERVICES & SUPPLY	1, 014, 927					11. 00 13. 00 13. 01 14. 00
19. 00			0					•
INPATIENT ROUTINE SERVICE COST CENTERS			220	-	0	543, 112		•
31.00   03100   INTERSIVE CARE UNIT   0   0   0   0   0   31.00	-		220			010, 112		1 // 00
50.00   050000   050000   050000   054,0112   2,370,828   50.00   52.00   05200   05	31.00 ( 43.00 (	03100 INTENSIVE CARE UNIT 04300 NURSERY	0	0	1	1	0	31. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   1.074   0   0   5.60 7.44   52 0.00			1 550	6 363	I 0	5/13 113	2 370 828	50 00
60.0 0 GOOO LABORATORY					1	0		1
64.00   06400   INTRAVENDUS THERAPY   83.8   2,803   0   0   269,302   64.00   65.00   06600   06500 RESPIRATORY THERAPY   129   1,213   0   0   728,408   65.00   66.00   06600 PHYSICAL THERAPY   1   381   0   0   232,448   67.00   67.00   06700   0CCUPATI DONL THERAPY   1   381   0   0   232,448   67.00   68.00   06800 SPECH PATHOLOGY   1   234   0   0   149,919   88.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   275   0   0   61.197   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   975   0   27,776   72.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   995,218   13,025   0   0   3,272,079   73.00   73.00   07300 DRUGS CHARGED TO PATIENTS   995,218   13,025   0   0   3,272,079   73.00   74.00   07400 RENAL DIALYSIS   0   0   0   0   0   0   0   0   75.00   07500   OXOGO ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   76.97   07697 CARDI AC REHABILITATION   0   0   0   0   0   0   0   0   76.97   07697 CARDI AC REHABILITATION   0   0   0   0   0   0   0   0   79.00   09000   UNISTING FUNCTION   0   0   0   0   0   0   0   88.00   08800 RUBAL HEALTH CLINIC   0   0   0   0   0   0   0   0   89.00   08900 FUDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   89.00   09000   UNISTING SPECIALTY CLINIC   0   822   0   0   118,172   90.00   90.01   09001 VISTING SPECIALTY CLINIC   0   4   183   0   0   676,711   90.02   91.00   09100   UNISTING SPECIALTY CLINIC   4   183   0   0   676,711   90.02   91.00   09100   UNISTING SEPCIALTY CLINIC   0   0   0   0   5,213,423   91.00   92.00   09200   MADILARNE SERVICES   0   0   0   0   0   0   0   91.01   09001   VISTING SPECIALTY CLINIC   0   0   0   0   0   0   91.01   09000   MISSABLE COST CENTERS   0   0   0   0   0   0   0   91.01   09000   MISSABLE COST CENTERS   0   0   0   0   0   0   0   91.01   09000   MISSABLE COST CENTERS   0   0   0   0   0   0   0   0   0   91.01   09000   SPECIALTY CLINIC   0   0   0   0   0   0   0   0   0			7, 476			0		•
65.00   06500   RESPI RATORY THERAPY   129   1, 213   0   0   728, 408   65. 00   66. 00   6600   PH/SI CAL THERAPY   1   381   0   0   232, 448   67. 00   67. 00   07. 00			838		1	0		1
67.00   06700   OCCUPATI ONAL THERAPY   1   381   0   0   232, 448   67. 00   68. 00   680. SPEECH PATHOLOGY   1   234   0   0   144, 919   68. 00   680. SPEECH PATHOLOGY   1   234   0   0   144, 919   68. 00   680. SPEECH PATHOLOGY   1   234   0   0   144, 919   68. 00   67. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00	65.00	06500 RESPIRATORY THERAPY	129	1, 213	0	0	728, 408	65. 00
68.00   06.800   SPEECH PATHOLOGY   1   234   0   0   14.9, 919   68. 00   71. 00   77.00   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   217   0   0   0   61. 197   71. 00   72. 00   72.00   72.00   72.00   73. 00   73.00   74.00			6		0	0		
72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   975, 20   75   0   0   27,776   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   75.			1		Ö	Ö		
73. 00   07300   DRUGS CHARGED TO PATIENTS   995, 218   13, 025   0   0   3, 272, 079   73. 00   73. 01   07301   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 01   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   0   74. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0			0		0	0		
73. 01   07301   DRUGS CHARGED TO PATIENTS   0   0   0   0   73. 01   74. 00   07400   RENALD IALYSIS   0   0   0   0   0   74. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDINAL AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDINAL AC REHABILLITATION   0   0   0   0   76. 97   07697   CARDINAL AC REMABILLITATION   0   0   0   0   76. 97   0769900   CARDINAL AC REHABILLITATION   0   0   0   0   76. 97   0769900   CARDINAL AC REMABILLITATION   0   0   0   0   76. 97   0769900   CARDINAL AC REMABILLITATION   0   0   0   0   76. 97   0769900   CARDINAL AC			995, 218		l e	0		
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   75. 00   76. 97   O7697   CARDIAC REHABILITATION   0   0   0   0   0   0   76. 97   O7697   O76	73. 01	D7301 DRUGS CHARGED TO PATIENTS			1	0	0	73. 01
76. 97			0	0	0	0	1	•
88.00   08800 RURAL HEALTH CLINIC			0	0	0	0	_	•
89. 00   08900   EDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   89. 00   90. 00   09000   CLINIC   0   0   0   118.72   90. 00   90. 01   09001   VISITING SPECIALTY CLINIC   0   1, 209   0   0   846, 524   90. 01   90. 02   09002   PAOLI PRIMARY CARE CLINIC   4   183   0   0   676, 711   90. 02   91. 00   09200   DEMERGENCY   6, 674   25, 454   0   0   5, 213, 423   91. 00   92. 00   09200   DESERVATION BEDS (NON-DISTINCT PART   0   0   0   0   0   0   01. 00   10100   MOME HEALTH AGENCY   0   0   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0   0   113. 00   11300   INTEREST EXPENSE   113. 00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   1, 014, 927   82, 716   0   543, 112   26, 181, 670   18. 00   190. 01   9000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   190. 01   190. 02   19002   OUTREACH   0   0   0   0   0   0   0   190. 01   190. 03   19003   FOUNDATION   0   0   0   0   0   0   190. 02   190. 04   19004   SPRING VALLEY FAMILY PRACTICE   0   0   0   0   0   0   0   190. 04   190. 04   19004   SPRING VALLEY FAMILY PRACTICE   0   0   0   0   0   0   0   0   190. 04   190. 05   19005   PAOLI FAMILY PRACTICE   0   0   0   0   0   0   0   0   0					1	1 1		
90. 00   09000   CLINIC   0   82   0   0   118, 172   90. 00   90. 01   9001 VI SITING SPECIALTY CLINIC   0   1,209   0   0   0   846, 524   0   0. 01   90. 02   9002   PAOLI PRI MARY CARE CLINIC   4   183   0   0   676, 711   90. 02   91. 00   9100   EMERGENCY   6, 674   25, 454   0   0   5, 213, 423   91. 00   92. 00   09200   OSERVATION BEDS (NON-DISTINCT PART   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   0   0			0	0	0	0	0	•
90. 02   09002   PAOLI PRI MARY CARE CLINIC   4   183   0   0   676, 711   90. 02   91. 00   09100   EMERGENCY   6, 674   25, 454   0   0   5, 213, 423   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   92. 00   OD   0   0   0   0   0   0   0   0   0	90.00	09000 CLINIC	O		0	Ö		90.00
91. 00   09100   EMERGENCY   0,6674   25,454   0   0   5,213,423   91. 00   92.00   09200   095ERVATI ON BEDS (NON-DISTINCT PART   92. 00   00   00   00   00   00   00   00			0		1	0		1
OTHER REIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O			6, 674		l e	0		
95. 00   09500   AMBULANCE SERVICES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								92. 00
101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   0   0   101. 00			O	0		ol ol	0	95 00
113. 00   11300   INTEREST EXPENSE     113. 00	101. 00	10100 HOME HEALTH AGENCY						
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   1,014,927   82,716   0   543,112   26,181,670   118.00					1			112 00
NONREI MBURSABLE COST CENTERS   190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00			1, 014, 927	82, 716	o	543, 112	26, 181, 670	
190. 01 19001 VISITING SPECIALTY CLINIC 0 0 0 0 0 190. 01 190. 02 19002 OUTREACH 0 0 0 0 0 44, 952 190. 02 190. 03 19003 FOUNDATION 0 0 0 0 0 0 190. 03 190. 04 19004 SPRI NG VALLEY FAMILY PRACTICE 0 0 0 0 0 0 190. 04 190. 05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 0 4, 771 190. 05 190. 06 19006 OTHER PROPERTY 0 0 0 0 0 4, 771 190. 05 190. 06 19100 RESEARCH 0 0 0 0 0 191. 00 191. 00 1912. 00 192. 00 193. 00		NONREI MBURSABLE COST CENTERS	-1					
190. 02 19002 OUTREACH 0 0 0 0 44, 952 190. 02 190. 03 19003 FOUNDATI ON 0 0 0 0 0 0 190. 03 190. 04 19004 SPRI NG VALLEY FAMILY PRACTICE 0 0 0 0 0 0 190. 04 190. 05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 0 4, 771 190. 05 190. 06 19006 OTHER PROPERTY 0 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 193. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0		
190. 04 19004   SPRING VALLEY FAMILY PRACTICE			o	Ö	Ö	Ö		
190. 05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 4, 771 190. 05 190. 06 19006 OTHER PROPERTY 0 0 0 0 0 65, 890 190. 06 191. 0019100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 193. 00 193. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
190. 06 19006 OTHER PROPERTY  0 0 0 0 0 65, 890 190. 06 191. 0019100 RESEARCH  0 0 0 0 0 0 191. 00 192. 0019200 PHYSI CI ANS' PRI VATE OFFI CES  0 0 0 0 0 0 192. 00 193. 0019300 NONPAI D WORKERS  0 0 0 0 0 193. 00 200. 00 Cross Foot Adj ustments  201. 00 Negati ve Cost Centers  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
192. 0d 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 193. 0d 19300 NONPALD WORKERS 0 0 0 0 0 193. 00 200. 0d Cross Foot Adjustments 0 0 0 0 0 0 200. 00 201. 0d Negative Cost Centers 0 0 0 0 0 0 201. 00	190. 06	19006 OTHER PROPERTY	O	0	O	Ö	65, 890	190. 06
193. 0d 19300 NONPALD WORKERS 0 0 0 0 193. 00 200. 00 0 200. 00 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			0	0	0	0		
200.00   Cross Foot Adjustments   0   0   0   200.00   201.00   Negative Cost Centers   0   0   0   0   0   0   0   0   0			0	0		o		
	200. 00	Cross Foot Adjustments		-		O	0	200. 00
			0 1, 014, 927	0 82, 716	0	543, 112		

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1306 | Period: From 01/01/2020 | Part | From 01/01/2020 | Part |

Date/Time Prepared: 12/31/2020 7/14/2021 11:21 am Cost Center Description Intern & Total esidents Cost Post Stepdown Adjustments 25, 00 26. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 UTI LI TI ES 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9 00 00900 HOUSEKEEPI NG 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01301 HOUSE SUPERVISORS 13.01 13.01 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 01700 SOCIAL SERVICE 17.00 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30 00 4, 364, 445 31.00 03100 INTENSIVE CARE UNIT 31.00 43.00 04300 NURSERY 113,078 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 370, 828 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 560, 744 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 3, 027, 392 54.00 54.00 0 06000 LABORATORY 2, 763, 086 60.00 60.00 06400 I NTRAVENOUS THERAPY 64.00 269, 302 64 00 65.00 06500 RESPIRATORY THERAPY 728, 408 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 386, 138 66.00 O 06700 OCCUPATI ONAL THERAPY 67.00 232, 448 67.00 68.00 06800 SPEECH PATHOLOGY 149, 919 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 61, 197 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 27, 776 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 3, 272, 079 73.00 07301 DRUGS CHARGED TO PATIENTS 73.01 73.01 07400 RENAL DIALYSIS 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 07697 CARDIAC REHABILITATION 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 90.00 09000 CLI NI C 0 118, 172 90.00 09001 VISITING SPECIALTY CLINIC 90.01 846, 524 90.01 90.02 09002 PAOLI PRIMARY CARE CLINIC 676, 711 90.02 0 09100 EMERGENCY 91 00 91.00 5, 213, 423 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 0 95.00 95 00 09500 AMBULANCE SERVICES 101. 00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 26, 181, 670 118 00 118 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 190. 01 19001 VISITING SPECIALTY CLINIC 0 190. 01 190. 0219002 OUTREACH 0 44, 952 190 02 190. 03 19003 FOUNDATI ON 190. 03 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190.04 190. 05 19005 PAOLI FAMILY PRACTICE 4, 771 190. 05 0 190. 06 19006 OTHER PROPERTY 190.06 65, 890 191. 00 19100 RESEARCH 191. 00 192. 0019200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 193. 00 19300 NONPALD WORKERS 193 00 C 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 26, 297, 283 202.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-1306	From 01/01/2020	Worksheet B Part II Date/Time Prepared:	

			To	12/31/2020	Date/Time Pre	epared:
		CAPITAL RELATED COSTS			7/14/2021 11:	Z I alli
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New Capital Related	t t			BENEFITS DEPARTMENT	
	Costs	1 00	2.00	2.4	4.00	
GENERAL SERVICE COST CENTERS	0	1.00	2. 00	2A	4. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	8, 588		27, 553		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	224, 934	32, 106		327, 941 124, 847	3, 205	5.00
7. 00   00700   OPERATION OF PLANT 7. 01   00701   UTILITIES		38, 913 0	85, 934	124, 847	1, 288 0	7. 00 7. 01
8.00 00800 LAUNDRY & LINEN SERVICE	0	2, 632	5, 812	8, 444	0	8.00
9. 00   00900 HOUSEKEEPI NG	0	8, 272	18, 268	26, 540	701	9. 00
10. 00 01000 DI ETARY	0	15, 860		50, 884	244	10.00
11. 00   01100   CAFETERI A	0	8, 816		28, 285	294	11.00
13. 00   01300   NURSI NG ADMI NI STRATI ON 13. 01   01301   HOUSE SUPERVI SORS		13, 571	29, 968	43, 539 0	1, 312 1, 249	13. 00 13. 01
14.00 01400 CENTRAL SERVI CES & SUPPLY		18, 351	40, 526	58, 877	0	14. 00
15.00 01500 PHARMACY	0	10, 255	22, 646	32, 901	840	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	6, 605	14, 587	21, 192	0	16. 00
17. 00   01700   SOCI AL   SERVI CE 19. 00   01900   NONPHYSI CI AN   ANESTHETI STS	0 0	0	0	0	1 001	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS I NPATIENT ROUTINE SERVICE COST CENTERS	1 0	0	U	U	1, 091	19. 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	64, 696	142, 868	207, 564	3, 573	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
43. 00 04300 NURSERY	0	2, 193	4, 843	7, 036	80	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	1 0	52, 870	116, 755	169, 625	1, 412	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM		5, 237	11, 565	16, 802	573	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	51, 186		164, 221	2, 794	
60. 00 06000 LABORATORY	0	15, 421	34, 056	49, 477	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	3, 947	8, 717	12, 664	241	64. 00
65. 00   06500  RESPI RATORY THERAPY 66. 00   06600  PHYSI CAL THERAPY	0	2, 895 35, 948		9, 288 115, 334	992 1, 193	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		7, 983		25, 611	265	
68.00 06800 SPEECH PATHOLOGY	0	5, 132	11, 333	16, 465	170	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS 73.01 O7301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00 73. 01
74. 00 07400 RENAL DI ALYSI S		0	0	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	1 0	0	ا ما	٥	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	0	0	0	
90. 00 09000 CLINIC	0	333	736	1, 069		90.00
90.01 09001 VISITING SPECIALTY CLINIC	0			97, 941		90. 01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0			43, 820		
91.00 O9100 EMERGENCY 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	35, 887	79, 251	115, 138 0	3, 986	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
95.00 O9500 AMBULANCE SERVICES	0			0	0	
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS  113.00 11300 INTEREST EXPENSE	1					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	224, 934	491, 882	1, 086, 242	1, 803, 058	27, 504	118. 00
NONREI MBURSABLE COST CENTERS		,	., .,	.,,	,	
190.0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 01
190. 0219002 OUTREACH 190. 0319003 FOUNDATI ON		3, 930 0	0	3, 930 0		190. 02 190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE		0	0	0		190.03
190.05 19005 PAOLI FAMILY PRACTICE	0	Ö	O	Ö		190. 05
190. 06 19006 OTHER PROPERTY	0	24, 843	0	24, 843		190. 06
191. 00 19100 RESEARCH	0	0	0	0		191.00
192.0019200 PHYSICIANS' PRIVATE OFFICES 193.0019300 NONPAID WORKERS	0	0	0	0		192. 00 193. 00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	224, 934	520, 655	1, 086, 242	1, 831, 831	27, 553	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1306

				1	0 12/31/2020	7/14/2021 11:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	
	·	& GENERAL	PLANT		LINEN SERVICE		
		5. 00	7. 00	7. 01	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	1		ı			
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	221 147					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	331, 146	147 107				5.00
7.00	00700 OPERATION OF PLANT	20, 992	147, 127				7.00
7. 01	00701 UTI LI TI ES	6, 745	1 070	-,			7. 01
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	842	1, 078		10, 405		8.00
10.00	01000 DI ETARY	7, 552	3, 390 6, 499			38, 311	9. 00 10. 00
11.00	01100 CAFETERI A	3, 848 3, 216	3, 613		0	1, 613 897	11.00
	01300 NURSING ADMINISTRATION	11, 987	3, 135		0	1, 380	•
	01301 HOUSE SUPERVI SORS	9, 512	3, 133		0	1, 300	1
	01400 CENTRAL SERVI CES & SUPPLY	4, 516	7, 520		0	0	•
	01500 PHARMACY	11, 417	4, 202		0	0	1
	01600 MEDI CAL RECORDS & LI BRARY	410	2, 707		0	672	1
	01700 SOCI AL SERVI CE	0	2, 707		0	0,2	1
	01900 NONPHYSI CI AN ANESTHETI STS	6, 761	0		0	0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0, 701			O.		17.00
30.00	03000 ADULTS & PEDIATRICS	32, 357	26, 510	997	2, 776	6, 579	30. 00
	03100 INTENSIVE CARE UNIT	0	0		_, 0	1	31. 00
	04300 NURSERY	803	899		0	223	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	15, 017	21, 665	816	753	5, 377	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 160	2, 146		165	1	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	31, 377	20, 975		1, 848	5, 206	54.00
60.00	06000 LABORATORY	32, 757	6, 319	238	0	1, 568	60.00
64.00	06400 I NTRAVENOUS THERAPY	2, 304	1, 618	61	0	401	64. 00
65.00	06500 RESPIRATORY THERAPY	8, 085	1, 186	45	0	294	65.00
66.00	06600 PHYSI CAL THERAPY	15, 620	525	555	319	3, 656	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	2, 520	115		71	812	67. 00
	06800 SPEECH PATHOLOGY	1, 621	75	79	46	522	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	419	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	190	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	28, 507	0	0	0	0	
	07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 01
	07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	ı					00.00
	08800 RURAL HEALTH CLINIC	0	0		0		
	08900 FEDERALLY QUALIFIED HEALTH CENTER	1, 445	0		0	0	
	09000  CLINIC   09001  VISITING SPECIALTY CLINIC		137		Ŭ	34	90. 00 90. 01
90.01	09002 PAOLI PRIMARY CARE CLINIC	6, 669 6, 183	12, 510 5, 597		131	3, 105 1, 389	90.01
	09100 EMERGENCY	51, 337	14, 706		4, 296		•
	09200 OBSERVATION BEDS (NON-DISTINCT PART	51, 557	14, 700	334	4, 270	3,030	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	Ö	0				101.00
	SPECIAL PURPOSE COST CENTERS	·	-	<u> </u>	-		
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	330, 169	147, 127	6, 362	10, 405	37, 911	118. 00
	NONREI MBURSABLE COST CENTERS						
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 01
	19002 OUTREACH	471	0	0	0		190. 02
	19003 FOUNDATI ON	0	0	0	0		190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
	19005 PAOLI FAMILY PRACTICE	60	0	0	0		190. 05
190.06	19006 OTHER PROPERTY	446	0	383	0		190. 06
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00		ا ا	_	_	_	_	200.00
201. 00		001 111	0	0	10 405		201. 00
202. 00	TOTAL (sum lines 118 through 201)	331, 146	147, 127	6, 745	10, 405	38, 311	K07. 00

