This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0051 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2022 1:09 pm use only] Manually prepared cost report Ilf 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. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
[19] 19. NPR Date:
[10] 19. NPR Date:
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[16] 19. NPR Date:
[17] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLOOMINGTON HOSPITAL (15-0051) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Mic	hael Craig	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Mi chael Crai g			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		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	809, 071	-31, 657	0	0	1. 00
2.00 Subprovi der - I PF	0	0	0		0	2. 00
3.00 Subprovi der - I RF	0	9, 566	0		0	3. 00
4. 00 SUBPROVI DER 1						4. 00
5.00 Swing Bed - SNF	0	0	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
200. 00 Total	0	818, 637	-31, 657	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 displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX	IU HEALTH BLOOMI IDENTIFICATION DATA			15-0051	Peri od: From 01/01/ To 12/31/	2021	of For Workshe Part I Date/Ti 5/26/20	et S-2 me Pre	pared:
	1.00	2.00		3. 00		4	4. 00			
1 00	Hospital and Hospital Health Care Co									1 00
1. 00 2. 00	Street: 601 WEST SECOND STREET City: BLOOMINGTON	PO Box: 1149 State: IN	Zip Cod	o. 47402	Coun	ty: MONROE				1. 00 2. 00
2.00	orty. Bedomineron	Component Name	CCN	CBSA	Provi der		Pavme	nt Syst	em (P.	2.00
			Number	Number		Certi fi ed		0, or		
							V	XVIII		
	Harrital and Harrital Based Community	1.00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
3. 00	Hospital and Hospital-Based Componen Hospital	IU HEALTH BLOOMINGTON	150051	14020	1 1	07/01/1966	N	P	Р	3.00
3.00	nospi tai	HOSPI TAL	130031	14020	'	077 017 1700	'`	'	' '	3.00
4.00	Subprovi der - IPF									4. 00
5.00	Subprovider - IRF	IU HEALTH BLOOMINGTON	15T051	14020	5	10/01/2002	N	P	P	5. 00
4 00	Subaravi dan (Othan)	HOSPI TAL								/ 00
6. 00 7. 00	Subprovider - (Other) Swing Beds - SNF									6. 00 7. 00
8. 00	Swing Beds - NF									8.00
9. 00	Hospi tal -Based SNF									9. 00
10.00	Hospi tal -Based NF									10.00
11. 00	Hospi tal -Based OLTC									11. 00
12.00	Hospi tal -Based HHA									12.00
13.00	Separately Certified ASC									13.00
14. 00	Hospi tal -Based Hospi ce									14.00
15. 00 16. 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									15. 00 16. 00
17. 00	Hospital-Based (CMHC) I									17.00
18. 00	Renal Dialysis									18. 00
	Other									19. 00
			•	'		From:		То	:	
	,					1. 00		2. (
	Cost Reporting Period (mm/dd/yyyy)					01/01/2	021	12/31/	/2021	20.00
21. 00	Type of Control (see instructions)					2				21. 00
					1. 00	2. 00		3. 0	00	
	Inpatient PPS Information								,,,	
22. 00	Does this facility qualify and is it	currently receiving pa	yments for	-	Υ	N				22. 00
	disproportionate share hospital adju			₹						
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		endment							
22. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un		ts for thi	s	Υ	Y				22. 01
22.01	cost reporting period? Enter in colu				•					22.01
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N			cost						
	reporting period occurring on or aft									
22. 02	Is this a newly merged hospital that payments to be determined at cost re				N	N				22. 02
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th			-						
	October 1.									