				įτ	0 12/31/2020	Date/Time Pre 7/14/2021 11:	
Cost Center	Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	HOUSE SUPERVI SORS	CENTRAL SERVICES & SUPPLY	21 dili
		10. 00	11. 00	13. 00	13. 01	14. 00	
GENERAL SERVICE CO 1.00 00100 CAP REL COST				T			1. 00
2. 00   00200 CAP REL COST 4. 00   00400 EMPLOYEE BEN 5. 00   00500 ADMI NI STRATI	TS-MVBLE EQUIP NEFITS DEPARTMENT   VE & GENERAL						2. 00 4. 00 5. 00
7. 00 00700 OPERATION OF 7. 01 00701 UTILITIES 8. 00 00800 LAUNDRY & LI 9. 00 00900 HOUSEKEEPING	NEN SERVICE						7. 00 7. 01 8. 00 9. 00
10. 00 01000 DI ETARY		63, 333	27 441				10.00
11.00   01100   CAFETERI A 13.00   01300   NURSI NG   ADMI	NI STRATI ON	0	36, 441 1, 690				11. 00 13. 00
13. 01 01301 HOUSE SUPER\		0	1, 585		12, 346		13. 01
14. 00 01400 CENTRAL SERV	/ICES & SUPPLY	0	0	0	0	71, 196	
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL   RECO	DRDS & LIBRARY	0	1, 433	0	0	5, 408 2	15. 00 16. 00
17. 00 01700 SOCI AL SERVI		Ö	0	Ö	Ö	0	17. 00
19. 00 01900 NONPHYSI CI AN		0	672	0	0	0	19. 00
30. 00 03000 ADULTS & PE	SERVICE COST CENTERS	63, 333	5, 924	25, 159	4, 911	11, 244	30. 00
31. 00 03100 INTENSIVE CA		03, 333	0, 724	23, 139	4, 911	11, 244	31.00
43.00 04300 NURSERY		0	111	495	97	2, 619	43. 00
ANCI LLARY SERVI CE 50. 00 05000 OPERATI NG RO		ol	1 021	7 004	1 202	0	50.00
50. 00 05000 OPERATING RO 52. 00 05200 DELIVERY RO		0	1, 931 799	7, 086 3, 555	1, 383 694	0	52.00
54. 00 05400 RADI OLOGY-DI		0	4, 276			6, 416	
60. 00 06000 LABORATORY	THEDADY	0	4, 244		0	0	60.00
64. 00   06400   I NTRAVENOUS 65. 00   06500   RESPI RATORY		0	307 1, 613		267 0	1, 651 7, 446	64. 00 65. 00
66. 00 06600 PHYSI CAL THE		Ö	1, 782	Ö	Ö	2, 085	
67. 00 06700 OCCUPATI ONAL		0	398		0	463	
68. 00 06800 SPEECH PATHO 71. 00 07100 MEDICAL SUPP	DLOGY PLIES CHARGED TO PATIENTS	0	300	0	0	298 4, 236	68. 00 71. 00
72. 00 07200 I MPL. DEV. 0		0	0	0	0	1, 924	
73.00 07300 DRUGS CHARGE		0	0	0	0	0	73. 00
73. 01   07301   DRUGS CHARGE 74. 00   07400   RENAL DI ALYS		0	0	0	0	0	73. 01 74. 00
75. 00 07500 ASC (NON-DIS		0	0	0	0	0	75.00
76. 97 07697 CARDI AC REHA		0	0	0	0	0	76. 97
OUTPATIENT SERVIC		ol		1 ^		-	00.00
88.00   08800 RURAL HEALTH 89.00   08900 FEDERALLY QU	JALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00 09000 CLINIC	SALLI I EB TIERETTI SETTEN	0	95	Ö	Ö	0	90.00
90. 01 09001 VI SI TI NG SPE		0	1, 596		430	888	90. 01
90. 02 09002 PAOLI PRIMAR 91. 00 09100 EMERGENCY	RY CARE CLINIC	0	1, 190 6, 417		326 4, 028	3, 577 22, 922	
	BEDS (NON-DISTINCT PART	J	0, 417	20,037	4,020	22, 722	92. 00
OTHER REIMBURSABL		-1			-1		
95.00 09500 AMBULANCE SE 101.00 10100 HOME HEALTH		0	0			0	95. 00 101. 00
SPECIAL PURPOSE C		U <sub>I</sub>	0	0	U U		101.00
113. 00 11300   NTEREST EXF	PENSE						113. 00
118. 00 SUBTOTALS (S	SUM OF LINES 1 through 117)	63, 333	36, 363	63, 252	12, 346	71, 179	118. 00
NONREI MBURSABLE C	R, COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
190. 01 19001 VI SI TI NG SPE		0	0	0	Ö		190. 01
190. 0219002 OUTREACH		0	78		0		190. 02
190. 0319003 FOUNDATI ON 190. 0419004 SPRING VALLE	FY FAMILY PRACTICE	0	0	0	0		190. 03 190. 04
190.05 19005 PAOLI FAMILY	/ PRACTICE	0	0	0	0		190.04
190. 06 19006 OTHER PROPER	RTY	0	0	0	0		190. 06
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS'	PRIVATE OFFICES	0	0	0	0		191. 00 192. 00
193. 00 19300 NONPALD WORK		o	0	0	0		193. 00
200.00 Cross Foot A	Adjustments						200. 00
201.00 Negative Cos 202.00 TOTAL (sum I	st Centers ines 118 through 201)	0 63, 333	0 36, 441	0 63, 252	0 12, 346	0 71, 196	201.00
202. 04 TIVIAL (SUIII I	Thes ITO through 201)	03, 333	30, 441	I US, 232	12, 340	/ 1, 190	<u>r</u> uz. 00

Health Financial Systems IU HEALTH PAOLI HOSPITAL

ALLOCATION OF CAPITAL RELATED COSTS

IN Lieu of Form CMS-2552-10

Provider CCN: 15-1306 Period: Worksheet B

From 01/01/2020 Part II 12/31/2020 Date/Time Prepared: 7/14/2021 11:21 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN Subtotal RECORDS & **ANESTHETI STS** LI BRARY 19.00 24.00 15.00 16.00 17.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 UTI LI TI ES 7.01 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 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 13.00 13.01 01301 HOUSE SUPERVI SORS 13.01 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 56, 359 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 25, 085 16.00 17 00 01700 SOCIAL SERVICE 17 00 01900 NONPHYSICIAN ANESTHETISTS 8, 536 19.00 19.00 NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 151 2,001 393, 079 30.00 03100 INTENSIVE CARE UNIT 0 31 00 31.00 0 43.00 04300 NURSERY 78 0 12, 480 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 87 1, 930 С 227, 082 50.00 000 05200 DELIVERY ROOM & LABOR ROOM 52 00 Ω 326 30, 834 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 415 4, 377 243, 983 54.00 06000 LABORATORY 96, 797 60.00 2, 194 60.00 06400 I NTRAVENOUS THERAPY 47 21, 779 64.00 850 64.00 65.00 06500 RESPIRATORY THERAPY 368 29, 324 65 00 66.00 06600 PHYSI CAL THERAPY 570 141,639 66.00 67 00 06700 OCCUPATI ONAL THERAPY 0 116 30, 494 67.00 06800 SPEECH PATHOLOGY 68.00 0 71 19,647 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 66 4,721 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 137 72.00 23 07300 DRUGS CHARGED TO PATIENTS 73.00 55, 264 3, 950 87, 721 73.00 07301 DRUGS CHARGED TO PATIENTS 73.01 73.01 07400 RENAL DIALYSIS 74.00 C 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 07697 CARDIAC REHABILITATION 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 C 90 00 logoool CLT NEC 25 2,928 90.00 0 09001 VISITING SPECIALTY CLINIC C 90.01 367 126, 894 90.01 09002 PAOLI PRIMARY CARE CLINIC 65, 318 90.02 90.02 56 91.00 09100 EMERGENCY 371 7, 717 С 255, 761 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 101. Od10100 HOME HEALTH AGENCY 0101 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56, 359 25, 085 1, 792, 618 118. 00 NONREIMBURSABLE COST CENTERS 0 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 VISITING SPECIALTY CLINIC 0 190. 01 190. 0219002 OUTREACH 190. 0319003 FOUNDATI ON 4, 945 190. 02 0 0 0000 0 190. 03 0 0 190.04 19004 SPRING VALLEY FAMILY PRACTICE 0 190.04 190. 05 19005 PAOLI FAMILY PRACTICE 60 190. 05 190. 06 19006 OTHER PROPERTY 0 25, 672 190. 06 0 191. 00 19100 RESEARCH 0 191.00 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 193. 00 19300 NONPALD WORKERS 0 193.00 200.00 Cross Foot Adjustments 8.536 8, 536 200. 00 201.00 Negative Cost Centers 0 201. 00

56, 359

25.085

8,536

1, 831, 831 202. 00

TOTAL (sum lines 118 through 201)

Health Financial Systems

IU HEALTH PAOLI HOSPITAL

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1306 | Period: From 01/01/2020 | Part II

Date/Time Prepared: 12/31/2020 7/14/2021 11:21 am Cost Center Description Intern & Total esidents Cost Post Stepdown Adjustments 26.00 25, 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 UTI LI TI ES 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9 00 00900 HOUSEKEEPI NG 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01301 HOUSE SUPERVISORS 13.01 13.01 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 01700 SOCIAL SERVICE 17.00 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30 00 393.079 31.00 03100 INTENSIVE CARE UNIT 0 31.00 43.00 04300 NURSERY 12, 480 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 227, 082 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 30, 834 52.00 243, 983 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 0 06000 LABORATORY 96, 797 60.00 60.00 06400 I NTRAVENOUS THERAPY 64.00 21, 779 64 00 0 65.00 06500 RESPIRATORY THERAPY 29, 324 65.00 66.00 06600 PHYSI CAL THERAPY 0 141, 639 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 30, 494 67.00 68.00 06800 SPEECH PATHOLOGY 19.647 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 721 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 2, 137 72.00 07300 DRUGS CHARGED TO PATIENTS 87, 721 73.00 73.00 07301 DRUGS CHARGED TO PATIENTS 73.01 73.01 74.00 07400 RENAL DIALYSIS 74.00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 C 07697 CARDIAC REHABILITATION 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 90.00 09000 CLI NI C 0 2, 928 90.00 09001 VISITING SPECIALTY CLINIC 126, 894 90.01 90.01 90.02 09002 PAOLI PRIMARY CARE CLINIC 0 65, 318 90.02 09100 EMERGENCY 91 00 91.00 255, 761 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 0 95.00 95 00 09500 AMBULANCE SERVICES 101. 00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 1, 792, 618 118 00 118 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 190. 01 19001 VISITING SPECIALTY CLINIC 0 190. 01 0) 190. 02 19002 OUTREACH 4, 945 190 02 190. 03 19003 FOUNDATI ON 190. 03 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190.04 0 190. 05 19005 PAOLI FAMILY PRACTICE 190. 05 60 190. 06 19006 OTHER PROPERTY 190.06 25, 672 191. 00 19100 RESEARCH 191. 00 192. 0019200 PHYSICIANS' PRIVATE OFFICES 192. 00 0 193. 00 19300 NONPALD WORKERS 193 00 200.00 Cross Foot Adjustments 8,536 200. 00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 1,831,831 202.00

	Financial Systems ALLOCATION - STATISTICAL BASIS	IU HEALTH PAC	DLI HOSPITAL Provider C	CN: 15 1204   F	In Lieu Period:	u of Form CMS-2 Worksheet B-1	
CU31 F	ALLOCATION - STATISTICAL BASIS		Provider C	F	rom 01/01/2020		
		CADITAL DEL	LATED COSTS		T 12/31/2020	7/14/2021 11:	
			LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1. 00	2.00	SALARIES) 4.00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT	59, 353	1	Ι	ı	Ι	1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	34, 333	56, 073				2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	979 3, 660	•			18, 449, 395	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	4, 436				1, 169, 516	7. 00
7. 01	00701 UTILITIES	0	0	C	0	375, 792	7. 01
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	300 943		223, 861	0	46, 900 420, 731	
10.00	01000 DI ETARY	1, 808	1, 808	77, 918	0	214, 402	10. 00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1, 005 1, 547		93, 821 418, 843	0	179, 157 667, 828	
13. 01	01301 HOUSE SUPERVI SORS	0		398, 793		529, 955	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	2, 092		249 247	0	251, 577	14. 00 15. 00
	01600 MEDI CAL RECORDS & LI BRARY	1, 169 753		268, 267 C	Ö	636, 082 22, 852	
	01700 SOCI AL SERVI CE	0		0.40.014	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	348, 314	<u> </u>	376, 705	19. 00
30.00	03000 ADULTS & PEDIATRICS	7, 375	1	1, 140, 379		.,,	
	03100 INTENSIVE CARE UNIT 04300 NURSERY	0 250		25, 460	0	0 44, 744	31. 00 43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	05000  OPERATING ROOM   05200  DELIVERY ROOM & LABOR ROOM	6, 027 597	6, 027 597	450, 837 182, 748		836, 652 287, 461	50. 00 52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 835				1, 748, 103	
60. 00 64. 00	06000   LABORATORY   06400   INTRAVENOUS THERAPY	1, 758 450			0	1, 824, 979 128, 388	
65. 00	06500 RESPIRATORY THERAPY	330				450, 453	
66.00	06600 PHYSI CAL THERAPY	4, 098	· ·	380, 927		870, 269	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	910 585		84, 571 54, 415		140, 406 90, 327	67. 00 68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		C	0	23, 319	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	10, 593 1, 588, 240	
73.01	07301 DRUGS CHARGED TO PATIENTS	Ö	ő	Ö	ő	0	73. 01
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	74. 00 75. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	
00.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		1 0	1 6	1 0	1 0	00.00
88. 00 89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	88. 00 89. 00
90.00	09000 CLINIC	38		37, 669		80, 482	90.00
	09001 VISITING SPECIALTY CLINIC 09002 PAOLI PRIMARY CARE CLINIC	3, 480 1, 557				371, 578 344, 503	
91.00	09100 EMERGENCY	4, 091			Ö	2, 860, 256	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95.00	09500 AMBULANCE SERVICES	0		C	0	0	95. 00
101. 00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	101.00
	11300 I NTEREST EXPENSE	l					113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	56, 073	56, 073	8, 778, 592	-7, 847, 888	18, 394, 946	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С	0	0	190. 00
	19001 VISITING SPECIALTY CLINIC	0		15 (77	0		190. 01
	19002 OUTREACH 19003 FOUNDATI ON	448	0	15, 677 0	0	26, 233 0	190. 02 190. 03
190. 04	19004 SPRING VALLEY FAMILY PRACTICE	0	0	C	0	1	190. 04
	19005 PAOLI FAMILY PRACTICE 19006 OTHER PROPERTY	0 2, 832	0	0	0	3, 347 24, 869	190. 05 190. 06
191.00	19100 RESEARCH	0	Ö		Ö	0	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0	0	0		192. 00 193. 00
200. 00		I	ĺ		Ī		200. 00
201. 00 202. 00		E20 455	1 004 242	2 2/1 170		7 047 000	201.00
202.00	Cost to be allocated (per Wkst. B, Par	t 520, 655	1, 086, 242	2, 241, 170		7, 847, 888	ZUZ. UU
203. 00	Unit cost multiplier (Wkst. B, Part I)	8. 772177	19. 371926	0. 254844		0. 425374	203. 00

Heal th Financia	I Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	u of Form CMS-2	<u> 2552-10</u>
COST ALLOCATION	N - STATISTICAL BASIS		Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Pre 7/14/2021 11:	epared:
		CAPI TAL REL	LATED COSTS				
Cos	st Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2. 00	4. 00	5A	5. 00	
204. 00 Cos	st to be allocated (per Wkst. B, Par	t		27, 553	3	331, 146	204. 00
206. 00 NAH (pe	t cost multiplier (Wkst. B, Part II HE adjustment amount to be allocated er Wkst. B-2)			0. 003133	3		206. 00
	HE unit cost multiplier (Wkst. D, rts III and IV)						207. 00

12/31/2020 Date/Time Prepared: 7/14/2021 11:21 am Cost Center Description OPERATION OF UTI LI TI ES LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE PLANT (SQUARE FEET) (SQUARE FEET) (MEALS SERVED) (POUNDS OF (SQUARE FEET) LAUNDRY) 7.00 7.01 8.00 9.00 10.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 40, 929 7.00 7.01 00701 UTI LI TI ES 49,830 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 300 300 11, 186 8.00 9 00 00900 HOUSEKEEPI NG 943 42.942 9 00 943 4,602 10.00 01000 DI ETARY 1,808 1,808 0 1, 808 10.00 1,005 11.00 01100 CAFETERI A 1,005 1,005 0 11.00 13.00 01300 NURSING ADMINISTRATION 872 1,547 1,547 0 13.00 01301 HOUSE SUPERVI SORS 13.01 0 13.01 01400 CENTRAL SERVICES & SUPPLY 14.00 2,092 2,092 0 14.00 15.00 01500 PHARMACY 1, 169 1, 169 0 15.00 01600 MEDICAL RECORDS & LIBRARY 753 16 00 753 16 00 753 0 01700 SOCIAL SERVICE 17.00 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 375 7, 375 2, 984 7, 375 4,602 30 00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 43.00 04300 NURSERY 250 250 250 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 6,027 6, 027 810 6,027 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 597 597 177 597 0 52.00 5,835 05400 RADI OLOGY-DI AGNOSTI C 5.835 5.835 1, 987 54.00 0 54.00 06000 LABORATORY 1, 758 1, 758 1, 758 60.00 60.00 0 64.00 06400 INTRAVENOUS THERAPY 450 450 450 0 64 00 65.00 06500 RESPIRATORY THERAPY 330 330 330 0 65.00 66.00 06600 PHYSI CAL THERAPY 146 4, 098 343 4, 098 66.00 06700 OCCUPATI ONAL THERAPY 67.00 32 910 910 0 67.00 76 68.00 06800 SPEECH PATHOLOGY 21 585 49 585 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 C 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 C 0 73.00 07301 DRUGS CHARGED TO PATIENTS 73.01 0 73.01 07400 RENAL DIALYSIS 74.00 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 75.00 0 07697 CARDIAC REHABILITATION 76.97 0 76.97 DUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 C 0 89.00 90.00 09000 CLI NI C 38 38 38 0 90.00 09001 VISITING SPECIALTY CLINIC 3, 480 3, 480 90.01 90.01 3, 480 141 90.02 09002 PAOLI PRIMARY CARE CLINIC 1, 557 1, 557 1,557 90.02 0 91 00 09100 EMERGENCY 91.00 4, 091 4,091 4,619 4,091 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95 00 09500 AMBULANCE SERVICES C 0 101. 00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 40, 929 46, 998 11, 186 42, 494 4, 602 118. 00 118 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 01 19001 VISITING SPECIALTY CLINIC 0 190. 01 C 190. 02 19002 OUTREACH 0 190.02 448 190. 03 19003 FOUNDATI ON 0190.03 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 190.04 190. 05 19005 PAOLI FAMILY PRACTICE 0 190.05 190. 06 19006 OTHER PROPERTY 0190.06 2.832 191. 00 19100 RESEARCH 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 193. 00 19300 NONPALD WORKERS 0193 00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 425, 969 202. 00 202.00 Cost to be allocated (per Wkst. B, Part 1, 666, 998 648, 243 535, 644 82, 294 1) 203.00 Unit cost multiplier (Wkst. B, Part I 40. 729019 10.749428 7. 356875 15.095780 92. 561712 203. 00 63, 333 204. 00 204.00 Cost to be allocated (per Wkst. B, Par 147, 127 6,745 10, 405 38, 311  $\Pi$ 205.00 3.594688 0.135360 0.930181 0.892157 13. 762060 205. 00 Unit cost multiplier (Wkst. B, Part II)

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2020		
			]	o 12/31/2020	Date/Time Pre 7/14/2021 11:	epared: 21 am
Cost Center Description	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	(SQUARE FEET)	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)		(POUNDS OF			
			LAUNDRY)			
	7.00	7. 01	8.00	9. 00	10.00	
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH PAC		20N, 1E 1204   D		of Form CMS-2 Worksheet B-1	
CUST ALLUCATION - STATISTICAL DASIS		Provider C		eriod: rom 01/01/2020 o 12/31/2020	Date/Time Pre	epared:
Cost Center Description	CAFETERI A	NURSI NG	HOUSE	CENTRAL	7/14/2021 11: PHARMACY	21 am
	(MAN HOURS)	ADMINISTRATION	SUPERVISORS (DIRECT NRSING	SERVICES & SUPPLY	(COSTED REQUIS.)	
		HRS)	HRS)	(COSTED	KEQUI 3. )	
	11. 00	13. 00	13. 01	REQUIS.) 14.00	15. 00	
GENERAL SERVICE COST CENTERS		10.00		00	.0.00	
1. 00   00100 CAP REL COSTS-BLDG & FIXT 2. 00   00200 CAP REL COSTS-MVBLE EQUIP			ł			1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT						5. 00 7. 00
7. 01   00700  0FERATION OF FEANT 7. 01   00701   UTILITIES						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900 HOUSEKEEPI NG 10. 00   01000 DI ETARY			1			9. 00 10. 00
11. 00 01100 CAFETERI A	225, 481					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	10, 459	1				13. 00
13. 01   01301   HOUSE SUPERVI SORS 14. 00   01400   CENTRAL SERVI CES & SUPPLY	9, 807 0	C	,	391, 923		13. 01 14. 00
15. 00 01500 PHARMACY	8, 867	i c	ő	29, 772	1, 619, 693	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	1	0	11	0	16. 00
17. 00   01700   SOCI AL SERVI CE 19. 00   01900   NONPHYSI CI AN ANESTHETI STS	4, 160	C	1	0	0 351	17. 00 19. 00
INPATIENT ROUTINE SERVICE COST CENTERS	4, 100		<u> </u>	o <sub>l</sub>		1
30. 00 03000 ADULTS & PEDI ATRI CS	36, 652	34, 973		61, 899	4, 335	1
31. 00   03100   I NTENSI VE CARE UNIT 43. 00   04300   NURSERY	0 689	1	1	14, 417	0 136	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS				,		10.00
50. 00   05000   OPERATI NG ROOM 52. 00   05200   DELI VERY ROOM & LABOR ROOM	11, 947 4, 945	9, 850		0	2, 488	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   54. 00   05400   RADI OLOGY-DI AGNOSTI C	26, 457	4, 941 1, 498		35, 319	0 11, 930	52. 00 54. 00
60. 00 06000 LABORATORY	26, 262	C	O	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	1, 901 9, 981	1, 901	1, 901 0	9, 088	1, 337	64.00
66. 00   06600 PHYSI CAL THERAPY	11, 026	1	-	40, 989 11, 476	206 9	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 465	C	o	2, 548	2	67. 00
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 854 0	C	0	1, 639 23, 318	1	68. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		C		10, 592	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	1, 588, 240	•
73. 01   07301   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DI ALYSI S	0	C		0	0	
75.00 07500 ASC (NON-DISTINCT PART)	Ö	1	· -		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	C	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS  88. 00   08800   RURAL   HEALTH   CLINIC	1 0		ol l	ol	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	Č	Ö	Ö	0	89. 00
90. 00   09000   CLINI C	590		0	0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC 90.02 09002 PAOLI PRIMARY CARE CLINIC	9, 875 7, 363			4, 886 19, 693	0 7	90. 01 90. 02
91. 00 09100 EMERGENCY	39, 701			126, 183	10, 651	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES	0	C	ol ol	O	0	95. 00
101. 00 10100 HOME HEALTH AGENCY	0		1	0	0	101. 00
SPECIAL PURPOSE COST CENTERS  113. 0011300   NTEREST EXPENSE	Ι	ı	1			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	225, 001	87, 921	87, 921	391, 830	1, 619, 693	•
NONREI MBURSABLE COST CENTERS						]
190.0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.0119001 VISITING SPECIALTY CLINIC	0	· ·	1	0		190. 00 190. 01
190. 02 19002 OUTREACH	480			93		190. 01
190. 03 19003 FOUNDATI ON	0	C	o	Ō	0	190. 03
190.0419004 SPRING VALLEY FAMILY PRACTICE 190.0519005 PAOLI FAMILY PRACTICE	0	C		0		190. 04 190. 05
190. 06 19006 OTHER PROPERTY	0			0		190. 05 190. 06
191. 00 19100 RESEARCH	0	ď	o o	o	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C	0	0		192.00
193. OQ19300 NONPALD WORKERS 200. OQ	0		ή	0		193. 00 200. 00
201.00 Negative Cost Centers	I	1	1			201.00

1. 429269

36, 441

1, 042, 352

11. 855552

63, 252

769, 401

8. 751049

12, 346

466, 284

1. 189734 71, 196

201. 00 1, 014, 927 202. 00

0. 626617 203. 00 56, 359 204. 00

H)

201.00 202.00

203. 00 204. 00

Cross Foot Adjustments
Negative Cost Centers
Cost to be allocated (per Wkst. B, Part

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

Health Fina	ncial Systems	IU HEALTH PAC	LI HOSPITAL		In Lieu	of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2020	Worksheet B-1	
					Fo 12/31/2020		
	Cost Center Description	CAFETERI A	NURSI NG	HOUSE	CENTRAL	PHARMACY	
		(MAN HOURS)	ADMINI STRATI ON	SUPERVI SORS	SERVICES &	(COSTED	
			(DIRECT NRSING	(DIRECT NRSIN	SUPPLY	REQUIS.)	
			HRS)	HRS)	(COSTED		
					REQUIS.)		
		11. 00	13. 00	13. 01	14. 00	15. 00	
205. 00	Unit cost multiplier (Wkst. B, Part II	0. 161615	0. 719419	0. 140422	0. 181658	0. 034796	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/14/2021 11: 21 am Provi der CCN: 15-1306

				7/14/2021 11:	21 am
Cost Center Description	MEDICAL RECORDS	SSOCIAL SERVICE	NONPHYSI CI AN		
	& LI BRARY	(TIME SPENT)	ANESTHETI STS		
	GROSS CHARGES		(ASSI GNED		
	Ì	1	`TIME)		
	16. 00	17. 00	19. 00		
GENERAL SERVICE COST CENTERS					
1.00 O0100 CAP REL COSTS-BLDG & FLXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
7.00 O0700 OPERATION OF PLANT					7. 00
7. 01  00701 UTI LI TI ES					7. 01
8.00   00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY		1			10.00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13. 00
					•
13. 01 01301 HOUSE SUPERVI SORS					13. 01
14.00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00   01500   PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	64, 333, 698	1			16. 00
17. 00 01700 SOCIAL SERVICE	0	0			17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	1 0	ا ما	100		19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	•		100		1 55
30. 00 03000 ADULTS & PEDIATRICS	5, 130, 583	O	ol		30.00
		1	· ·		10
31. 00   03100   I NTENSI VE CARE UNI T	0	1	0		31.00
43. 00 04300 NURSERY	200, 764	0	0		43. 00
ANCILLARY SERVICE COST CENTERS					4
50.00   05000   OPERATING ROOM	4, 948, 039	1	100		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	835, 249	0	0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 222, 796	0	ol		54.00
60. 00 06000 LABORATORY	5, 626, 497	1	0		60.00
64. 00 06400 I NTRAVENOUS THERAPY	2, 179, 291	1	Ô		64. 00
			0		•
	943, 060	1	U		65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 460, 695	1	U		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	296, 321	1	0		67. 00
68.00 06800 SPEECH PATHOLOGY	181, 690	0	0		68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	168, 512	0	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	58, 535	0	o		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 128, 041	1	ol		73. 00
73. 01 07301 DRUGS CHARGED TO PATIENTS	10, 120, 011	Ĭ	Ŏ		73. 01
74. 00 07400 RENAL DI ALYSI S			0		74. 00
	0		U		•
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	U		75. 00
76.97 O7697 CARDIAC REHABILITATION	0	0	0		76. 97
OUTPATIENT SERVICE COST CENTERS		,			4
88.00 08800 RURAL HEALTH CLINIC	0	0	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89. 00
90. 00  09000 CLINIC	63, 498	0	0		90.00
90.01 09001 VISITING SPECIALTY CLINIC	940, 484	. 0	o		90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	142, 597		o		90. 02
91. 00 09100 EMERGENCY	19, 807, 046		o o		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	17,007,040	Ĭ			1
					92. 00
OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES	1 0	J	٥١		1 05 00
	0		0		95.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0		101. 00
SPECIAL PURPOSE COST CENTERS	_				1
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 64, 333, 698	0	100		118. 00
NONREI MBURSABLE COST CENTERS					1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
190. 01 19001 VI SI TING SPECIALTY CLINIC	0	Ö	ol		190. 01
190. 0219002 OUTREACH		_	٥		190. 02
190. 0319003 FOUNDATI ON					190. 02
			0		
190. 0419004 SPRING VALLEY FAMILY PRACTICE	1 0	] 0	0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	1 0	l 이	이		190. 05
190.06 19006 OTHER PROPERTY	0	이	0		190. 06
191. 00 19100 RESEARCH	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	ol	o		192. 00
193. 00 19300 NONPALD WORKERS	0	o	o		193. 00
200.00 Cross Foot Adjustments	I	]	1		200.00
201.00 Negative Cost Centers	1				201.00
1 1 3	02 714		E40 110		•
202.00 Cost to be allocated (per Wkst. B, Pa	art 82, 716	0	543, 112		202. 00
			F 404 1000		
203.00 Unit cost multiplier (Wkst. B, Part			5, 431. 120000		203. 00
204.00 Cost to be allocated (per Wkst. B, Pa	art 25, 085	0	8, 536		204. 00
	1				
205.00 Unit cost multiplier (Wkst. B, Part	0. 000390	0. 000000	85. 360000		205. 00

Health Fina	ncial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C		Peri od: From 01/01/2020	Worksheet B-1	1
						Date/Time Pre 7/14/2021 11:	epared: 21 am
	Cost Center Description	IEDI CAL RECORDS	SOCIAL SERVICE	NONPHYSI CI AN			
		& LI BRARY	(TIME SPENT)	ANESTHETI STS	5		
		GROSS CHARGES		(ASSI GNED			
				TIME)			
		16. 00	17. 00	19. 00			
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	1	U HEALTH PAOL	_I HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGE	GES		Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/14/2021 11:	epared: 21 am
			Title	XVIII	Hospi tal	Cost	
					Costs		
Cost Center Description		Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(f	rom Wkst. B,	Adj .		Di sal I owance		
	P	Part I, col.					
	_	26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST	CENTERS						
30.00 03000 ADULTS & PEDIATRICS		4, 364, 445		4, 364, 44	1	0	
31.00 03100 INTENSIVE CARE UNIT		0		,	0	0	31. 00
43. 00 04300 NURSERY		113, 078		113, 07	8 0	0	43. 00
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM		2, 370, 828		2, 370, 82		0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	И	560, 744		560, 74		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		3, 027, 392		3, 027, 39		0	
60. 00   06000   LABORATORY		2, 763, 086		2, 763, 08		0	
64. 00 06400 I NTRAVENOUS THERAPY		269, 302		269, 30		0	
65. 00 06500 RESPI RATORY THERAPY		728, 408	0	· ·	1	0	65.00
66. 00 06600 PHYSI CAL THERAPY		1, 386, 138	0	,	1	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		232, 448	0	232, 44		0	
68. 00 06800 SPEECH PATHOLOGY	FO DATI FAITO	149, 919	0	149, 91		0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED T		61, 197		61, 19		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATI	ENIS	27, 776		27, 77			,
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07301 DRUGS CHARGED TO PATIENTS		3, 272, 079		3, 272, 07	0	0	
73. 01 07301 DRUGS CHARGED TO PATTENTS 74. 00 07400 RENAL DI ALYSI S		0					
75. 00 07500 ASC (NON-DISTINCT PART)		0				0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0				0	
OUTPATIENT SERVICE COST CENTERS		U			J U	U	70.97
88. 00 08800 RURAL HEALTH CLINIC		0			0 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH	1 CENTER	0		l .		0	
90. 00 09000 CLINIC	CENTER	118, 172		118, 17	9	0	
90.01 09001 VISITING SPECIALTY CLINIC		846, 524		846, 52		0	
90. 02 09002 PAOLI PRIMARY CARE CLINIC		676, 711		676, 71	1	0	
91. 00 09100 EMERGENCY		5, 213, 423		5, 213, 42		0	
92.00 09200 OBSERVATION BEDS (NON-DIST	TINCT PART	1, 507, 451		1, 507, 45		0	
OTHER REIMBURSABLE COST CENTERS		1,007,101		1,007,10	• 1		72.00
95. 00 09500 AMBULANCE SERVICES		0			0	0	95. 00
101.0010100 HOME HEALTH AGENCY		o			ol	0	101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	-1			-1		
113. 00 11300   NTEREST EXPENSE							113. 00
200.00 Subtotal (see instructions	s)	27, 689, 121	0	27, 689, 12	1 o	0	200. 00
201.00 Less Observation Beds		1, 507, 451		1, 507, 45			201. 00
202.00 Total (see instructions)		26, 181, 670	0		1		202. 00
, , ,	•			-	- '		-

Health Financial Systems	IU HEALTH PAO	II HOSPITAI		In lieu	of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			l F	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I	epared:
			e XVIII	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 CENT	ERS					
30. 00 03000 ADULTS & PEDIATRICS	2, 003, 131		2, 003, 131	1		30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
43. 00 04300 NURSERY	200, 764		200, 764	1		43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	436, 055	4, 511, 984	4, 948, 039	0. 479145	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	502, 944	332, 305	835, 249	0. 671350	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	244, 494	10, 978, 302	11, 222, 796	0. 269754	0.000000	54.00
60. 00 06000 LABORATORY	489, 887	5, 136, 610	5, 626, 497	0. 491085	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	2, 179, 291	2, 179, 29	0. 123573	0.000000	64.00
65. 00 06500 RESPIRATORY THERAPY	221, 470	721, 590	943, 060	0. 772388	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	216, 591	1, 244, 104	1, 460, 695	0. 948958	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	49, 286	247, 035	296, 32	0. 784447	0. 000000	67. 00
68.00 06800 SPEECH PATHOLOGY	6, 820	174, 870	181, 690	0. 825136	0. 000000	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO P.	ATIENTS 9, 765	158, 747	168, 512	0. 363161	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	S 0	58, 535	58, 535	0. 474520	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 481, 643	8, 646, 398	10, 128, 04	0. 323071	0.000000	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	C	)	0. 000000	0.000000	73. 01
74.00 07400 RENAL DIALYSIS	0	C	)	0. 000000	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	)	0. 000000	0.000000	75. 00
76. 97 07697 CARDIAC REHABILITATION	0	C	) (	0. 000000	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C	(			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CE	NTER 0	C	(			89. 00
90. 00  09000   CLINIC	0	63, 498	63, 498	1. 861035	0. 000000	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	940, 484	940, 484	0. 900094	0. 000000	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	142, 597			0. 000000	90. 02
91.00 09100 EMERGENCY	226, 271	19, 580, 775	19, 807, 046	0. 263211	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINC	T PART 9, 077	3, 118, 375	3, 127, 452	0. 482006	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	C	(	0. 000000	0. 000000	95.00
101.0010100 HOME HEALTH AGENCY	0	C	)			101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	6, 098, 198	58, 235, 500	64, 333, 698	3 <b> </b>		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	6, 098, 198	58, 235, 500	64, 333, 698	3		202. 00

Health Financial Systems	III UEALTU DAOLI	HOCDI TAI	In Liou	of Form CMS	2552 10
Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	IU HEALTH PAOLI	Provi der CCN: 15-1306	Period: From 01/01/2020	of Form CMS-: Worksheet C Part I Date/Time Pro 7/14/2021 11:	
		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
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					1
50. 00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
64, 00 06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65, 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0. 000000				73. 01
74. 00 07400 RENAL DIALYSIS	0. 000000				74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
OUTPATIENT SERVICE COST CENTERS	0. 000000				1 / 0. //
88. 00 08800 RURAL HEALTH CLINIC					88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00 109000 CLINIC	0. 000000				90.00
90. 01 09001 VISITING SPECIALTY CLINIC	0. 000000				90. 01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000				90. 02
91. 00 09100 EMERGENCY	0.000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92. 00
OTHER REIMBURSABLE COST CENTERS	0.000000				12.00
95. 00 09500 AMBULANCE SERVICES	0. 000000				95. 00
101. 0010100 HOME HEALTH AGENCY	0.000000				101.00
SPECIAL PURPOSE COST CENTERS					101.00
113. 0011300 I NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)	1				200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					202.00
202. 09   10101 (300 111311 0011 0113)	1				FUZ. 00

Health Financial Systems	IU HEALTH PAOI	LI HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CN: 15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet C	
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.	·				
	26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				•		
30. 00 03000 ADULTS & PEDI ATRI CS	4, 364, 445		4, 364, 44	5 0	4, 364, 445	30. 00
31.00 03100 INTENSIVE CARE UNIT	0			o o	0	31.00
43. 00 04300 NURSERY	113, 078		113, 07	8 0	113, 078	43. 00
ANCILLARY SERVICE COST CENTERS						Ī
50.00 05000 OPERATING ROOM	2, 370, 828		2, 370, 82	8 0	2, 370, 828	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	560, 744		560, 74	4 0	560, 744	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 027, 392		3, 027, 39	2 0	3, 027, 392	54.00
60. 00 06000 LABORATORY	2, 763, 086		2, 763, 08		2, 763, 086	60.00
64.00 06400 INTRAVENOUS THERAPY	269, 302		269, 30		269, 302	
65. 00 06500 RESPIRATORY THERAPY	728, 408	0			728, 408	
66. 00 06600 PHYSI CAL THERAPY	1, 386, 138	0	· ·		1, 386, 138	
67. 00 06700 OCCUPATI ONAL THERAPY	232, 448	0	232, 44		232, 448	
68.00 06800 SPEECH PATHOLOGY	149, 919	0	149, 91		149, 919	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 197	· ·	61, 19		61, 197	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	27, 776		27, 77		27, 776	
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 272, 079		3, 272, 07		3, 272, 079	
73. 01 07301 DRUGS CHARGED TO PATIENTS	0, = 1 = , 0 1		1 0, = 1 = 7 0 1	0	0	1
74. 00 07400 RENAL DI ALYSI S	Ô			0	0	
75. 00 07500 ASC (NON-DISTINCT PART)	Ô			0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	Ô			0	0	
OUTPATIENT SERVICE COST CENTERS	۷۱			<u> </u>	J	1
88. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	
90. 00 09000 CLINIC	118, 172		118, 17	2 0	118, 172	
90. 01 09001 VISITING SPECIALTY CLINIC	846, 524		846, 52		846, 524	
90. 02 09002 PAOLI PRIMARY CARE CLINIC	676, 711		676, 71		676, 711	
91. 00 09100 EMERGENCY	5, 213, 423		5, 213, 42		5, 213, 423	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 507, 451		1, 507, 45		1, 507, 451	•
OTHER REIMBURSABLE COST CENTERS	., 00,,, 10,,		1,007,10	•	1,007,101	1 /2:00
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95. 00
101. 00 10100 HOME HEALTH AGENCY	0			0	_	101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>		1
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	27, 689, 121	0	27, 689, 12	1 0	27, 689, 121	
201. 00 Less Observation Beds	1, 507, 451	O	1, 507, 45		1, 507, 451	
202.00 Total (see instructions)	26, 181, 670	0				
	20, 101, 010	O	25, 151, 67	-1	20, 101, 070	