22. 03	Did this hospital receive a geograph				N	N		N		22. 03
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for			71						
	reporting period occurring on or aft									
	Does this hospital contain at least	100 but not more than 4	99 beds (a	as						
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" fo	or						
00.04	yes or "N" for no.									00.04
22. 04	Did this hospital receive a geograph rural as a result of the revised OMB				N	N		N		22. 04
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin	g period prior to Octob	er 1. Ente	er						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41 yes or "N" for no.	2.105)? Enter in colum	пз, "Y" f	or						
23. 00	Which method is used to determine Me	dicaid days on lines 24	and/or 25	,		3 N				23. 00
25.00	below? In column 1, enter 1 if date									20.00
	if date of discharge. Is the method	of identifying the days	in this o							
	reporting period different from the									
	reporting period? In column 2, ente	r "Y" for yes or "N" fo	r no.			I				I

	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.								
25. 00	If this provider is an IRF, enter the in-state	0	24	0	0	2	15		25. 00
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,								
	out-of-state Medicaid days in column 3, out-of-state								
	Medicaid eligible unpaid days in column 4, Medicaid								
	HMO paid and eligible but unpaid days in column 5.				Urban/R	ural S D	ate of	Geogr	
					1. (2.		
26. 00	Enter your standard geographic classification (not wa		at the beg	ginning of 1	the	1			26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	age) status	at the endural. If ap	d of the cos	st	1			27. 00
05.00	enter the effective date of the geographic reclassifi	cation in	column 2.						05.00
35.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number or	perioas SC	H STATUS II	י	0			35. 00
	jorrout in the cost ropertring porrou.				Begi nr		Endi	ng:	
24 00	Enter anni aghi a haginning and anding dates of COII at	tatua Cuba	orint line	2/ for numb	1. (00	2.	00	24 00
36. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 FOR NUME	ber				36. 00
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the numbe			ıs	0			37. 00
37. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37. 01
38. 00	If line 37 is 1, enter the beginning and ending dates								38. 00
	greater than 1, subscript this line for the number of enter subsequent dates.	f periods i	n excess of	one and					
	enter subsequent dates.				Y/	N	Υ/	'N	
22.22					1. (2.		20.00
39.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet taccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii)), (ii), or the mileage	(iii)? Ent	er in colum nts in	nn		Ν	ı	39. 00
40. 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reductior "N" for no in column 1, for discharges prior to Octob						N	I	40. 00
	no in column 2, for discharges on or after October 1.								
						1. 00	2. 00	3. 00	-
	Prospective Payment System (PPS)-Capital					1.00	2.00	7 3. 00	
45. 00	Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordance	N	Υ	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	•		,		N	N	N	46. 00
47.00	Pt. III.	: +-10	-+ "\/ 6	!!N!!		N.	N.		47.00
	Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment Teaching Hospitals			,		N N	N N	N N	47. 00 48. 00
56. 00	Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr	e to column	1 is "Y",	or if this	hospi tal	N			56. 00
F7.00	year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col	umn 2.		. 3					F7.00
57.00	If line 56 is yes, is this the first cost reporting pGME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y"	yes or "N th of this ", complet	" for no ir cost report e Worksheet	n column 1. ing period?	If column 1 ? Enter "Y"				57.00
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement f	or physicia	ans' service	es as				58. 00
59. 00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59. 00

	a, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					
	· · · · · · · · · · · · · · · · · · ·		'			
					1. 00	
	ACA Provisions Affecting the Health Resources and Sen	rvices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting peri	od for which	0. 00	62.00
	your hospital received HRSA PCRE funding (see instructions)					
62. 01	52.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00					
	during in this cost reporting period of HRSA THC prog	gram. (see instruction	ns)			
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings				