Health Financial Systems	IU HEALTH PAO	II HOSPITAL		Inlie	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	76 11212111 1116	Provi der C		Peri od: From 01/01/2020	Worksheet C	epared:
		Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	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 & PEDI ATRI CS	2, 003, 131		2, 003, 13	1		30.00
31.00 03100 INTENSIVE CARE UNIT	0		l .	0		31. 00
43. 00 04300 NURSERY	200, 764		200, 76	4		43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	436, 055	4, 511, 984			0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	502, 944	332, 305			0. 000000	
54. 00   05400 RADI OLOGY-DI AGNOSTI C	244, 494	10, 978, 302			0. 000000	
60. 00   06000   LABORATORY	489, 887	5, 136, 610			0. 000000	
64.00 06400 INTRAVENOUS THERAPY	0	2, 179, 291			0. 000000	
65. 00 06500 RESPIRATORY THERAPY	221, 470	721, 590			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	216, 591	1, 244, 104			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	49, 286	247, 035			0. 000000	
68.00 06800 SPEECH PATHOLOGY	6, 820	174, 870			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 765	158, 747			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	58, 535			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 481, 643	8, 646, 398			0. 000000	
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	
74. 00 07400 RENAL DI ALYSI S	0	0	1	0. 000000	0. 000000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	1	0. 000000	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0. 000000	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	0	0	l .	0. 000000	0. 000000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	l .	0. 000000	0. 000000	
90. 00 09000 CLINIC	0	63, 498			0. 000000	
90. 01 09001 VISITING SPECIALTY CLINIC	0	940, 484			0. 000000	
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	142, 597			0. 000000	
91. 00 09100 EMERGENCY	226, 271	19, 580, 775			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 077	3, 118, 375	3, 127, 45	2 0. 482006	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS	l al		i	0 000000	0.000000	05 00
95. 00 09500 AMBULANCE SERVICES	0	0	b .	0. 000000	0. 000000	
101. 00 10100 HOME HEALTH AGENCY	U	0		U		101. 00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   NTEREST EXPENSE	1		1			112 00
	4 000 100	E0 33E E00	64 222 40			113. 00 200. 00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	6, 098, 198	58, 235, 500	64, 333, 69	0		200. 00 201. 00
	4 000 100	E0 33E E00	64 222 40			
202.00   Total (see instructions)	6, 098, 198	58, 235, 500	64, 333, 69	<b>ા</b>		202. 00

ealth Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lieu	of Form CMS-	-2552 - 1
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1306	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pr 7/14/2021 11	epared
		Title XIX	Hospi tal	PPS	. 21 am
Cost Center Description	PPS Inpatient		1		
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
0.00 03000 ADULTS & PEDIATRICS					30.0
1.00 03100 INTENSIVE CARE UNIT					31.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
0.00   05000   OPERATING ROOM	0. 479145				50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 671350				52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 269754				54.0
0. 00  06000 LABORATORY	0. 491085				60.0
4.00 06400 INTRAVENOUS THERAPY	0. 123573				64. C
5. 00 06500 RESPIRATORY THERAPY	0. 772388				65.0
6. 00 06600 PHYSI CAL THERAPY	0. 948958				66.0
7. 00 06700 OCCUPATI ONAL THERAPY	0. 784447				67.0
8.00 06800 SPEECH PATHOLOGY	0. 825136				68. C
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 363161				71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 474520				72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 323071				73.0
3.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000				73.0
4.00 07400 RENAL DIALYSIS	0. 000000				74. 0
5.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.0
6.97 07697 CARDIAC REHABILITATION	0. 000000				76. 9
OUTPATIENT SERVICE COST CENTERS					
8.00 08800 RURAL HEALTH CLINIC	0. 000000				88. 0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 0
0. 00  09000   CLI NI C	1. 861035				90.0
O.01 09001 VISITING SPECIALTY CLINIC	0. 900094				90. (
O.02 09002 PAOLI PRIMARY CARE CLINIC	4. 745619				90. (
1. 00 09100 EMERGENCY	0. 263211				91. 0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 482006				92.0
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES	0. 000000				95.0
01.0010100 HOME HEALTH AGENCY					<b>_</b> 101. 0
SPECIAL PURPOSE COST CENTERS					
13. 00 11300 I NTEREST EXPENSE					113. 0
00.00 Subtotal (see instructions)					200. 0
01.00 Less Observation Beds					201. 0
02.00 Total (see instructions)					202. 0

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provi der C	F	Period: From 01/01/2020	Worksheet C Part II Date/Time Pre	epared:
			VI V		7/14/2021 11:	21 am
	1 =		e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	(Wkst. B, Part				Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 ·	-	Amount	
			col. 2)			
	1. 00	2.00	3. 00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000 OPERATING ROOM	2, 370, 828	227, 082	2, 143, 746	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	560, 744	30, 834	529, 910	0	0	52.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	3, 027, 392	243, 983	2, 783, 409	0	0	54.00
60. 00 06000 LABORATORY	2, 763, 086	96, 797	2, 666, 289	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	269, 302	21, 779	247, 523	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	728, 408	29, 324	699, 084	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 386, 138	141, 639	1, 244, 499	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	232, 448	30, 494			0	67. 00
68. 00 06800 SPEECH PATHOLOGY	149, 919	19, 647	130, 272	2	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 197	4, 721	56, 476	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	27, 776				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 272, 079	•	· ·		0	73. 00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	1	ol o	0	
74. 00 07400 RENAL DI ALYSI S	0	0	1 6	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	Ö	0			l ő	75. 00
73. 00   07300  730 (100   07371101   7747)	I	0	1	1	l ĕ	73.00

0

118, 172

846, 524

676, 711

5, 213, 423

1,507,451

23, 211, 598

1, 507, 451

21, 704, 147

115, 244

719, 630

611, 393

4, 957, 662

1, 371, 684

21, 688, 772

1, 371, 684

20, 317, 088

0 76.97

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0 89.00

0 90. 01

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0 91.00

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0

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88.00

90.00

90.02

95.00

113. 00

<u>0</u>101.00

0 200.00

0 201. 00 0 202. 00

2, 928

126, 894

65, 318

255, 761

135, 767

1, 522, 826

1, 387, 059

135, 767

09000 CLINIC

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

101. 00 10100 HOME HEALTH AGENCY

113. 00 11300 I NTEREST EXPENSE

OUTPATIENT SERVICE COST CENTERS

09001 VISITING SPECIALTY CLINIC

09002 PAOLI PRIMARY CARE CLINIC

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

SPECIAL PURPOSE COST CENTERS

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (sum of lines 50 thru 199)

Total (line 200 minus line 201)

07697 CARDIAC REHABILITATION

08800 RURAL HEALTH CLINIC

76.97

88.00

89.00

90.00

90.01

90.02

91.00

92.00

200.00

201.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL	In Lieu	of Form CMS-25	52-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F REDUCTIONS FOR MEDICALD ONLY	RATIOS NET OF	Provider CCN: 15-1306	From 01/01/2020	Worksheet C Part II Date/Time Prep 7/14/2021 11:2	
		Title XIX	Hospi tal	PPS	
Cost Center Description		Total Charges Outpatien			

		Ti +I	e XIX	Hospi tal	PPS	. Z I dili
Cost Center Description	Cost Net of	Total Charges		Поэрг саг	113	
oost conten bescription		(Worksheet C,				
	Operating Cost					
	Reduction	8)	/ col . 7)			
	6. 00	7.00	8.00			· I
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 370, 828	4, 948, 039	0. 479145			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	560, 744					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 027, 392			•		54.00
60. 00 06000 LABORATORY	2, 763, 086			•		60.00
64.00 06400 INTRAVENOUS THERAPY	269, 302					64.00
65. 00 06500 RESPIRATORY THERAPY	728, 408					65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 386, 138		0. 948958			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	232, 448			1		67. 00
68. 00 06800 SPEECH PATHOLOGY	149, 919			,		68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 197			İ		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	27, 776					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 272, 079					73. 00
73. 01 07301 DRUGS CHARGED TO PATLENTS	0	0	0. 000000			73. 01
74.00 07400 RENAL DIALYSIS	0	0	0. 000000	•		74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 000000			75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0	0. 000000	)		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000	o <b>j</b>		89. 00
90. 00 09000 CLINIC	118, 172	63, 498	1. 861035			90.00
90.01 09001 VISITING SPECIALTY CLINIC	846, 524	940, 484	0. 900094			90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	676, 711	142, 597	4. 745619	· i		90. 02
91. 00 09100 EMERGENCY	5, 213, 423	19, 807, 046	0. 263211			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 507, 451	3, 127, 452	0. 482006			92. 00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0. 000000	)		95. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0. 000000	)		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (sum of lines 50 thru 199)	23, 211, 598			1		200. 00
201.00 Less Observation Beds	1, 507, 451					201. 00
202.00 Total (line 200 minus line 201)	21, 704, 147	62, 129, 803				202. 00

Health Financial Systems	IU HEALTH PAC	OLI HOSPITAL		In Liou	ı of Form CMS-2	0552 10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI		Provi der C	CN: 15_1306	Peri od:	Worksheet D	2332-10
ALTORITONIMENT OF THEATTENT ANGIERALT SERVICE CALL	TAL 00313	Triovider c	CN. 13-1300	From 01/01/2020	Part II	
				To 12/31/2020	Date/Time Pre 7/14/2021 11:	epared:
		T! +1 -	V/V/I I I	11	7/14/2021 11:	21 am
Ocat Ocatan Decardation	denited Delete		XVIII	Hospi tal	Cost	
Cost Center Description	Capital Relate Cost (from				Capital Costs (column 3 x	
		(from Wkst. C,		Program		
	II, col. 26)	Part I, col. 8)	(001. 1 ÷ 001	. Charges	column 4)	
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	227, 082	4, 948, 039	0. 04589	3 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	30, 834				0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	243, 983				1, 673	
60. 00 06000 LABORATORY	96, 797				2, 610	•
64. 00 06400 I NTRAVENOUS THERAPY	21, 779				2,010	•
65. 00 06500 RESPIRATORY THERAPY	29, 324				3, 351	65.00
66. 00 06600 PHYSI CAL THERAPY	141, 639	· ·			3, 997	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	30, 494				1, 131	67. 00
68.00 06800 SPEECH PATHOLOGY	19, 647	· ·			184	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 721				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 137	58, 535	0. 03650	8 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	87, 721	10, 128, 041	0. 00866	1 605, 433	5, 244	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	73. 01
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	o o	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	o o	0	75. 00
76.97 O7697 CARDIAC REHABILITATION	0	0	0. 00000	0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0. 00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000		0	89. 00
90. 00  09000  CLI NI C	2, 928		0. 04611	2 0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	126, 894				0	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	65, 318				0	90. 02
91. 00 09100 EMERGENCY	255, 761				269	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	135, 767	3, 127, 452	0. 04341	1, 050	46	92. 00
OTHER REIMBURSABLE COST CENTERS	1			,		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)	1, 522, 826	62, 129, 803	l	1, 017, 659	18, 505	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1306 From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared:

			I	o 12/31/2020	Date/Time Pre   7/14/2021 11:	epared: 21 am
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	543, 112	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	00.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	70.01
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	0	0	U U	0	76. 97
88. 00 08800 RURAL HEALTH CLINIC			· ·	1 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	
90. 00 1089001 FEDERALLY QUALITYTED HEALTH CENTER	0	0			0	
90. 00   09000  CETNIC 90. 01   09001  VESTING SPECIALTY CLINIC	0	0			1 0	90.00
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	0		0	1 0	90.01
91. 00 1091001 EMERGENCY	0	0		0	1 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		Ŭ.	0	
OTHER REIMBURSABLE COST CENTERS			<u> </u>	<u> </u>		72.00
95. 00 09500 AMBULANCE SERVICES			I			95.00
200.00 Total (lines 50 through 199)	543, 112	0	0	0	0	200.00
			•			•

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY : THROUGH COSTS	SERVICE OTHER P.	ASS Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pro 7/14/2021 11:	epared: 21 am
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 + col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	543, 112		4, 948, 039	0. 109763	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		835, 249	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		11, 222, 796	0. 000000	54.00
60. 00 06000 LABORATORY	0	0		5, 626, 497		
64.00 06400 INTRAVENOUS THERAPY	0	0	1	2, 179, 291		
65.00 06500 RESPIRATORY THERAPY	0	0	1	943, 060		
66.00 06600 PHYSI CAL THERAPY	0	0	1	1, 460, 695		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	296, 321		
68.00 06800 SPEECH PATHOLOGY	0	0		181, 690		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		168, 512	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		58, 535	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		10, 128, 041	0. 000000	73.00
73.01 07301 DRUGS CHARGED TO PATLENTS	0	0		0	0. 000000	
74. 00 07400 RENAL DI ALYSI S	0	0		0	0. 000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0	0. 000000	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	(	0	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0. 000000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0. 000000	
90. 00 09000 CLI NI C	0	0	1	63, 498		
90.01 09001 VISITING SPECIALTY CLINIC	0	0		940, 484		
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0		142, 597		
91. 00 09100 EMERGENCY	0	0		19, 807, 046		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	3, 127, 452	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	543, 112		62, 129, 803		200.00

Total (lines 50 through 199)

Heal t	h Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S IGH COSTS	SERVICE OTHER PA	ASS Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	epared:
				20/11/1		7/14/2021 11:	21 am
		_		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.	Ŭ	Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	0	(	0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	(	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	76, 935	(	0	0	54.00
60.00	06000 LABORATORY	0. 000000	151, 707		0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0. 000000	0	(	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	107, 757	(	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	41, 216		0	0	66.00
	la casal a social carrier and a succession			I .	-I	1	1

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0 89.00

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0 91.00

0 92.00

71.00

73.00

0 73.01

75.00

90.00

90.01

95.00

0 200. 00

67. 00 06700 OCCUPATI ONAL THERAPY

07400 RENAL DIALYSIS

09000 CLINIC

09100 EMERGENCY

06800 SPEECH PATHOLOGY

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

07301 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

09001 VISITING SPECIALTY CLINIC

09002 PAOLI PRIMARY CARE CLINIC

OTHER REIMBURSABLE COST CENTERS

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

07500 ASC (NON-DISTINCT PART)

07697 CARDIAC REHABILITATION

08800 RURAL HEALTH CLINIC

09500 AMBULANCE SERVICES

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

68.00

71.00

73.00

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74.00

75.00

76.97

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89.00

90.00

90.01

90.02

91.00

92.00

95.00

Heal th Financial Systems	Health Financial Systems		IU HEALTH PAC	DLI HOSPITAL		In Liou	of Form CMS 1	2552 10
Cost Center Description		R HEALTH SERVICES AI			F	eriod: rom 01/01/2020	Worksheet D Part V	
Cost Center Description				Title	XVIII			
Ratio From   Norsheet C, Part I, col.   Part I, c							Costs	
Worksheet C,   Part I, col . 9   Inst. )   Services   Services   Subject To   Sub	Cost Center Descri	ption	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
Part I, col. 9   Subject To Ded. & Coins.   Csee Inst.)			Ratio From	Services (see	Rei mbursed	Reimbursed	(see inst.)	
Ded. & Coins, (see inst.)   Ded. & Coins, (see inst.)			Worksheet C,	inst.)	Servi ces	Services Not		
1.00   2.00   3.00   4.00   5.00			Part I, col. 9		Subject To	Subject To		
NACILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00					Ded. & Coins.	Ded. & Coins.		
NACILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00					(see inst.)	(see inst.)		
ANCILLARY SERVICE COST CENTERS   SerVICES   SerVICES   SerVICE COST CENTERS   SerVICE COST COST CENTERS   SerVICE COST COST CENTERS   SerVICE COST CENTERS   S			1, 00	2.00			5. 00	
52.00   05200   DELI VERY ROOM & LABOR ROOM   0.671350   0   0   0   0   52.00	ANCILLARY SERVICE COST C	ENTERS	•	•		•		
54. 00   05400   RADI OLOGY - DI AGNOSTI C   0. 269754   0   3, 111, 209   0   0   54. 00   60. 00   06000   LABORATORY   0. 491085   0   1, 279, 168   0   0   60. 00   65. 00   06400   INTRAVENOUS THERAPY   0. 123573   0   562, 895   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   0. 72388   0   217, 478   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 948958   0   377, 198   0   0   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0. 784447   0   54, 738   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 825136   0   7, 237   0   0   68. 00   68. 00   06800   SPEECH PATHOLOGY   0. 825136   0   7, 237   0   0   68. 00   67. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 363161   0   37, 728   0   0   71. 00   67. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 363161   0   37, 728   0   0   72. 00   67. 00   07300   DRUGS CHARGED TO PATIENTS   0. 323071   0   3, 406, 873   2, 350   0   73. 01   67. 00   07300   DRUGS CHARGED TO PATIENTS   0. 323071   0   3, 406, 873   2, 350   0   73. 01   67. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   0   67. 00   07500   ASC (NON-DI STI NCT PART)   0. 000000   0   0   0   0   67. 00   07500   ASC (NON-DI STI NCT PART)   0. 000000   0   0   0   0   67. 00   07500   ASC (NON-DI STI NCT PART)   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   HEALTH CENTER   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   DRUGALLY OUALIFIED   0. 000000   0   0   0   0   67. 00   07000   07000   07000   07000   07000   07	50. 00 05000 OPERATI NG ROOM		0. 479145	0	1, 033, 854	. 0	0	50.00
60. 00   06000   LABORATORY   0. 491085   0   1,279,168   0   0   60. 00   64. 00   06400   INTRAVENOUS THERAPY   0. 123573   0   562,895   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   0. 772388   0   217,478   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 948958   0   377,198   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 784447   0   54,738   0   0   67. 00   68. 00   06800   SPECH PATHOLOGY   0. 825136   0   7,237   0   0   68. 00   69. 00   06800   SPECH PATHOLOGY   0. 825136   0   7,237   0   0   68. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 363161   0   37,728   0   0   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0. 474520   0   17,278   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 323071   0   3,406,873   2,350   0   73. 00   73. 01   07301   DRUGS CHARGED TO PATI ENTS   0. 000000   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0. 000000   0   0   0   0   75. 00   07500   ASC (NON-DISTINCT PART)   0. 0000000   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 000000   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 000000   0   0   0   76. 97   000791   VISITING SPECI ALTY CLINIC   0. 990094   0   394,941   0   0   90. 00   76. 97   09002   PAOLI PRI MARY CARE CLINIC   4. 745619   0   13,276   0   0   90. 00   77. 00   09000   CLINIC   0. 263211   0   4,762,977   2,047   0   91. 00   78. 00   09500   AMBULANCE SERVICES   0. 0000000   0   0   0   79. 00   09500   AMBULANCE SERVICES   0. 0000000   0   0   0   70. 00   09500   AMBULANCE SERVICES   0. 0000000   0   0   70. 00   09500   OMBULANCE SERVICES   0. 0000000   0   0   0   70. 00   09500   OMBULANCE SERVICES   0. 0000000   0   0   0   70. 00   09500   OMBULANCE SERVICES   0. 0000000   0   0   0   70. 00   09500   OMBULANCE SERVICES   0. 0000000   0   0   0   70. 00   09500   OMBULANCE SERVICES   0. 0000000   0   0   0   70. 00   0000000000000000000000000000000	52.00 05200 DELIVERY ROOM & LA	BOR ROOM	0. 671350	0	C	0	0	52.00
64. 00   06400   INTRAVENDUS THERAPY   0. 123573   0   562, 895   0   0   64. 00   65. 00   06500   RESPIRATORY THERAPY   0. 772388   0   217, 478   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 948958   0   377, 198   0   0   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0. 784447   0   54, 738   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 825136   0   7, 237   0   0   68. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 363161   0   37, 728   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 474520   0   17, 278   0   0   72. 00   73. 01   07301   DRUGS CHARGED TO PATIENTS   0. 323071   0   3, 406, 873   2, 350   0   73. 01   74. 00   07400   RENAL DI ALYSI S   0. 0000000   0   0   0   0   75. 00   07500   ASC (NON-DISTINCT PART)   0. 0000000   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 0000000   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 0000000   0   0   0   76. 97   09001   VISITING SPECIALTY CLINIC   0. 900094   0   32, 341   0   0   90. 00   79. 01   09002   CLINIC   0. 900094   0   394, 941   0   0   90. 00   79. 02   09002   PADLI PRI MARY CARE CLINIC   4. 745619   0   13, 276   0   90. 02   79. 00   09500   BMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   79. 00   09500   DEMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   79. 00   09500   DEMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   70. 00   09500   DEMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   70. 00   09500   DEMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   70. 00   09500   DEMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   70. 00   09500   DEMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   70. 00   09500   DEMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   70. 00   09500   DEMERGENCY   0. 0000000   0   0   0   0   0   70. 00   09500   DEMERGENCY   0. 0000000   0   0   0   0   0   70. 00   09500   DEMERGENCY   0. 0000000	54. 00 05400 RADI OLOGY-DI AGNOST	IC	0. 269754	0	3, 111, 209	0	0	54.00
65. 00   06500   RESPI RATORY THERAPY   0. 772388   0   217, 478   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 948958   0   377, 198   0   0   66. 00   67. 00   06700   0CUPATI ONAL THERAPY   0. 948958   0   377, 198   0   0   67. 00   68. 00   06700   0CUPATI ONAL THERAPY   0. 948958   0   377, 198   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 825136   0   7, 237   0   0   68. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0. 363161   0   37, 728   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 474520   0   17, 278   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 323071   0   3, 406, 873   2, 350   0   73. 00   73. 01   07301   DRUGS CHARGED TO PATI ENTS   0. 000000   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   0   75. 00   07500   ASC (NON-DI STI NCT PART)   0. 000000   0   0   0   0   76. 97   07697   CARDI AC REHABL LI TATI ON   0. 000000   0   0   0   0   76. 97   07697   CARDI AC REHABL LI TATI ON   0. 000000   0   0   0   79. 00   09000   CLI NI C   0. 900094   0   324, 341   0   0. 90. 00   790. 01   09001   VI SI TI NG SPECI ALTY CLI NI C   0. 900094   0   394, 941   0   0. 90. 01   790. 02   09002   PAOLI PRI MARY CARE CLI NI C   4. 745619   0   13, 276   0   0   791. 00   09200   DESERVATI ON BEDS (NON-DI STI NCT PART   0. 482006   0   1, 101, 456   0   70   07697	60. 00 06000 LABORATORY		0. 491085	0	1, 279, 168	0	0	60.00
66.00   06600   PHYSI CAL THERAPY   0.948958   0   377, 198   0   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0.784447   0   54,738   0   0   67.00   68.00   06800   SPECCH PATHOLOGY   0.825136   0   7,237   0   0   68.00   71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0.363161   0   37,728   0   0   71.00   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.474520   0   17,278   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0.323071   0   3,406,873   2,350   0   73.00   73.01   07301   DRUGS CHARGED TO PATI ENTS   0.000000   0   0   0   0   0   74.00   07400   RENAL DI ALYSI S   0.000000   0   0   0   0   75.00   07500   ASC (NON-DI STI NCT PART)   0.000000   0   0   0   0   76.97   07697   CARDI AC REHABI LI TATI ON   0.000000   0   0   0   0   76.97   07697   CARDI AC REHABI LI TATI ON   0.000000   0   0   0   76.97   09000   CUINI C   0.90004   0   394,941   0   0.90.00   79.00   09000   DINI G SPECI ALTY CLI NI C   0.900094   0   394,941   0   0.90.00   79.00   09000   DEBREGENCY   0.263211   0   4,762,977   2,047   0.91.00   79	64.00 06400 INTRAVENOUS THERAP	Υ	0. 123573	0	562, 895	0	0	64.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 784447 0 54,738 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 825136 0 7, 237 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 363161 0 37,728 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 474520 0 17, 278 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 323071 0 3,406,873 2,350 0 73. 00 73. 01 07301 DRUGS CHARGED TO PATI ENTS 0. 0.000000 0 0 0 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSIS 0.000000 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 0 0 0 0 75. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 0 0 0 0 76. 97 001PATI ENT SERVI CE COST CENTERS  88. 00 08900 RURAL HEALTH CLINI C 89. 00 90. 01 09001 VI SI TI NG SPECI ALTY CLINI C 0. 900094 0 394, 941 0 0 90. 01 90. 02 09002 PAOLI PRI MARY CARE CLINI C 4. 745619 0 13, 276 0 0 90. 01 90. 02 09002 PAOLI PRI MARY CARE CLINI C 4. 745619 0 13, 276 0 0 90. 02 91. 00 09200 OSESRVATI ON BEDS (NON-DI STI NCT PART 0. 482006 0 1, 101, 1456 0 92. 00 0THER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 0 0.000000 201. 00 Less PBP Clinic Lab. Services-Program 0 0 16, 410, 647 4, 397 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program	65. 00 06500 RESPIRATORY THERAP	Υ	0. 772388	0	217, 478	0	0	65.00
68.00   06800   SPEECH PATHOLOGY   0.825136   0   7,237   0   0   68.00   71.00   O7100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.363161   0   37,728   0   0   71.00   72.00   07200   IMPL   DEV. CHARGED TO PATIENTS   0.474520   0   17,278   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0.323071   0   3,406,873   2,350   0   73.01   73.01   07301   DRUGS CHARGED TO PATIENTS   0.000000   0   0   0   0   0   74.00   07400   RENAL   DIALYSIS   0.000000   0   0   0   0   0   75.00   07500   ASC (NON-DISTINCT PART)   0.000000   0   0   0   0   0   76.97   07697   CARDIA C REHABI LITATION   0.000000   0   0   0   0   0   76.97   07697   CARDIA C REHABI LITATION   0.000000   0   0   0   0   76.97   07697   CARDIA C REHABI LY QUALIFIED HEALTH CENTER   88.00   08800   RURAL   HEALTH   CLINIC   88.00   89.00   09900   CLINIC   1.861035   0   32,341   0   0   90.00   90.01   09900   VISITING   SPECIALTY   CLINIC   0.990094   0   394,941   0   0   90.01   90.02   099002   PAOLI   PRI MARY   CARE   CLINIC   4.745619   0   13,276   0   99.02   91.00   09100   EMERGENCY   0.263211   0   4,762,977   2,047   0   91.00   92.00   09200   OBSERVATION   BEDS   (NON-DISTINCT PART   0.482006   0   1,101,456   0   92.00   0THER   REIMBURSABLE   COST   CENTERS   0.000000   0   0   0   0   0   0   0   0	66.00 06600 PHYSI CAL THERAPY		0. 948958	0	377, 198	0	0	66.00
68.00   06800   SPEECH PATHOLOGY   0.825136   0   7,237   0   0   68.00   71.00   O7100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.363161   0   37,728   0   0   71.00   72.00   07200   IMPL   DEV. CHARGED TO PATIENTS   0.474520   0   17,278   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0.323071   0   3,406,873   2,350   0   73.01   73.01   07301   DRUGS CHARGED TO PATIENTS   0.000000   0   0   0   0   0   74.00   07400   RENAL   DIALYSIS   0.000000   0   0   0   0   0   75.00   07500   ASC (NON-DISTINCT PART)   0.000000   0   0   0   0   0   76.97   07697   CARDIA C REHABI LITATION   0.000000   0   0   0   0   0   76.97   07697   CARDIA C REHABI LITATION   0.000000   0   0   0   0   76.97   07697   CARDIA C REHABI LY QUALIFIED HEALTH CENTER   88.00   08800   RURAL   HEALTH   CLINIC   88.00   89.00   09900   CLINIC   1.861035   0   32,341   0   0   90.00   90.01   09900   VISITING   SPECIALTY   CLINIC   0.990094   0   394,941   0   0   90.01   90.02   099002   PAOLI   PRI MARY   CARE   CLINIC   4.745619   0   13,276   0   99.02   91.00   09100   EMERGENCY   0.263211   0   4,762,977   2,047   0   91.00   92.00   09200   OBSERVATION   BEDS   (NON-DISTINCT PART   0.482006   0   1,101,456   0   92.00   0THER   REIMBURSABLE   COST   CENTERS   0.000000   0   0   0   0   0   0   0   0	67. 00 06700 OCCUPATIONAL THERA	PY	0. 784447	0	54, 738	0	0	67. 00
71. 00	68.00 06800 SPEECH PATHOLOGY		0. 825136	0			0	68.00
72. 00		HARGED TO PATIENTS					0	
73. 00							0	
73. 01   07301   DRUGS CHARGED TO PATIENTS   0.000000   0   0   0   73. 01   74. 00   07400   RENAL DI ALYSIS   0.000000   0   0   0   0   75. 00   07500   ASC (NON-DISTINCT PART)   0.000000   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0.000000   0   0   0   0   76. 97   0UTPATI ENT SERVI CE COST CENTERS   0.000000   0   0   0   0   88. 00   08800   RURAL HEALTH CLINI C   88. 00   89. 00   09000   CLINI C   1.861035   0   32, 341   0   0   90. 01   90. 01   09001   VISITING SPECIALTY CLINI C   0.900094   0   394, 941   0   0   90. 01   90. 02   09002   PAOLI PRI MARY CARE CLINI C   4.745619   0   13, 276   0   0   90. 02   91. 00   09100   EMERGENCY   0.263211   0   4, 762, 977   2, 047   0   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0.482006   0   1, 101, 456   0   0   92. 00   07500   09500   AMBULANCE SERVI CES   0.000000   0   0   0   00   00   00							0	
74. 00						-, 0		
75. 00   07500   ASC (NON-DISTINCT PART)   0.000000   0   0   0   0   0   0   75. 00   0   0   0   0   0   0   0   0   0					-	, o	_	
76. 97 O7697 CARDI AC REHABILITATION		PART)			-	Ŏ	0	
SECTION   SERVICE COST CENTERS   SECTION   S						Ŏ	ŭ	
88. 00			0.00000	<u> </u>		· U	J	1 70. 77
89. 00								88 00
90. 00   09000   CLINIC   1.861035   0   32,341   0   0   90.00   90. 01   09001   VISITING SPECIALTY CLINIC   0.900094   0   394,941   0   0   90.01   90. 02   09002   PAOLI PRIMARY CARE CLINIC   4.745619   0   13,276   0   0   90.02   91. 00   09100   EMERGENCY   0.263211   0   4,762,977   2,047   0   91.00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0.482006   0   1,101,456   0   0   95. 00   09500   AMBULANCE SERVICES   0.000000   0   0.000000   95. 00   Subtotal (see instructions)   0   16,410,647   4,397   0   200.00   201. 00   Less PBP Clinic Lab. Services-Program   0   0   201.00								
90. 01   09001   VISITING SPECIALTY CLINIC   0.900094   0   394, 941   0   0   90. 01   90. 02   09002   PAOLI PRIMARY CARE CLINIC   4.745619   0   13, 276   0   0   90. 02   91. 00   09100   EMERGENCY   0.263211   0   4,762, 977   2, 047   0   91. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0.482006   0   1, 101, 456   0   0   92. 00   09500   AMBULANCE SERVICES   0.000000   09500   AMBULANCE SERVICES   0.000000   0   16, 410, 647   4, 397   0   200. 00   201. 00   Cless PBP Clinic Lab. Services-Program   0   0   0   201. 00   00   00   00   00   00   00   0		o nenem oemen	1 861035	l o	32 341	0	0	
90. 02   09002   PAOLI PRIMARY CARE CLINIC   4. 745619   0   13, 276   0   0   90. 02   91. 00   09100   EMERGENCY   0. 263211   0   4, 762, 977   2, 047   0   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 482006   0   1, 101, 456   0   0   92. 00   OTHER REIMBURSABLE COST CENTERS   0. 000000   0   0   0   0   0   0   0		CLINIC					_	
91. 00   09100   EMERGENCY   0. 263211   0   4,762,977   2,047   0   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 482006   0   1,101,456   0   0   92. 00   OTHER REIMBURSABLE COST CENTERS   0. 000000   0   0   0   0   0   0   0							_	
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0. 482006   0   1, 101, 456   0   0   92. 00   0   0   0   0   0   0   0   0   0		0211110					_	
OTHER REIMBURSABLE COST CENTERS  95.00		NON_DISTINCT PART						
95. 00			0. 402000	<u> </u>	1, 101, 430	·		/2.00
200.00       Subtotal (see instructions)       0       16,410,647       4,397       0 200.00         201.00       Less PBP Clinic Lab. Services-Program       0       0       0       201.00			0.000000		(			95 00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00			0.00000	l .	16, 410, 647	4.397	n	
				I	13, 113, 047	1, 377		
		2. 231 VI 003 1 1 091 dill				Ĭ		

Only Charges Net Charges (line 200 - line 201)

16, 410, 647

4, 397

0 202. 00

Health Financial Systems	IU HEALTH PAO	II HOSPITAL		In lieu	of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		Provi der C		Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pr 7/14/2021 11	epared:
		Title	XVIII	Hospi tal	Cost	
	Cos Ost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not				
ANCILLARY SERVICE COST CENTERS						
50. 00	495, 366 0 839, 261 628, 180 69, 559 167, 977 357, 945 42, 939 5, 972 13, 701 8, 199 1, 100, 662 0 0	0 0 0 0 0 0 0 0 759 0 0				50. 00 52. 00 54. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 73. 01 74. 00 75. 00 76. 97
88. 00   08800   RURAL HEALTH CLINIC 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC 90. 01   09001   VISITING SPECIALTY CLINIC 90. 02   09002   PAOLI   PRIMARY CARE CLINIC 91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATION   BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	60, 188 355, 484 63, 003 1, 253, 668 530, 908	0 0 0 539 0				88. 00 89. 00 90. 00 90. 01 90. 02 91. 00 92. 00
95.00 09500 AMBULANCE SERVICES 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	5, 993, 012 0	1, 298				95. 00 200. 00 201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	5, 993, 012	1, 298				202. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-1306  Component CCN: 15-Z306	Period: Worksheet D From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared:
	Compensate Cont. 16 2500	7/14/2021 11: 21 am

			Component	CCN: 15-2306   1	0 12/31/2020	7/14/2021 11:	21 am
			Title	xVIII Sv	ving Beds - SNF		
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATING ROOM	543, 112	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73. 01	07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	09001 VISITING SPECIALTY CLINIC	0	0	0	0	0	90. 01
90.02	09002 PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90. 02
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	543, 112	0	0	0	0	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	IU HEALTH PAO ERVICE OTHER PA			eri od:	u of Form CMS-2 Worksheet D	<u> 2552-10</u>
THROUGH COSTS		Component		rom 01/01/2020 o 12/31/2020	Date/Time Pre	
		Ti +l o	: XVIII Sv	ving Beds - SN	7/14/2021 11: Cost	21 am
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	`		Part I, col.		
	Ludcati on cost	4)	col s. 2, 3,	8)	7)	
		'/	and 4)		(see	
			u.i.u. 17		instructions)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				•	•	
50.00 05000 OPERATING ROOM	0	543, 112	C	4, 948, 039	0. 109763	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	835, 249	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	11, 222, 796	0. 000000	54.00
60. 00 06000 LABORATORY	0	0	C	5, 626, 497	0. 000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	C	2, 179, 291		
65. 00 06500 RESPIRATORY THERAPY	0	0	C	943, 060		
66. 00 06600 PHYSI CAL THERAPY	0	0	C	1, 460, 695	1	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	296, 321	1	
68.00 06800 SPEECH PATHOLOGY	0	0	C	181, 690		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	168, 512	1	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	58, 535		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	10, 128, 041		
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	C	0	0. 000000	
74.00 07400 RENAL DIALYSIS	0	0	C	0	0. 000000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	C	0	0. 000000	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	C	0	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS	1 -					
88.00 08800 RURAL HEALTH CLINIC	0	0	O	0	0. 000000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0. 000000	
90. 00 09000 CLINIC	0	0	0	63, 498		
90. 01 09001 VISITING SPECIALTY CLINIC	0	0		940, 484	1	
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0	0		142, 597		
91. 00 09100 EMERGENCY	0	0		19, 807, 046	1	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	0		3, 127, 452	0. 000000	92. 00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	543, 112	C	62, 129, 803		200.00
200. oq   Total (Titles 50 till ough 199)	ı	1 543, 112	ı	1 02, 127, 003	I	K00.00

					6.5. 0110.4	
Health Financial Systems	IU HEALTH PAOL		ON 45 4007 I		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	SS Provi der C		Period: From 01/01/2020	Worksheet D	
THROUGH COSTS		Component		To 12/31/2020	Date/Time Pre	epared:
		<u>'</u>			7/14/2021 11:	21 am
				<u>wing Beds - SNI</u>		
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	0		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	14, 754		0	0	
60. 00  06000 LABORATORY	0. 000000	21, 161		0	0	
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0	1	0	0	
65.00 06500 RESPIRATORY THERAPY	0. 000000	20, 732		0	0	65. 00
66.00 06600 PHYSI CAL THERAPY	0. 000000	83, 391		0	0	66. 00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	16, 201		0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 748	(	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	(	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	57, 590		0	0	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0		0	0	73. 01
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		o <b>l</b> 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	(	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	(	0	0	89. 00
90. 00 09000 CLINIC	0. 000000	0		0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000	0		0	0	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000	0		0	0	90. 02
91. 00 09100 EMERGENCY	0. 000000	0		0	0	91.00
02 00 00200 OBSERVATION PERS (NON DISTINCT DARK	0.000000	0	I ,			02.00

0. 000000

215, 577

92.00

95. 00 0 200. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS)
95.00 09500 AMBULANCE SERVICES
200.00 Total (lines 50 through 199)

	Financial Systems	IU HEALTH PAC				of Form CMS-2	2552-10
APPORTI C	ONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COS	T Provi der C	CN: 15-1306   P	Period: From 01/01/2020	Worksheet D	
			Component		o 12/31/2020	Part V   Date/Time Pre	epared:
						Date/Time Pro 7/14/2021 11:	21 am
			Title		wing Beds - SNF		
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C, Part I, col. 9	inst.)	Servi ces	Services Not Subject To		
		Part I, Cor. 9		Subject To Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
IAI	NCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	5000 OPERATING ROOM	0. 479145	0	C	0	0	50.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0. 671350	0	C	Ó	0	52.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 269754	0	C	0	0	54.00
60.00 06	6000 LABORATORY	0. 491085	0	C	0	0	60.00
	6400 I NTRAVENOUS THERAPY	0. 123573		C	0	0	64.00
	6500 RESPI RATORY THERAPY	0. 772388		C	0	0	65.00
	6600 PHYSI CAL THERAPY	0. 948958		O	0	0	
	6700 OCCUPATI ONAL THERAPY	0. 784447		O	0	0	67. 00
	6800 SPEECH PATHOLOGY	0. 825136		C	0	0	68. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 363161		_	0	0	
	7200 I MPL. DEV. CHARGED TO PATIENTS	0. 474520		ı	0	0	,
	7300 DRUGS CHARGED TO PATIENTS	0. 323071		0	0	0	73. 00
	7301 DRUGS CHARGED TO PATIENTS	0.000000			0	0	,
	7400 RENAL DIALYSIS 7500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000		_		0	7 00
75.00 0	7500 ASC (NON-DISTINCT PART) 7697 CARDIAC REHABILITATION	0. 000000				0	
	UTPATIENT SERVICE COST CENTERS	0.000000	<u> </u>	U	<u>,                                    </u>	0	70.97
	8800 RURAL HEALTH CLINIC	I	I				88. 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
	9000 CLINIC	1. 861035	0	O	0	0	
	9001 VISITING SPECIALTY CLINIC	0. 900094		Ö	o o	0	
	9002 PAOLI PRIMARY CARE CLINIC	4. 745619		C	o	0	10
91.00 09	9100 EMERGENCY	0. 263211	0	C	0	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 482006		C	0	0	92.00
	THER REIMBURSABLE COST CENTERS						]
	9500 AMBULANCE SERVICES	0. 000000		C			95. 00
200. 00	Subtotal (see instructions)		0	C	0		200. 00
201. 00	Less PBP Clinic Lab. Services-Program			0	0		201. 00
l	Only Charges	1			1		

Only Charges Net Charges (line 200 - line 201)