63.00	Has your facility trained residents in nonprovider se				N	63. 00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	57. (see instru	ctions)		

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMP		TA Provi de	TAL r CCN: 15-0051	Peri od: From 01/01/2021		
			Unwei ghted FTEs Nonprovi der Si te	FTEs in	Date/Time Pre 5/26/2022 1:0 Ratio (col. 1/ (col. 1 + col. 2))	9 pm
Section 5504 of the ACA Base Ye	or ETE Docidonts in N	opprovidor Sottino	1. 00	2.00	3. 00	
64.00 Enter in column 1, if line 63 ii in the base year period, the nuresident FTEs attributable to re	July 1, 2009 and befor s yes, or your facilit mber of unweighted nor	re June 30, 2010. ty trained residen n-primary care	,			64. 00
resident FTEs that trained in y	e number of unweighted our hospital. Enter in	n column 3 the rat				
of (column 1 divided by (column	1 + column 2)). (see Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	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 residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			O. Unwei ghted	0.00		
			FTEs Nonprovi der Si te	FTES in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Current		n Nonprovider Sett	1.00 tingsEffective	2.00 for cost reporti	3.00 ng periods	
beginning on or after July 1, 2 66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-primar occurring in all nonpr unweighted non-primar tal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.	00 0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1.00	2. 00	3. 00	4. 00 00 0. 00	5. 00 0. 000000	47.00
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)				0.00	9. 5000000	37. 30

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 1:09 pm 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 75.00 75.00 Υ 0 Ν Ν 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 'Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 N Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 87.00 N XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90.00 yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in Ν N 91.00 full or 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)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. N 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter Ν Ν 93.00 Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν N 94.00 applicable column. 95.00 If line 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 in the 0 00 0 00 95 00 96.00 Ν N 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 N stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 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 charges on Wkst. Ν 98.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 Υ 98.02 Ν for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of N 98.04 Ν outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Ν Υ Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Ν Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105.00 106.00 of this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

ealth Financial Systems IU HEALTH BLOOMIN OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		eri od:	Worksheet S-	2
		To	com 01/01/2021 0 12/31/2021		epare
			V	5/26/2022 1: XI X	09 pm
			1. 00	2.00	_
8.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 42	N		108.
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	
19.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109
				1.00	
D. 00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "' complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable.	Y" for yes or	"N" for no. If	yes,	N	110
			1.00	2.00	_
1.00 f this facility qualifies as a CAH, did it participate in t	he Frontier C	ommuni tv	1. 00 N	2.00	111
Health Integration Project (FCHIP) demonstration for this co- "Y" for yes or "N" for no in column 1. If the response to co- integration prong of the FCHIP demo in which this CAH is par- Enter all that apply: "A" for Ambulance services; "B" for ad- for tele-health services.	st reporting lumn 1 is Y, ticipating in	period? Enter enter the column 2.	·		
		1. 00	2. 00	3.00	-
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	peri od? "Y", enter e	N			112
Miscellaneous Cost Reporting Information 5.00 s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N		1	0115
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9. for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider: the definition in CMS Pub. 15-1, chapter 22, §2208.1.	, or E only) 3" percent includes	IV			0 115
ine definition in C _M S Fub. 13-1, chapter 22, §2206.1. 6.00 s this facility classified as a referral center? Enter "Y" - "N" for no.	for yes or	Y			116