0 202. 00

Heelth Firensial Customs	III IIFALTII DAG	LL HOCDLTAI		la liau	of Form CMC 2552 1	10
Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	IU HEALTH PAC AND VACCINE COS		CN: 15-1306	Peri od:	of Form CMS-2552-1 Worksheet D	10
·		Component	CCN: 15-Z306	From 01/01/2020 To 12/31/2020	Part V Date/Time Prepared	d٠
					7/14/2021 11: 21 am	m_
	Con		XVIII	Swing Beds - SNF	Cost	_
Cost Center Description	Cost Reimburse	sts Cost				
oust defiter bescription	Servi ces	Reimbursed				
	Subject To Ded.					
	& Coins. (see					
	inst.)	Ded. & Coins.				
	6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				_
50. 00 05000 OPERATING ROOM	0	0			50.0	00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 0	00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.0	
60. 00 06000 LABORATORY	0	0			60.0	
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY		0			64. 0 65. 0	
66. 00   06600   PHYSI CAL THERAPY		0			66. 0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			67.0	
68.00 06800 SPEECH PATHOLOGY	0	0			68. 0	00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71. 0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 DRUGS CHARGED TO PATIENTS	0	0			73. 0 73. 0	
74. 00 07400 RENAL DI ALYSI S		0			74. 0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0			75. 0	
76. 97 O7697 CARDIAC REHABILITATION	0	0			76. 9	<del>9</del> 7
OUTPATIENT SERVICE COST CENTERS			Т			
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	1				88. 0 89. 0	
90.00 09000 CLINIC	0	0			90.0	
90. 01 09001 VISITING SPECIALTY CLINIC	Ö	0			90.0	
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0			90.0	)2
91. 00 09100 EMERGENCY	0	0			91. 0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	0			92. 0	)0
95. 00 09500 AMBULANCE SERVICES	0		Ī		95. 0	20
200.00 Subtotal (see instructions)	0	0			200. 0	
201.00 Less PBP Clinic Lab. Services-Program	0				201. 0	00
Only Charges						00
202.00   Net Charges (line 200 - line 201)	0	0	l		202. 0	JU

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020		nared.
				10 12/31/2020	7/14/2021 11:	21 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Cost (from	Adjustment	Capi tal	Days	3 / col. 4)	
	Wkst. B, Part		Related Cost			
	II, col. 26)		(col. 1 - col			
			2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	393, 079	45, 177	347, 90	1, 312	265. 17	30. 00
31.00 INTENSIVE CARE UNIT	0			0	0. 00	31.00
43. 00 NURSERY	12, 480		12, 48	129	96. 74	43.00
200.00 Total (lines 30 through 199)	405, 559		360, 38	1, 441		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11	2, 917				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
43. 00 NURSERY	25					43.00
200.00 Total (lines 30 through 199)	36	5, 336				200. 00

Health Financial Systems	IU HEALTH PAC				of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part II	narod
				10 12/31/2020	Date/Time Pre 7/14/2021 11:	21 am
		Titl	e XIX	Hospi tal	PPS	21 4111
Cost Center Description	apital Relate	Total Charges	Ratio of Cos		Capital Costs	
· ·		(from Wkst. C,		Program	(column 3 x	
	Wkst. B, Part	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	II, col. 26)	8)	2)	Ŭ	ŕ	
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	227, 082	4, 948, 039	0. 04589	3 28, 405	1, 304	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	30, 834				1, 164	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	243, 983				11	54.00
60. 00   06000   LABORATORY	96, 797				212	
64.00 06400 INTRAVENOUS THERAPY	21, 779				0	64. 00
65.00 06500 RESPIRATORY THERAPY	29, 324	· ·			17	65. 00
66.00 06600 PHYSI CAL THERAPY	141, 639				0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	30, 494		0. 10290		0	67. 00
68.00 06800 SPEECH PATHOLOGY	19, 647				60	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 721				33	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 137				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	87, 721	10, 128, 041	0. 00866		104	
73.01 07301 DRUGS CHARGED TO PATLENTS	0	0	0. 00000		0	73. 01
74.00 07400 RENAL DIALYSIS	0	0	0. 00000		0	,
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000		0	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS		•	1	_		
88.00 08800 RURAL HEALTH CLINIC	0	0			0	00.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	07.00
90. 00 09000 CLINIC	2, 928				0	
90. 01 09001 VISITING SPECIALTY CLINIC	126, 894				0	
90. 02 09002 PAOLI PRIMARY CARE CLINIC	65, 318				0	70.02
91. 00 09100 EMERGENCY	255, 761				84	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	135, 767	3, 127, 452	0. 04341	1 0	0	92.00

1, 522, 826

62, 129, 803

93, 569

2, 989 200. 00

92.00 95.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS)
95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH C	OSTSProvi der C	CN: 15-1306	Period: From 01/01/2020	Worksheet D	
				To 12/31/2020	Date/Time Pre	
					7/14/2021 11:	21 am
	I		e XIX	Hospi tal	PPS	
Cost Center Description				Allied Health		
	Post-Stepdown		Post-Stepdowr		Medical .	
	Adjustments	1.00	Adjustments		Education Cost	
LAIDATI ENT DOUTLAIE CEDVI CE COCT CENTEDO	1A	1.00	2A	2. 00	3. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS  30. 00   03000   ADULTS & PEDIATRICS	1	1 0	ı		0	30.00
31. 00   03000   ADDETS & PEDIATRICS		0		0	0	
43. 00   04300   NURSERY		0		0	0	
200.00 Total (lines 30 through 199)					_	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dation	tPer Diem (col.	Inpatient	200.00
oost ochter beschiptron	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	bays	3 . coi . o)	Trogram bays	
		minus col. 4)				
	4.00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1, 31	2 0.00	11	30.00
31.00 03100 INTENSIVE CARE UNIT		0		0.00	0	31.00
43. 00 04300 NURSERY		0	12	9 0.00	25	43.00
200.00 Total (lines 30 through 199)		0	1, 44	1	36	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x	4				
	col. 8)					
LANDATI ENT. DOUTING OFFINIOS OFFITEDO	9. 00					
I NPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS						20.00
						30. 00 31. 00
31. 00   03100   NTENSI VE CARE UNIT 43. 00   04300   NURSERY		1				43.00
200.00 Total (lines 30 through 199)						200.00
200. 04   10tal (111165 30 till bugli 199)	1	T				۲۰۰۰ ۰۰۰

Health Financial Systems

IU HEALTH PAOLI HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1306

THROUGH COSTS

IN Lieu of Form CMS-2552-10

Period: From 01/01/2020 Part IV

To 12/31/2020 Date/Time Prepared: 7/1/4/0001 11 2017

				0 12/31/2020	7/14/2021 11:	21 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursi ng 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	543, 112	0	C	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
60. 00   06000   LABORATORY	0	0	C	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	C	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 01
74.00 07400 RENAL DIALYSIS	0	0	(	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(	0	0	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	(	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	00.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90. 00 09000 CLI NI C	0	0		0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0	0		0	0	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0		0	0	90. 02
91. 00 09100 EMERGENCY	0	0		0	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			)	0	92.00
OTHER REIMBURSABLE COST CENTERS	1					05 05
95. 00 09500 AMBULANCE SERVICES	F40 440	_			_	95.00
200.00   Total (lines 50 through 199)	543, 112	0	l (	y <b>y</b> O	0	200. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY : THROUGH COSTS	SERVICE OTHER P.	ASS Provider C		Period: From 01/01/2020 Fo 12/31/2020	Worksheet D Part IV Date/Time Pre 7/14/2021 11:	epared: 21 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	543, 112	(	4, 948, 039	0. 109763	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(	835, 249	0. 000000	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(	11, 222, 796	0. 000000	54.00
60. 00  06000 LABORATORY	0	0	(	5, 626, 497		
64.00 06400 INTRAVENOUS THERAPY	0	0	(	2, 179, 291		
65. 00 06500 RESPIRATORY THERAPY	0	0	(	943, 060		
66.00 06600 PHYSI CAL THERAPY	0	0	(	1, 460, 695		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	296, 321		
68.00 06800 SPEECH PATHOLOGY	0	0	(	181, 690		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	168, 512	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	58, 535	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	10, 128, 041	0. 000000	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	(	0	0. 000000	
74. 00 07400 RENAL DIALYSIS	0	0	(	0	0. 000000	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(	0	0. 000000	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	(	0	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(	0	0. 000000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(	0	0. 000000	
90. 00 09000 CLINIC	0	0	(	63, 498		
90.01 09001 VISITING SPECIALTY CLINIC	0	0	(	940, 484		
90.02 09002 PAOLI PRIMARY CARE CLINIC	0	0	(	142, 597		
91. 00 09100 EMERGENCY	0	0	(	19, 807, 046		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	3, 127, 452	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	543, 112		62, 129, 803		200.00

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR THROUGH COSTS	RY SERVICE OTHER PA	ASS Provider (		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 7/14/2021 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	

			['	0 12/31/2020	7/14/2021 11:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	, and the second	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	28, 405	3, 118	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	31, 525	C	0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	494	C	0	0	54. 00
60. 00   06000   LABORATORY	0. 000000	12, 347	C	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0	C	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	551	C	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	C	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	C	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	554	C	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 181	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	12, 008	C	0	0	73. 00
73.01 07301 DRUGS CHARGED TO PATIENTS	0. 000000	0	C	0	0	73. 01
74.00 07400 RENAL DIALYSIS	0. 000000	0	C	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	C	0	0	75. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	C	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	C	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	C	0	0	89. 00
90. 00 09000 CLINIC	0. 000000	0	C	0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000	0	C	0	0	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000	0	C	0	0	90. 02
91. 00 09100 EMERGENCY	0. 000000	6, 504	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	C	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)		93, 569	3, 118	0	0	200. 00

		T.I. D.A.O. I	LIGORI TAL		6.5. 04	0 0550 40
	Financial Systems IU HEAL ATION OF INPATIENT OPERATING COST	TH PAOLI	HOSPITAL Provider CCN: 15-1306	Peri od:	of Form CM Worksheet	
00 01				From 01/01/2020	Date/Time	
				10 12/31/2020	7/14/2021	11: 21 am
	Ocat Ocatas December 1		Title XVIII	Hospi tal	Cos	t
	Cost Center Description			ľ	1. 00	
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days and swi	na hod de	ave eveluding newborn)	1	1, 5	75 1.00
	Inpatient days (including private room days, excluding private room days.				1, 3	
	Private room days (excluding swing-bed and observat				ys, do	0 3.00
4. 00	not complete this line. Semi-private room days (excluding swing-bed and obs	servation	hed days)		g	4.00
5. 00	Total swing-bed SNF type inpatient days (including			nber 31 of the c		63 5.00
/ 00	reporting period		do) often Decembe	21		0 ( 00
6. 00	Total swing-bed SNF type inpatient days (including reporting period (if calendar year, enter 0 on this		oolii days) arter becellibe	er 31 or the cos	ι	0 6.00
7. 00	Total swing-bed NF type inpatient days (including p		oom days) through Decemb	er 31 of the co	st 1	00 7.00
8. 00	reporting period Total swing-bed NF type inpatient days (including p	orivata ro	nom davs) after December	31 of the cost		0 8.00
0.00	reporting period (if calendar year, enter 0 on this		John days) arter becember	31 of the cost		0.00
9. 00	Total inpatient days including private room days ap	pplicable	to the Program (excludi	ng swing-bed an	d 3	9. 00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to tit	le XVIII	only (including private	room days) thr	ouah 1	63 10.00
	December 31 of the cost reporting period (see instr	ructions)			_	
11. 00	Swing-bed SNF type inpatient days applicable to tit	le XVIII	only (including private	e room days) aft	er	0 11.00
12. 00	December 31 of the cost reporting period (if calend Swing-bed NF type inpatient days applicable to titl	aar year, es V or )	enter u on this line) (IX only (includina priv	vate room days)	through	0 12.00
	December 31 of the cost reporting period				_	
13. 00	Swing-bed NF type inpatient days applicable to titl December 31 of the cost reporting period (if calend			vate room days)	after	0 13.00
14.00	Medically necessary private room days applicable to	o the Prog	gram (excluding swing-be	ed days)		0 14.00
15.00	Total nursery days (title V or XIX only)	Ì				0 15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT					0 16.00
17.00	Medicare rate for swing-bed SNF services applicable	e to servi	ces through December 31	of the cost re	oorti ng	17. 00
10 00	period  Medicara rata for swips had SNE carvices applicable	to convi	cos after December 21 c	of the cost rope	cti na	18. 00
16.00	Medicare rate for swing-bed SNF services applicable period	e to servi	ces arter becember 31 c	or the cost repor	ting	16.00
19. 00	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 service	res after December 31 of	the cost renor	tina O	00 20.00
	peri od			3331 . 340.	cring or	20.00
	Total general inpatient routine service cost (see i Swing-bed cost applicable to SNF type services thro			neting ported (		45 21.00
22. 00	line 17)	bugn becen	iber 31 of the cost repo	orting period (i	пеэх	0 22.00
23. 00	Swing-bed cost applicable to SNF type services after	er Decembe	er 31 of the cost report	ing period (lin	e 6 x	0 23.00
24 00	line 18) Swing-bed cost applicable to NF type services throu	iah Docomk	oor 21 of the cost repor	sting ported (Li	20 7 v 21 6	.05 24 00
24.00	line 19)	igii beceiik	ber 31 of the cost repor	tring perrou (ii	16 / X 21, C	75 24.00
25. 00	Swing-bed cost applicable to NF type services after	December	31 of the cost reporti	ng period (line	8 x	0 25.00
26 00	line 20) Total swing-bed cost (see instructions)				501, 6	06 26.00
	General inpatient routine service cost net of swing	g-bed cost	t (line 21 minus line 26	o)	3, 862, 8	
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excludir	na swina k	and observation had	charges)		0 28.00
	Private room charges (excluding swing-bed charges)	ig swillg-L	bed and observation bed	criai ges)		0 28.00
30.00	Semi-private room charges (excluding swing-bed char	9 /		ļ		0 30.00
	General inpatient routine service cost/charge ratio		7 ÷ line 28)	ļ	0. 0000	00 31.00 00 32.00
	Average private room per diem charge (line 29 ÷ lin Average semi-private room per diem charge (line 30		1	}		00 32.00
	Average per diem private room charge differential (			ructions)		00 34.00
	Average per diem private room cost differential (li			/		00 35.00

5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the c reporting period	ost 163	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cos reporting period (if calendar year, enter 0 on this line)	t 0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the co reporting period	st 100	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed an	d 335	9. 00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) thr	ough 163	10. 00
11.00	December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) aft	er 0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	through 0	12. 00
13.00	December 31 of the cost reporting period  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	after 0	13. 00
14.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost re	porting	17. 00
	period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost repo	Ü	18. 00
	peri od		,
	Medical drate for swing-bed NF services applicable to services through December 31 of the cost repperiod		,
	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporperiod		,
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (I line 17)	4, 364, 445 ine 5 x 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (lin line 18)	e 6 x 0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (li line 19)	ne 7 x 21,695	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line line 20)	8 x 0	25. 00
	Total swing-bed cost (see instructions)	501, 606	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	3, 862, 839	27. 00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	29. 00 30. 00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
	Average private room per diem charge (line 29 ÷ line 3)	0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (I minus line 36)	ne 23, 862, 839	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 944. 24	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	986, 320	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	986, 320	41. 00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lieu	u of Form CMS-	<u>2552-10</u>
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN		eriod: rom 01/01/2020	Worksheet D-	1
			Т	o 12/31/2020	Date/Time Pr 7/14/2021 11	epared: : 21 am_
Cost Center Description	<b>T</b> otal Inpatient	Title X	(VIII   Average Per	Hospital Program Days	Cost Program Cost	
Sout Sainte. Seedinption		npatient DaysDi	em (col. 1 ÷		(col. 3 x col.	
	1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	0	0	0. 00	0	C	42.00
43.00 INTENSIVE CARE UNIT	0	0	0. 00	0	C	43. 00
44. 00 CORONARY CARE UNIT 45. 00 BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00 SURGICAL INTENSIVE CARE UNIT						46. 00
47.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
48.00 Program inpatient ancillary service cost (	Wkst D 2 col	3 line 200)			1. 00 429, 225	19.00
49.00 Total Program inpatient costs (sum of line			ons)		1, 415, 545	•
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program in	npatient routine	services (fro	m Wkst D. s	um of Parts I	and III) C	50.00
51.00 Pass through costs applicable to Program in					,	1
52.00 Total Program excludable cost (sum of line 53.00 Total Program inpatient operating cost exc		related non-ph	vsician anes	thetist and m	edi cal C	
education costs (line 49 minus line 52)		- Crated, Hon phi		thetrot, and in	our cur	30.00
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					C	54.00
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)					0. 00 0	55.00
57.00 Difference between adjusted inpatient operations.	ating cost and t	arget amount (	line 56 minu	s line 53)	C	1
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost	reporting period	l endina 1996 i	undated and	compounded by	the 0.00	58.00
market basket						1
60.00 Lesser of lines 53/54 or 55 from prior yea 61.00 If line 53/54 is less than the lower of li						60.00
operating costs (line 53) are less than ex 56), otherwise enter zero (see instruction		nes 54 x 60), (	or 1% of the	target amount	(line	
62.00 Relief payment (see instructions)	,				· ·	62.00
63.00 Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see instr	ructions)			C	63.00
64.00 Medicare swing-bed SNF inpatient routine co	osts through Dec	cember 31 of the	e cost repor	ting period (S	ee 479, 911	64. 00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine co	osts after Decem	nber 31 of the	cost reporti	ng period (See	С	65. 00
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient rou	tine costs (line	e 64 plus line e	65)(title XV	III onlv). For	CAH 479.911	66. 00
(see instructions) 67.00 Title V or XIX swing-bed NF inpatient rout	•	•	, ,	3,		47.00
12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient rout		,		1 31	,	67.00
13 x line 20)				portring perrod		68.00
69.00 Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILIT	Y, AND ICF/IID	ONLY			69.00
70.00 Skilled nursing facility/other nursing fac 71.00 Adjusted general inpatient routine service	,		,	7)		70. 00 71. 00
72.00 Program routine service cost (line 9 x line	e 71) <sup>.</sup>	•	•			72. 00
73.00 Medically necessary private room cost appl 74.00 Total Program general inpatient routine se						73. 00 74. 00
75.00 Capital-related cost allocated to inpatien line 45)				Part II, colu	nn 26,	75. 00
76.00 Per diem capital-related costs (line 75 ÷ 77.00 Program capital-related costs (line 9 x li	,					76. 00 77. 00
78.00 Inpatient routine service cost (line 74 mi	nus line 77)					78. 00
79.00 Aggregate charges to beneficiaries for exc 80.00 Total Program routine service costs for co	•	•		inus line 79)		79. 00 80. 00
81.00 Inpatient routine service cost per diem li	mitation			,		81. 00
82.00 Inpatient routine service cost limitation 83.00 Reasonable inpatient routine service costs	•					82. 00 83. 00
84.00 Program inpatient ancillary services (see	instructions)					84. 00 85. 00
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (s	um of lines 83 t	through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PART IV - COMPUTATION DED PART IV - COMPUTATION OF OBSERVATION BED PART IV - COMPUTATION BED PART IV - COMPUTATION DED PART IV - COMPUTATIO					512	87. 00
88.00 Adjusted general inpatient routine cost pe	r diem (line 27				2, 944. 24	88. 00
89.00 Observation bed cost (line 87 x line 88) (	see Instructions	S)			1, 507, 451	<b> </b> 89. 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/14/2021 11:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capi tal -related cost	393, 079	4, 364, 445	0. 09006	4 1, 507, 451	135, 767	90.00
91.00 Nursing School cost	0	4, 364, 445	0. 00000	0 1, 507, 451	0	91.00
92.00 Allied health cost	0	4, 364, 445	0. 00000	0 1, 507, 451	0	92.00
93.00 All other Medical Education	0	4, 364, 445	0. 00000	0 1, 507, 451	0	93. 00