7.00 s this facility legally-required to carry malpractice insur	ance? Enter	N			117
"Y" for yes or "N" for no. 3.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.		1			118
		Premiums	Losses	Insurance	
		1. 00	2.00	2.00	4
8.01 List amounts of malpractice premiums and paid losses:		402, 522		3.00	0118
8.02 Are malpractice premiums and paid losses reported in a cost of	center other	than the	1. 00 N	2.00	118
Administrative and General? If yes, submit supporting scheduland amounts contained therein. O OO DO NOT USE THIS LINE					119
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for t	" for yes or he Outpatient	N	N	120
	ntable device	s charged to	Υ		121
			Y	5. 00	122
patients? Enter "Y" for yes or "N" for no.		r in column 2			
patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	is "Y", ente		NI NI		125
patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	is "Y", ente		N		125
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, en	is "Y", ente r yes and "N" ter the certi	for no. If	N		
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2	r yes and "N" ter the certi	for no. If	N		126
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2. 6.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2.	r yes and "N" ter the certi er the certif	for no. If fication date ication date	N		125 126 127
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 3 in	r yes and "N" ter the certi er the certif er the certif	for no. If fication date ication date	N		126
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entering in column 1 and termination date, if applicable, in column 2, noulmn 1 and termination date, if applicable, in column 2, noulmn 1 and termination date, if applicable, in column 2, noulmn 1 and termination date, if applicable, in column 2, noulmn 1, and termination date, if applicable, in column 2, noulmn 1, and termination date, if applicable, in column 2, noulmn 1, and termination date, if applicable, in column 2, noulmn 1, and termination date, if applicable, in column 2, noulmn 1, and termination date, if applicable, in column 2, noulmn 3, noulmn 3, noulmn 3, noulmn 4, noulmn 5, noulmn 1, n	r yes and "N" ter the certifer the certifer the certifer.	for no. If fication date ication date	N		126
 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entering in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, entering column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, entering this is a Medicare certified liver transplant center, entering the column 2. 	r yes and "N" ter the certif. er the certiff. r the certifi	for no. If fication date ication date ication date cation date in	N		120 121 128

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	IU HEALTH BLOOM X IDENTIFICATION DATA	Provider CC	:N: 15-0051		In Lie /01/2021 //31/2021	u of Form CMS- Worksheet S- Part I Date/Time Pro	2 epared:
						5/26/2022 1:0	09 pm
					1. 00	2.00	
131.00 f this is a Medicare certified in date in column 1 and termination of	late, if applicable, in co	olumn 2.					131. 00
132.00 f this is a Medicare certified is in column 1 and termination date,			cation date				132. 00
133.00 Removed and reserved 134.00 If this is an organ procurement or	ganization (OPO), enter 1	the OPO number i	n column 1				133. 00 134. 00
and termination date, if applicabl	e, in column 2.						
140.00 Are there any related organization chapter 10? Enter "Y" for yes or '	N" for no in column 1. If	yes, and home	office costs	6	Υ	15H059	140. 00
are claimed, enter in column 2 the	e home office chain number		i ons)		3. 00		
If this facility is part of a chai			ugh 143 the i	name and		of the	
home office and enter the home of							
141.00 Name: INDIANA UNIVERSITY HEALTH	INC Contractor's Name: W PO Box:	PS	Contract	or's Num	nber: 0810)1	141. 00 142. 00
143. 00 Ci ty: I NDI ANAPOLI S	State:	N	Zi p Code	:	4620	2-3082	143. 00
						1 00	-
144.00 Are provider based physicians' cos	sts included in Worksheet	A?				1. 00 Y	144. 00
145.00 If costs for renal services are cl	aimed on Wkst A line 7/	1 are the costs	for		1. 00 Y	2.00	145. 00
inpatient services only? Enter "Y'	for yes or "N" for no ir	n column 1. If o	column 1 is		•		143.00
no, does the dialysis facility inc period? Enter "Y" for yes or "N"		n for this cost	reporti ng				
146.00 Has the cost allocation methodolog		ously filed cost	report?		N		146. 00
Enter "Y" for yes or "N" for no ir	column 1. (See CMS Pub.			=			
yes, enter the approval date (mm/c	dd/yyyy) in column 2.						