Heal th	Financial Systems IU HEALTH PAG	OLI HOSPITAL	In Lieu	of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1306	Period: From 01/01/2020 To 12/31/2020	Date/Time Pro	epared:
		Title XIX	Hospi tal	7/14/2021 11: PPS	:21 am
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				1
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed Inpatient days (including private room days, excluding swing-bed and observation bed and	wing-bed and newborn days)		1, 575 1, 312 ys, do         0	2.00
	not complete this line.			, .	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observational swing-bed SNF type inpatient days (including privateporting period		mber 31 of the c	800 pst 163	
6. 00	Total swing-bed SNF type inpatient days (including privareporting period (if calendar year, enter 0 on this line	)			
7. 00 8. 00	Total swing-bed NF type inpatient days (including private reporting period Total swing-bed NF type inpatient days (including private	3 /		st 100 0	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applical	)			
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVI	III only (including private			10.00
11.00	December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XV	III only (including private	e room days) aft	er O	11.00
12.00	December 31 of the cost reporting period (if calendar year Swing-bed NF type inpatient days applicable to titles V of December 31 of the cost reporting period		vate room days)	through 0	12. 00
	Swing-bed NF type inpatient days applicable to titles V of December 31 of the cost reporting period (if calendar year)	ar, enter 0 on this line)	,	after 0	13. 00
15.00	Medically necessary private room days applicable to the I Total nursery days (title V or XIX only)	Program (excluding swing-be	ed days)	129	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			25	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to se period	ervices through December 3	1 of the cost re	oorti ng	17. 00
	Medicare rate for swing-bed SNF services applicable to seperiod		·	Ü	18. 00
	Medical drate for swing-bed NF services applicable to ser period	<u> </u>	· l	Ü	
	Medicaid rate for swing-bed NF services applicable to seperiod  Total general inpatient routine service cost (see instruc		i the cost repor	4, 364, 445	20.00
	Swing-bed cost applicable to SNF type services through Dolline 17)		orting period (I		•
	Swing-bed cost applicable to SNF type services after Deceline 18) $$	•	` .		23. 00
	Swing-bed cost applicable to NF type services through Dec	·			
26. 00	Swing-bed cost applicable to NF type services after Decerline 20) Total swing-bed cost (see instructions)	mber 31 of the cost report	ng period (line	8 x 0 501, 606	
	General inpatient routine service cost net of swing-bed of PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	cost (line 21 minus line 20	5)	3, 862, 839	1
	General inpatient routine service charges (excluding swin	ng-bed and observation bed	charges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line	e 27 ÷ line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	/		0. 00	32. 00
	Average semi-private room per diem charge (line 30 ÷ line				33. 00
	Average per diem private room charge differential (line 3		ructions)		34.00
	Average per diem private room cost differential (line 34 Private room cost differential adjustment (line 3 x line				35. 00 36. 00

36.00 Private room cost differential adjustment (line 3 x line 35)

37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 862, 839)

2, 944. 24

32, 387

36.00 37.00

38.00

39.00

minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions)

39.00 Program general inpatient routine service cost (line 9 x line 38)

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of For	rm CMS-25	<u>552-10</u>
From 01/01/2020	neet D-1	
To 12/31/2020 Date/ 7/14/2	<u> 2021 11: 2</u>	oared: 21 am
Cost Center Description Total Inpatien Total Average Per Program Days Program	PPS m Cost	
Cost   npatient DaysDiem (col. 1 ÷ (col. 3	x col.	
	00	
42.00 NURSERY (title V & XIX only) 113,078 129 876.57 25 Intensive Care Type Inpatient Hospital Units	21, 914	42. 00
43.00 INTENSIVE CARE UNIT 0 0 0.00 0		43.00
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT		44. 00 45. 00
46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
Cost Center Description		47.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	00 47, 873	48. 00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	102, 174	49. 00
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III	, .	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6, 107	51. 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		52. 00 53. 00
education costs (line 49 minus line 52)	70, 731	55.00
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges	0 !	54. 00
55.00 Target amount per discharge	0.00	
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		56. 00 57. 00
58.00 Bonus 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	58.00
market basket		
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 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	0.00	60. 00 61. 00
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)		
62.00 Relief payment (see instructions)	- 1	62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0 (	63. 00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	0 (	64. 00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
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	66. 00
(see instructions)		
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (lin 12 x line 19)		67. 00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68. 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	0 (	69. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
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)		71. 00 72. 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)		73. 00 74. 00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26,		75. 00
line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
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		80. 00 81. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81)	1	82.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions)		83. 00 84. 00
85.00 Utilization review - physician compensation (see instructions)	1 8	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2	512 8 , 944. 24 8	87. 00 88. 00
		89.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/14/2021 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capi tal -related cost	393, 079	4, 364, 445	0. 09006	4 1, 507, 451	135, 767	90.00
91.00 Nursing School cost	0	4, 364, 445	0. 00000	0 1, 507, 451	0	91.00
92.00 Allied health cost	0	4, 364, 445	0. 00000	0 1, 507, 451	0	92.00
93.00 All other Medical Education	0	4, 364, 445	0. 00000	0 1, 507, 451	0	93. 00

Health Financial Systems IU HEALTH PAOL	I HOSPITAL		In Lieu	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-1306	Peri od:	Worksheet D-3	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	anarod.
			10 12/31/2020	7/14/2021 11:	21 am
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			668, 777		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATING ROOM		0. 47914		_	
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 67135		Ŭ	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY		0. 26975 0. 49108			
60. 00   06000   LABORATORY 64. 00   06400   I NTRAVENOUS THERAPY		0. 49108		74, 501 0	
65. 00   06500   RESPI RATORY THERAPY		0. 77238			
66. 00   06600   PHYSI CAL THERAPY		0. 94895			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 78444			
68. 00 06800 SPEECH PATHOLOGY		0. 82513			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 36316			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 47452	20 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 32307		195, 598	
73.01 07301 DRUGS CHARGED TO PATIENTS		0. 00000		0	
74. 00 07400 RENAL DI ALYSI S		0. 00000		0	
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 00000	0	0	76. 97
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		Ő	
90. 00 09000 CLINIC		1. 86103		0	90.00
90.01 09001 VISITING SPECIALTY CLINIC		0. 90009	04	0	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC		4. 74561		0	
91. 00 09100 EMERGENCY		0. 26321			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 48200	1, 050	506	92. 00
OTHER REI MBURSABLE COST CENTERS  95. 00   O9500   AMBULANCE SERVI CES		1	1		95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 017, 659	429, 225	
200.00 Less PBP Clinic Laboratory Services-Program only char	raes (line 6	11	1,017,059		200.00
202.00 Net charges (line 200 minus line 201)	903 (1110 0	· ſ	1, 017, 659		202.00
		1	1, 5, 507	1	1

Health Financial Systems IU HEALTH PAOLI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		ON 15 1207		u of Form CMS-1	
INPATIENT ANGILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 01/01/2020	Worksheet D-3	3
	Component		To 12/31/2020	Date/Time Pre 7/14/2021 11:	
		XVIII S	Swing Beds - SNI		
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		ı	1 0	ı	30.00
31. 00   03100  INTENSIVE CARE UNIT					31.00
43. 00   04300   NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					1 43.00
50. 00 05000 OPERATI NG ROOM		0. 47914	5 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 67135			
54. 00   05400 RADI OLOGY-DI AGNOSTI C		0. 26975		3, 980	54.00
60. 00 06000 LABORATORY		0. 49108	5 21, 161	10, 392	60.00
64.00 06400 INTRAVENOUS THERAPY		0. 12357	3 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 77238	8 20, 732	16, 013	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 94895		79, 135	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 78444			
68.00 O6800 SPEECH PATHOLOGY		0. 82513		1, 442	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 36316			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 47452		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 32307		1	•
73. 01 07301 DRUGS CHARGED TO PATIENTS		0. 00000		0	•
74. 00   07400   RENAL DI ALYSI S		0. 00000		0	
75. 00   07500   ASC (NON-DISTINCT PART)		0. 00000 0. 00000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0.00000	0	<u> </u>	70.97
88. 00   08800   RURAL HEALTH CLINIC		0. 00000	ol	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
90. 00 09000 CLINIC		1. 86103		Ö	
90. 01 09001 VISITING SPECIALTY CLINIC		0. 90009		Ö	
90.02 09002 PAOLI PRIMARY CARE CLINIC		4. 74561		0	90. 02
91. 00 09100 EMERGENCY		0. 26321	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 48200	6 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95. 00
Total (sum of lines 50 through 94 and 96 through 98)		J	215, 577	142, 277	10
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)	P	0		201.00
202.00 Net charges (line 200 minus line 201)			215, 577		202.00

Health Financial Systems IU HEA	LTH PAOLI HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1306	Period: From 01/01/2020	Worksheet D-3	3
			To 12/31/2020	Date/Time Pre 7/14/2021 11:	epared: 21 am
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			19, 856		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY			34, 785		43. 00
ANCILLARY SERVICE COST CENTERS			_		
50. 00 05000 OPERATING ROOM		0. 47914		·	•
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 67135		21, 164	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 26975			54.00
60. 00   06000   LABORATORY		0. 49108		· ·	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 12357		0	
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY		0. 77238 0. 94895		426	•
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY		0. 78444		0	
68. 00 06800 SPEECH PATHOLOGY		0. 78444		457	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 36316		429	•
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 47452		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 32307		3, 879	
73. 01 07301 DRUGS CHARGED TO PATIENTS		0. 00000		0	•
74. 00 07400 RENAL DIALYSIS		0. 00000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)		0. 00000	0	0	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 00000	0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0. 00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
90. 00   09000   CLINI C		1. 86103		0	
90. 01 09001 VISITING SPECIALTY CLINIC		0. 90009		0	
90. 02   09002   PAOLI PRIMARY CARE CLINIC 91. 00   09100   EMERGENCY		4. 74561 0. 26321		0 1, 712	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 48200		1, /12	•
OTHER REIMBURSABLE COST CENTERS		0. 48200	U U	U	72.00
95. 00 09500 AMBULANCE SERVICES		1	1		95. 00
200.00 Total (sum of lines 50 through 94 and 96 thro	ouah 98)		93, 569	47, 873	
201.00 Less PBP Clinic Laboratory Services-Program of		<b>b</b>	0		201. 00
202.00 Net charges (line 200 minus line 201)		]	93, 569		202. 00
		•	•	•	•

Health Financial Systems	IU HEALTH PAOLI HOSPITAL		In Lieu of Form	CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CC	From 01.	/01/2020 Workshee Part B 1/31/2020 Date/Tim 7/14/202	
	T:	V0 (1 1 1		` '

			10 12/31/2020	7/14/2021 11:	
		Title XVIII	Hospi tal	Cost	Z i dili
		THE AVIII	1103pi tui	0031	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5, 994, 310	1.00
2.00	Medical and other services reimbursed under OPPS (see instru	uctions)		0	2.00
3.00	OPPS payments	,		0	3.00
4.00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)	0	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	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	LV col 13 line 200		0	
	Organ acqui si ti ons	17, 601. 10, 11116 200		o o	10.00
	Total cost (sum of lines 1 and 10) (see instructions)			5, 994, 310	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 774, 310	11.00
	Reasonable charges				1
12 00	Ancillary service charges			0	12. 00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 60)		0	
	Total reasonable charges (sum of lines 12 and 13)	11116 07)		0	
14.00	Customary charges				14.00
15 00	Aggregate amount actually collected from patients liable for	nayment for services	on a chargo baci	5 0	15. 00
10.00	Amounts that would have been realized from patients liable f	or payment for services	s un a chargebas	i S i i au U	10.00
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)			0. 000000	
	Total customary charges (see instructions)		11 11 (	0	
19. 00	Excess of customary charges over reasonable cost (complete of	only it line is exceeds	line II) (see	0	19. 00
00.00	instructions)		11 10) (		
20.00	Excess of reasonable cost over customary charges (complete o	only if line 11 exceeds	line 18) (see	0	20. 00
	instructions)				
	Lesser of cost or charges (see instructions)			6, 054, 253	
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see ins	*		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	<u> </u>		0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instruction			74, 290	
26.00	Deductibles and Coinsurance amounts relating to amount on li	ne 24 (for CAH, see ins	structi ons)	2, 899, 967	26. 00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines	22 and 23] (see	3, 079, 996	27. 00
	instructions)				
28.00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28. 00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36	ó)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			3, 079, 996	30.00
31.00	Primary payer payments			1, 282	31.00
32.00	Subtotal (line 30 minus line 31)			3, 078, 714	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	(I CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			110, 948	34.00
	Adjusted reimbursable bad debts (see instructions)			72, 116	35.00
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		-61, 329	36.00
37.00	Subtotal (see instructions)	ŕ		3, 150, 830	37. 00
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
	Pioneer ACO demonstration payment adjustment (see instruction	ons)			39. 50
	Demonstration payment adjustment amount before sequestration	•		0	•
	Partial or full credits received from manufacturers for repl		ructions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION	(500 111311		0	
	Subtotal (see instructions)			3, 150, 830	
	Sequestration adjustment (see instructions)			20, 795	
	Demonstration adjustment (see firstructions)  Demonstration payment adjustment amount after sequestration			20, 743	40. 01
	Sequestration adjustment-PARHM pass-throughs			l	40. 02
	Interim payments			3, 396, 987	
				3, 390, 907	41.00
	Interim payments-PARHM			0	
	Tentative settlement (for contractors use only)			0	42. 00 42. 01
	Tentative settlement-PARHM (for contractor use only)			244 052	
	Balance due provider/program (see instructions)			-266, 952	
	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accord	aance with CMS Pub. 15-2	z, chapter 1, §1	15. 2 148, 171	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)	1		0	
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL	In Lieu	of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVI CES RENDERED	Provi der CCN: 15-1306	From 01/01/2020	Worksheet E-1 Part I Date/Time Pre 7/14/2021 11:	epared:
		Title XVIII	Hospi tal	Cost	
		Innationt Part A	Par	+ R	

				To 12/31/2020	Date/Time Pre 7/14/2021 11:	pared:
		Title	XVIII	Hospi tal	Cost	ZI alli
			t Part A		∸t B	
	•	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1. 00	Total interim payments paid to provider	1. 00	2. 00 1, 084, 05	3.00	4. 00 3, 396, 987	1.00
2. 00	Interim payments payable on individual bills, either			0	3, 396, 987	2.00
2.00	submitted or to be submitted to the contractor for service	es		o l	0	2.00
	rendered in the cost reporting period. If none, write "N					
	or enter a zero					
3.00	List separately each retroactive lump sum adjustment amou					3. 00
	based on subsequent revision of the interim rate for the					
	reporting period. Also show date of each payment. If none	ı				
	write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02			<b>5</b>	O	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		1	ol	0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM		•	0	0	3.50
3. 52			•	o O		3. 52
3. 53				Ö	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4 00	3. 50-3. 98)		1 004 05	_	2 20/ 207	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 084, 05	1	3, 396, 987	4. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after of	esk				5. 00
	review. Also show date of each payment. If none, write "N	ONE"				
	or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		l	ol	0	5. 01
5. 02	TENTATIVE TO PROVIDER			0	0	5. 01
5. 03				Ö	0	
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		<b>5</b>	0	0	5. 50
5. 51			ŀ	0	0	
5. 52	Substitute (sum of these F 01 F 40 miles on of these			0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			O	0	5. 99
6. 00	Determined net settlement amount (balance due) based on t	he				6. 00
5. 00	cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVI DER		230, 94	1	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	266, 952	
7. 00	Total Medicare program liability (see instructions)		1, 314, 99		3, 130, 035	7. 00
				Contractor	NPR Date	
		,	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		<i>-</i>	1.00	2.00	8. 00
	'			•	'	

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lieu	of Form CMS-	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES REI	NDERED			Period: From 01/01/2020	Worksheet E-7 Part I	
		Component	CCN: 15-Z306	To 12/31/2020	Date/Time Pro 7/14/2021 11:	epared: 21 am
		Titl∈	XVIII S	wing Beds - SNF	Cost	
		Inpatier	it Part A	Par	t B	
	n	nm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00 Total interim payments paid to provider			539, 90	4	0	1.00
2.00 Interim payments payable on individual bill submitted or to be submitted to the contract reporting period. If	tor for services			0	0	2. 00

	i npa ti en i	L Part A	Par	I 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		539, 904		0	1.00
2.00 Interim payments payable on individual bills, e	ei ther	0		0	2. 00
submitted or to be submitted to the contractor	for services				
rendered in the cost reporting period. If none	e, write "N <mark>ONE"</mark>				
or enter a zero					
3.00 List separately each retroactive lump sum adjus					3. 00
based on subsequent revision of the interim rat					
reporting period. Also show date of each paymer	nt. If none,				
write "NONE" or enter a zero. (1)					
Program to Provider 3.01 ADJUSTMENTS TO PROVIDER		ol		0	3. 01
		0		0	
3. 02 3. 03	1	0			3. 02 3. 03
3. 04	1	0		0	3.03
3. 05	1	0		0	3.04
Provider to Program		<u> </u>		0	3.03
3. 50 ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	1	Ö		0	3. 51
3. 52	1	o		0	3. 52
3. 53	i	0		0	3. 53
3. 54	]	0		0	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of l	i nes	0		0	3. 99
3. 50-3. 98)					,
4.00 Total interim payments (sum of lines 1, 2, and	, l	539, 904		0	4. 00
(transfer to Wkst. E or Wkst. E-3, line and col	umn as				
appropriate)					
TO BE COMPLETED BY CONTRACTOR	ant often deals				F 00
5.00 List separately each tentative settlement paymer review. Also show date of each payment. If none					5. 00
or enter a zero. (1)	e, WILLE NONE				
Program to Provider					
5. 01 TENTATI VE TO PROVI DER		O		0	5. 01
5. 02		o		l o	5. 02
5. 03	1	o		0	
Provider to Program	<u> </u>	-			
5. 50 TENTATIVE TO PROGRAM		0		0	5. 50
5. 51		0		0	5. 51
5. 52		0		0	5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of l	i nes	0		0	5. 99
5. 50-5. 98)					
6.00 Determined net settlement amount (balance due)	based on the				6. 00
cost report. (1)		00.000			
6. 01 SETTLEMENT TO PROVIDER		83, 309		0	6. 01
6.02 SETTLEMENT TO PROGRAM	ons)	422 212		0	6. 02
7.00 Total Medicare program liability (see instructi	UIIS)	623, 213	Contractor	NPR Date	7. 00
			Number	(Mo/Day/Yr)	
	0		1. 00	2. 00	
8.00 Name of Contractor			00	2.00	8. 00
•	•			•	

Heal th	Financial Systems IU HEALTH PAOLI	HOSPI TAL	In Lieu	of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1306	Peri od: From 01/01/2020	Worksheet E-	1
				Date/Time Pro 7/14/2021 11	epared:
		Title XVIII	Hospi tal	Cost	21 4111
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		-		4
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				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technolog	gy Wkst. S-2, Pt	l line	7. 00
	168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	•			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruct	i ons)		32.00
	· · · · · · · · · · · · · · · · · · ·	, (	/		

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-1306	Period: From 01/01/2020	Worksheet E-2
		Component CCN: 15-Z306		
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B

		Component CCN: 15-Z306	To 12/31/2020	Date/Time Pre   7/14/2021 11:	
		Title XVIII	Swing Beds - SNF		21 4111
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions	)	484, 710	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		101,710	Ü	2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Pa		D Part 143, 700	0	3. 00
	V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-b	ed pass-through, see			
2 01	instructions)				2 01
3. 01 4. 00	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teac	hina nroaram (see instr	ructions)	0. 00	3. 01 4. 00
5. 00	Program days	in ng program (see riisti	163	0.00	1
6.00	Interns and residents not in approved teaching program (see	instructions)		0	6. 00
7. 00	Utilization review - physician compensation - SNF optional m	ethod only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		628, 410	0	
9. 00 10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		628, 410	0	
	Deductibles billed to program patients (exclude amounts appl	icable to physician	020, 110	0	11. 00
	professi onal servi ces)	, J			
	Subtotal (line 10 minus line 11)		628, 410	0	
13. 00	Coinsurance billed to program patients (from provider record	s) (exclude coinsurance	for 1,056	0	13. 00
14 00	physician professional services) 80% of Part B costs (line 12 x 80%)			0	14. 00
	Subtotal (see instructions)		627, 354	0	
	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	tration) payment adjust	ment 0		16. 55
16. 99	(see instructions) Demonstration payment adjustment amount before sequestration			0	16. 99
	Allowable bad debts (see instructions)		0	0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)	0	0	
	Total (see instructions)		627, 354	0	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration)		4, 141	0	
	Sequestration adjustment-PARHM pass-throughs		J	O	19. 02
	Interim payments		539, 904	0	1
	Interim payments-PARHM				20. 01
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	83, 309	0	21. 01 22. 00
	Balance due provider/program-PARHM (see instructions)	and 21)	03, 307	O	22. 01
	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2	15, 431	0	•
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p		-L		000 00
200.00	Cures Act? Enter "Y" for yes or "N" for no.	eriod under the 21st Ce	entury		200.00
	Cost Reimbursement				1
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, lir	ie 66		201. 00
	(title XVIII hospital))				
202. 00	Medicare swing-bed SNF inpatient ancillary service costs (fr (title XVIII swing-bed SNF))	om Wkst. D-3, col. 3, I	ine 200		202. 00
203 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A i	n first year of the cur	rent 5-year		1
005 00	demonstration period)				005 00
	Medicare swing-bed SNF target amount	times line 204)			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbu				206. 00
207. 00	Program reimbursement under the §410A Demonstration (see ins				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E		s 1 and		208. 00
	3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instr	ructions)			209. 00
210.00	Reserved for future use Comparision of PPS versus Cost Reimbursement				210. 00
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (se	ee		215. 00
	instructions)	, (00			
			•		