						1.00	
147.00 Was there a change in the statisti						Y	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				no.		N N	148. 00 149. 00
The selling the selling to the selling.	ou best illianing methou.	Part A	Part B		tle V	Title XIX	1171.00
Does this facility contain a provi	dan that qualifies for an	1.00	2.00		3.00	4.00	
or charges? Enter "Y" for yes or '							
155.00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF		N	l N		N N	N	156. 00 157. 00
157. 00 Subprovider - 1 RF 158. 00 SUBPROVI DER		N	l N		IN	N	157.00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N N		N	N	160.00
161. 00 CMHC			N N		N	N	161. 00
						1.00	
Multicampus 165.00 Is this hospital part of a Multica	ampus hospital that has or	ne or more campu	uses in diffe	erent CBS	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State Zi	p Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column						0.0	0 166. 00
0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
cordiiir o (see Tristraetrons)							
Usal the La-Garanatical Tables of any (III)	T) !	D	J. D.:	-+ ^-+		1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful user				III ACT		Υ	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a meanir	ngful user (line		, enter	the		168. 00
reasonable cost incurred for the H			. augl: 6: 6	- o be!	-hir		140.01
168.01 If this provider is a CAH and is reexception under §413.70(a)(6)(ii)?					ып р		168. 01
169.00 If this provider is a meaningful u	user (line 167 is "Y") and				nter the	9.9	9169. 00
transition factor. (see instruction	ons)						1

Health Financial Systems	IU HEALTH BLOOMING	TON HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051					
			From 01/01/2021	Part I		
			To 12/31/2021			
				5/26/2022 1:0	9 pm	
			Begi nni ng	Endi ng		
	1. 00	2.00				
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)			170. 00			
			1. 00	2.00		
171.00 If line 167 is "Y", does this provid	ler have any days for indiv	viduals enrolled in	Y	1, 183	171. 00	
section 1876 Medicare cost plans rep	orted on Wkst. S-3, Pt. I,	line 2, col. 6? Enter				
"Y" for yes and "N" for no in column	ı 1. If column 1 is yes, er	nter the number of sectio	n			
1876 Medicare days in column 2. (see	e instructions)					

			'	0 12/31/2021	5/26/2022 1:0	
		<u>'</u>		Y/N	Date	
		6 11 110		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	sponses. Enter	all dates in s	the	
	Provider Organization and Operation	 			T	
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c		instructions)	N Date	V/I	1. 00
			Y/N 1.00	Date 2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N	2. 00	0.00	2. 00
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board	Y			3. 00
			Y/N	Type	Date	
	F:		1.00	2. 00	3. 00	
	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	А		4. 00
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5. 00
				Y/N	Legal Oper.	
				1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	the provider	N		6. 00
. 00 3. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		ved during the	Y N		7. 00 8. 00
0. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	r renewed in t		N		10.00
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11. 00
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			st reporting	Y N	12. 00 13. 00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		•		N	14. 00
15. 00	Did total beds available change from the prior cost reporti				Y	15. 00
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16. 00
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Υ	05/02/2022	Υ	05/02/2022	17. 00
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Report data for Other? Describe the other adjustments: Y/N Bate		Financial Systems I U HEALTH BLOOM				u of Form CM	
20.00 If I line 10 or 17 is yes, were adjustments made to PSSR N N N 2.0	HOSPII	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (JCN: 15-0051	From 01/01/2021	Part II Date/Time F	repared:
20.00 If I line 16 or 17 is yes, were adjustments ander to PSSR N N 20.			Descr				
Report data for Other? Describe the other adjustments: Y/N Date Y/N Date Y/N Date	20.00	If line 16 or 17 is was were adjustments made to DSOD		U			20. 00
1.00 2.00 3.00 4.00 2.10 2.00 3.00 4.00 2.10	20.00				IN .	IV.	20.00
2.0.00 Was the cost report prepared only using the provider's N							
Precords? If yes, see instructions. 1.00		In the second se	_	2.00		4. 00	
Commetted BY COST RELIBBILISED AND TEFFA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.00 Have assets been relife for Medicare purposes? If yes, see instructions 22.00 Have cassets been relife for Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 23.00 Have changes occurred in the Medicare depreciation expenses due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were assets subject to Sec 2314 of DEFFA acquired during the cost reporting period? If yes, see Instructions. 25.00 Were assets subject to Sec 2314 of DEFFA acquired during the cost reporting period? If yes, see Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copporting period? If yes, see Instructions. 28.00 Were men loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 29.00 Were men loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 30.00 Has expensed instructions. 30.01 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 30.01 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 31.00 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 32.01 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 33.02 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 34.03 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 35.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 35.00 Have changes or new agreements occurred in patient care services furnished thr	21.00		N N		IN .		21. 00