Heal th	Financial Systems IU HEALTH PAOLI	HOSPI TAL	In Lieu	of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1306	Peri od:	Worksheet E-3	3
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre 7/14/2021 11:	eparea:
		Title XVIII	Hospi tal	Cost	ZI alli
		THE AVIII	1103pi tai	1 0031	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - C	OST_RELMBURSEMEN		
1. 00	Inpatient services			1, 415, 545	1.00
	Nursing and Allied Health Managed Care payment (see instruct	tions)		0	•
3.00	Organ acquisition	,		0	3.00
4. 00	Subtotal (sum of lines 1 through 3)			1, 415, 545	
5. 00	Primary payer payments			0	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 429, 700	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable charges				1
7.00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8.00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				]
	Aggregate amount actually collected from patients liable for				11. 00
12.00	Amounts that would have been realized from patients liable 1	for payment for service	s on a charge ba	sis had 0	12. 00
	such payment been made in accordance with 42 CFR 413.13(e)				
	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 of	only if line 14 exceeds	line 6) (see	0	15. 00
	instructions)				ļ
16. 00	Excess of reasonable cost over customary charges (complete o	only if line 6 exceeds	line 14) (see	0	16. 00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17. 00
10.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	F. 4. 11 = 2.40)		0	10 00
	Direct graduate medical education payments (from Worksheet E	E-4, line 49)			18.00
	Cost of covered services (sum of lines 6, 17 and 18)			1, 429, 700	
	Deductibles (exclude professional component)			116, 864	
	Excess reasonable cost (from line 16)			1 212 027	
	Subtotal (line 19 minus line 20 and 21)			1, 312, 836	
	Coinsurance			1 212 024	_0.00
	Subtotal (line 22 minus line 23)	ulass) (see Instruction	0)	1, 312, 836	
25.00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instruction	5)	16, 768	<b>∠</b> 5.00

10, 899

12,772

0 29.50

1, 323, 735

1, 323, 735

1, 084, 057

230, 941

8,737

26.00

27.00

28.00

29.00

29.99

30.00

30.01

30.02

30.03

31.00

31.01

32.00

32. 01

33.00

33.01

35, 095 34. 00

29.00

29. 99

30.00

30.01

30.02

30.03

31.00

31.01

32.01

26.00 Adjusted reimbursable bad debts (see instructions)

Sequestration adjustment (see instructions)

32.00 Tentative settlement (for contractor use only)

Subtotal (see instructions)

Interim payments

Interim payments-PARHM

Sequestration adjustment-PARHM

Subtotal (sum of lines 24 and 25, or line 26)
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

27.00 Allowable bad debts for dual eligible beneficiaries (see instructions)

29.50 Pioneer ACO demonstration payment adjustment (see instructions)

Demonstration payment adjustment amount before sequestration

Demonstration payment adjustment amount after sequestration

33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)

33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)

34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §1 5.2

Tentative settlement-PARHM (for contractor use only)

BALANCE SHEET (If you are nonproprietary and do not maintain fund-typevider CCN: 15-1306 accounting records, complete the General Fund column only)

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Ti me Prepared:

			['	0 12/31/2020	7/14/2021 11:	21 am
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	Townson Asserts	1. 00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS Cash on hand in banks	1E 400 010	)	ı o	0	1 00
1. 00 2. 00	Temporary investments	15, 402, 319			0	
3. 00	Notes receivable	88, 636			0	
4. 00	Accounts recei vabl e	3, 378, 143	1	Ö	0	
5. 00	Other recei vabl e	-721, 528	1	Ö	0	
6.00	Allowances for uncollectible notes and accounts receivable		) c	0	0	6.00
7.00	Inventory	760, 633	C	0	0	7. 00
8.00	Prepai d expenses	121, 498	S C	0	0	
9. 00	Other current assets	0	C	0	0	
10.00	Due from other funds	10 000 701		0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	19, 029, 701		y U	0	11. 00
12.00	Land	183, 505	i c	O	0	12. 00
	Land improvements	438, 464	1	_	0	
	Accumulated depreciation	-388, 211		Ö	0	
	Bui I di ngs	6, 984, 220		O	0	
16.00	Accumulated depreciation	-3, 722, 418	C	0	0	16. 00
	Leasehold improvements	791, 602	1	0	0	
	Accumulated depreciation	-657, 524	C	0	0	
	Fixed equipment	0		0	0	
	Accumulated depreciation Automobiles and trucks	13, 607		0	0	
	Accumulated depreciation	13,607			0	
	Major movable equipment	11, 110, 417			0	
	Accumulated depreciation	-7, 423, 046	1	Ö	0	
	Mi nor equi pment depreciable	0	) c	O	0	•
	Accumulated depreciation	0	C	0	0	26. 00
	HIT designated Assets	0	) C	0	0	
	Accumulated depreciation	0	C	0	0	
	Mi nor equi pment-nondepreci abl e	7 220 (1)		0	0	
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	7, 330, 616		l O	0	30.00
31. 00	Investments	1, 225, 259		0	0	31.00
	Deposits on Leases	0		Ö	0	
	Due from owners/officers	0	o c	0	0	33. 00
	Other assets	12, 257, 905		0	0	
	Total other assets (sum of lines 31-34)	13, 483, 164		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	39, 843, 481		0	0	36. 00
27 00	CURRENT LIABILITIES Accounts payable	845, 204		ı o	0	27 00
	Salaries, wages, and fees payable	1, 181, 299			0	
	Payrol I taxes payable	271			0	
	Notes and Loans payable (short term)	0		Ö	0	1
41.00	Deferred income	0	) c	0	0	41.00
	Accelerated payments	7, 353, 915	5			42. 00
	Due to other funds	0	) C	0	0	
	Other current liabilities	2, 767, 725		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	12, 148, 414	k <u>l</u> C	0	0	45. 00
46 00	Mortgage payable	0		l o	0	46.00
47. 00	Notes payable	0		0	0	
	Unsecured Loans	0		ő	0	
	Other long term liabilities	32, 963	S C	Ö	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	32, 963		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12, 181, 377	' C	0	0	51. 00
	CAPI TAL ACCOUNTS			,		
	General fund balance	27, 662, 104	1			52. 00
	Specific purpose fund		C			53. 00
	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
	Governing body created - endowment fund balance					56.00
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	27, 662, 104		o	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	59) 39, 843, 481	[ c	O	0	60.00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES IU HEALTH PAOLI HOSPITAL Provi der CCN: 15-1306

			'	o 12/31/2020	Date/Time Pre 7/14/2021 11:	
	General	Fund	Speci al Pu	rpose Fund		21 0111
	1.00	2.00	3.00	4. 00	5. 00	
nd balances at beginning of period tincome (loss) (from Wkst. G-3, line 29) tal (sum of line 1 and line 2) ditions (credit adjustments) (specify) tal additions (sum of line 4-9) ototal (line 3 plus line 10) JNDING		25, 302, 249 2, 359, 858 27, 662, 107 0 27, 662, 107	0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
eet (line 11 minus line 18)	Endowment Fund	DI ant	Fund			
nd halanass at had pring of pariod		7. 00				1. 00
id balances at beginning of period tincome (loss) (from Wkst. G-3, line 29) tal (sum of line 1 and line 2) ditions (credit adjustments) (specify)	Ŭ	0 0 0 0	0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
tal additions (sum of line 4-9) ptotal (line 3 plus line 10) JNDING  tal deductions (sum of lines 12-17) and balance at end of period per balance	0 0	0 0 0 0 0	0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
tion tion tion tion	income (loss) (from Wkst. G-3, line 29) al (sum of line 1 and line 2) itions (credit adjustments) (specify)  al additions (sum of line 4-9) total (line 3 plus line 10) NDING  al deductions (sum of lines 12-17) d balance at end of period per balance et (line 11 minus line 18)  d balances at beginning of period income (loss) (from Wkst. G-3, line 29) al (sum of line 1 and line 2) itions (credit adjustments) (specify)  al additions (sum of line 4-9) total (line 3 plus line 10) NDING	d balances at beginning of period income (loss) (from Wkst. G-3, line 29) al (sum of line 1 and line 2) itions (credit adjustments) (specify)  al additions (sum of line 4-9) total (line 3 plus line 10)  NDING  al deductions (sum of lines 12-17) d balance at end of period per balance et (line 11 minus line 18)  and define 1 and line 2) itions (credit adjustments) (specify)  al (sum of line 1 and line 2) itions (credit adjustments) (specify)  al additions (sum of line 4-9) total (line 3 plus line 10)  NDING  al deductions (sum of lines 12-17) d dbalance at end of period per balance	d balances at beginning of period income (loss) (from Wkst. G-3, line 29) al additions (sum of line 4-9) total (line 11 minus line 18)  al balances at beginning of period 2, 359, 858 27, 662, 107 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00   2.00   3.00	1.00   2.00   3.00   4.00	General Fund   Special Purpose Fund   Endowment Fund

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Li eu	of Form CMS-2552-10
STATEMENT OF PATIENT REVENUES AND OPERATING	EXPENSES	Provi der CCN: 15-1306	Peri od:	Worksheet G-2

From 01/01/2020 Parts I & II To 12/31/2020 Date/Time Prepared: 7/14/2021 11:21 am 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, 100, 771 2, 100, 771 SUBPROVIDER - IPF 2.00 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 103, 124 Swing bed - SNF 103, 124 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) 2, 203, 895 2, 203, 895 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT n 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 2, 203, 895 2, 203, 895 17.00 Total inpatient routine care services (sum of lines 10 and 16) 17.00 18.00 Ancillary services 3, 658, 954 34, 389, 771 38, 048, 725 18.00 19.00 Outpatient services 235, 348 23, 845, 729 24, 081, 077 19.00 20.00 RURAL HEALTH CLINIC 20 00 0 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 22.00 HOME HEALTH AGENCY 0 22.00 23.00 AMBULANCE SERVICES 0 23.00 24.00 CMHC 24.00 25.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 26.00 HOSPI CE 26.00 OTHER NRCC 259, 482 259, 482 27.00 27.00 64, 593, 179 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, 6, 098, 197 58, 494, 982 28.00 PART II - OPERATING EXPENSES 27, 787, 693 29.00 Operating expenses (per Wkst. A, column 3, line 200) 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 36.00 Total additions (sum of lines 30-35) 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 27, 787, 693 43.00 Wkst. G-3, line 4)

In Lieu of Form CMS-2552-10						
Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)						
To   12/31/2020   Date/Time Prepared:	STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1306		Worksheet G-3	3	
1.00				Date/Time Pre	pared:	
1.00		7/14/2021 11:	21 am			
1.00			ļ	1 00		
2.00   Less contractual allowances and discounts on patients' accounts   36, 065, 431   2.00   28, 527, 748   3.00   3.	1 00 Tatal nations navenue (from West C 2 Dans			1 00		
3.00						
4.00   Less total operating expenses (from Wkst. 6-2, Part II, line 43)   27,787,693   4.00   Net income from service to patients (line 3 minus line 4)   740,055   740,055   700   740,055   740,						
Net income from service to patients (line 3 minus line 4)						
OTHER INCOME         OTHER INCOME           6. 00         Contributions, donations, bequests, etc         0         6. 00           7. 00         Income from investments         0         7. 00           8. 00         Revenues from telephone and other miscellaneous communication services         0         8. 00           9. 00         Revenue from television and radio service         0         9. 00           10. 00         Purchase discounts         0         10. 00           11. 00         Rebates and refunds of expenses         0         11. 00           12. 00         Parking lot receipts         0         12. 00           13. 00         Revenue from laundry and linen service         0         13. 00           14. 00         Revenue from laundry and linen service         0         13. 00           15. 00         Revenue from laundry and linen service         0         14. 00           15. 00         Revenue from laundry and linen service         0         14. 00           15. 00         Revenue from laundry and linen service         0         15. 00           16. 00         Revenue from laundry and linen service         0         15. 00           17. 00         Revenue from meals sold to employees and guests         0         16. 00						
7. 00       Income from investments       0       7. 00         8. 00       Revenues from telephone and other miscellaneous communication services       0       8. 00         9. 00       Revenue from telephone and other miscellaneous communication services       0       9. 00         10. 00       Purchase discounts       0       10. 00         11. 00       Revenue from deal scounts       0       11. 00         12. 00       Parking lot receipts       0       11. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from rental of living quarters       0       14. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       15. 00         17. 00       Revenue from sale of medical records and abstracts       0       17. 00         18. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       17. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Revenue from gifts, flowers,						
8.00 Revenues from telephone and other miscellaneous communication services 9.00 Revenue from television and radio service 9.00 Purchase discounts 11.00 Rebates and refunds of expenses 9.01 10.00 12.00 Parking lot receipts 9.01 12.00 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from mental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 18.00 Revenue from sale of medical records and abstracts 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 10.00 Revenue from gifts, flowers, coffee shops, and canteen 10.00 Rental of vending machines 10.00 Rental of bospital space 10.00 Rental of hospital space 10.00 Rental of hospital space 10.00 Revenue from sele of fully space 10.00 Rental of textbooks in the space of textbooks of the space of the spa	6.00 Contributions, donations, bequests, etc	0	6.00			
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from laundry and linen service       0       13.00         15.00       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 than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         20.00       Rental of hospital space       0       22.00         20.00       Rental of hospital space       0       22.00         24.50	7.00 Income from investments					
10.00   Purchase discounts	8.00 Revenues from telephone and other miscellaneous communication services				8. 00	
11.00   Rebates and refunds of expenses   0   11.00     12.00   Parking lot receipts   0   12.00     13.00   Revenue from laundry and linen service   0   13.00     14.00   Revenue from meals sold to employees and guests   0   14.00     15.00   Revenue from rental of living quarters   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   0   16.00     17.00   Revenue from sale of medical records and abstracts   0   17.00     18.00   Revenue from sale of medical records and abstracts   0   18.00     19.00   Revenue from gifts, flowers, coffee shops, and canteen   0   20.00     10.00   Rental of vending machines   0   21.00     10.00   Rental of hospital space   0   22.00     10.00   Rental of hospital space   0   22.00     10.00   MI SCELLANEOUS I NCOME   1, 392, 590     10.00   24.50   COVI D-19 PHE Funding   227, 213   24.50     10.01   24.50   25.00   0   0   0     10.02   26.00   0   0   0   0     10.03   0   0   0   0     10.04   0   0   0     10.05   0   0   0   0     10.06   0   0   0     10.07   0   0   0     10.08   0   0   0     10.09   0   0   0     10.00   0   0   0     1						
12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 15.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of medical and surgical supplies to other than patients 18.00 Revenue from sale of medical records and abstracts 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 19.00 Revenue from gifts, flowers, coffee shops, and canteen 19.00 Revenue from gifts, flowers, coffee shops, and canteen 19.00 Rental of vending machines 19.00 Rental of hospital space 19.00 MI SCELLANEOUS I NCOME 20.00 MI SCELLANEOUS I NCOME 21.00 Covid other income (sum of lines 6-24) 22.00 Covid other income (sum of lines 6-24) 23.00 OTHER EXPENSES (SPECIFY) 24.00 Total other expenses (sum of line 27 and subscripts) 20.10 Covid other expenses (sum of line 27 and subscripts) 20.11 Covid other expenses (sum of line 27 and subscripts)	10.00 Purchase discounts					
13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         22.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       21.00         23.00       Governmental appropriations       0       23.00         24.00       MISCELLANEOUS INCOME       1, 392, 590       24.00         25.00       Total other income (sum of lines 6-24)       1, 619, 803       25.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00     <						
14. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from rental of living quarters       0       15. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       16. 00         17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MISCELLANEOUS I NCOME       1, 392, 590       24. 00         24. 50       COVI D-19 PHE Funding       227, 213       24. 50         25. 00       Total other income (sum of lines 6-24)       1, 619, 803       25. 00         27. 00       OTHER EXPENSES (SPECI FY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0						
15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 18.00 Revenue from sale of medical records and abstracts 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 19.00 Revenue from gifts, flowers, coffee shops, and canteen 19.00 Revenue from gifts, flowers, coffee shops, and canteen 19.00 Rental of vending machines 19.00 Rental of hospital space 19.00 Rental of hospital space 20.00 Rental of hospital space 21.00 Governmental appropriations 22.00 MM SCELLANEOUS I NCOME 23.00 COVI D-19 PHE Funding 25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY) 28.00 Total other expenses (sum of line 27 and subscripts) 20.10 Total other expenses (sum of line 27 and subscripts)						
16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       MISCELLANEOUS INCOME       1, 392, 590       24.00         24.50       COVID-19 PHE Funding       227, 213       24.50         25.00       Total other income (sum of lines 6-24)       1, 619, 803       25.00         27.00       OTHER EXPENSES (SPECIFY)       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						
17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MISCELLANEOUS INCOME       1, 392, 590       24. 00         24. 50       COVID-19 PHE Funding       227, 213       24. 50         25. 00       Total other income (sum of lines 6-24)       1, 619, 803       25. 00         26. 00       Total (line 5 plus line 25)       2, 359, 858       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00						
18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       MI SCELLANEOUS INCOME       1,392,590       24.00         24.50       COVI D-19 PHE Funding       227, 213       24.50         25.00       Total other income (sum of lines 6-24)       1,619,803       25.00         26.00       Total (line 5 plus line 25)       2,359,858       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       MI SCELLANEOUS I NCOME       1, 392, 590       24.00         24.50       COVI D-19 PHE Funding       227, 213       24.50         25.00       Total other income (sum of lines 6-24)       1, 619, 803       25.00         26.00       Total (line 5 pl us line 25)       2, 359, 858       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						
20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SCELLANEOUS I NCOME       1, 392, 590       24. 00         24. 50       COVI D-19 PHE Funding       227, 213       24. 50         25. 00       Total other income (sum of lines 6-24)       1, 619, 803       25. 00         26. 00       Total (line 5 pl us line 25)       2, 359, 858       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00						
21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SCELLANEOUS I NCOME       1, 392, 590       24. 00         24. 50       COVI D-19 PHE Funding       227, 213       24. 50         25. 00       Total other income (sum of lines 6-24)       1, 619, 803       25. 00         26. 00       Total (line 5 pl us line 25)       2, 359, 858       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00				-		
22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SCELLANEOUS I NCOME       1, 392, 590       24. 00         24. 50       COVI D-19 PHE Funding       227, 213       24. 50         25. 00       Total other income (sum of lines 6-24)       1, 619, 803       25. 00         26. 00       Total (line 5 plus line 25)       2, 359, 858       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00				ŭ,		
23. 00 Governmental appropriations 24. 00 MISCELLANEOUS INCOME 24. 50 COVID-19 PHE Funding 25. 00 Total other income (sum of lines 6-24) 26. 00 Total (line 5 plus line 25) 27. 00 OTHER EXPENSES (SPECIFY) 28. 00 Total other expenses (sum of line 27 and subscripts) 23. 00 24. 00 27. 00 28. 00 29. 00 20.				ŭ,		
24. 00       MI SCELLANEOUS INCOME       1, 392, 590       24. 00         24. 50       COVI D-19 PHE Funding       227, 213       24. 50         25. 00       Total other income (sum of lines 6-24)       1, 619, 803       25. 00         26. 00       Total (line 5 plus line 25)       2, 359, 858       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00				0		
24. 50       COVI D-19 PHE Funding       227, 213       24. 50         25. 00       Total other income (sum of lines 6-24)       1, 619, 803       25. 00         26. 00       Total (line 5 plus line 25)       2, 359, 858       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00				1, 392, 590		
26. 00       Total (line 5 plus line 25)       2, 359, 858 26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0 27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0 28. 00						
27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	25.00 Total other income (sum of lines 6-24)			1, 619, 803	25. 00	
28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	26.00 Total (line 5 plus line 25)			2, 359, 858	26. 00	
29.00 Net income (or loss) for the period (line 26 minus line 28) 2,359,858 29.00				•		
	29.00 Net income (or loss) for the period (line 26 minus line 28)				29. 00	