Commetted BY COST RELIBBILISED AND TEFFA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.00 Have assets been relife for Medicare purposes? If yes, see instructions 22.00 Have cassets been relife for Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 23.00 Have changes occurred in the Medicare depreciation expenses due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were assets subject to Sec 2314 of DEFFA acquired during the cost reporting period? If yes, see Instructions. 25.00 Were assets subject to Sec 2314 of DEFFA acquired during the cost reporting period? If yes, see Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copporting period? If yes, see Instructions. 28.00 Were men loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 29.00 Were men loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 30.00 Has expensed instructions. 30.01 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 30.01 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 31.00 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 32.01 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 33.02 Has expensed for year a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 34.03 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 35.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 35.00 Have changes or new agreements occurred in patient care services furnished thr						1. 00	
Page 12.00 Have assets been relifed for Medicare purposes? If yes, see Instructions 22.		COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)			
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions. 27.00 Has the low of the set of years of yea							
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit coby. 28.00 Period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 32.00 If I in a sign of the provider has period? If yes, see instructions. 33.00 If I in a sign of the provider has period? If yes, see instructions. 34.00 Are seed Physicians 35.00 If I in a sign of the provider period? If yes, see instructions. 36.00 Were dead Physicians 37.00 I have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 36.00 Were dead Physicians 37.00 I if I in a sign of the provider period? If yes, see instructions. 38.00 If I in a sign of the provider period? If yes, see instructions. 39.00 If I in a sign of the provider period? If yes, see instructions. 39.00 If I in a sign of the provider period? If yes, see instructions. 39.00 If I in a sign of the provider period? If yes, see instructions. 30.00 Were home office costs claimed on the cost report? 30.00 Were home office costs, was the fiscal year end of the home office? 30.00 Were home office costs, was the fiscal year end of the home office? 30.00 Were home office costs, and the provider render servi					ing the cost		22. 00
24.00 Were new Teases and/or amendments to existing Leases entered into during this cost reporting period? 1	23.00		due to apprai	sars made dur	ing the cost		23.00
Nave there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. 25.	24. 00		ed into during	this cost re	eporting period?		24. 00
instructions. 2.0.0 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 2.0.0 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. Interest Expense 2.0.0 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 2.0.0 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions on the sex isting debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 3.1.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 3.2.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 3.2.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 3.2.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 3.2.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 3.2.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 3.2.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 3.2.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 3.2.00 If I in a 3 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 3.2.00 If I in a 3 is yes, were the requirements or amended existing agreements with the provider-based physicians? 3.2.00 If I in a 3 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting perior? If yes, see instructions. 3.2.00 If I in a 3 is yes, has a							05.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions 30.00 Has estixting debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 If files 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 35.00 If files 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. 36.00 Were home office costs 37.00 If files 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians of the provider facility under an arrangement with the provider-based physicians? If yes, see instructions. 38.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? If yes, see instructions. 39.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? If yes, see instructions. 39.00 If line 34 is yes, see instructions. 30.00 If line 34 is yes, has a home office costs statement been prepared by th	25. 00		tne cost repo	rting period?	'IT yes, see		25. 00
Instructions. 27.	26. 00		he cost report	ing period? I	f yes, see		26. 00
Copy. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions 29.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30. 10.00 Nas debt been replaced prior to its scheduled maturity with new debt? If yes, see 31. 10.00		instructions.	·	0 1			
Interest Expense 28.00 Were new Joans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.	27. 00		e cost reporti	ng period? If	ges, submit		27. 00
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43.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH.ORG 43.	72.00		I WOLAWA ONLYE	NOT IT HEALTH			72.00
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		report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE	Provi der Co		Peri od:	Worksheet S-2	
					From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/26/2022 1:0	pared:
			3.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the tit	tle/position	DI RECTOR				41. 00
	held by the cost report preparer in columns	s 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost	t report					42.00
	preparer.						
43.00	Enter the telephone number and email addres	ss of the cost					43.00
	report preparer in columns 1 and 2, respect	ti vel y.					

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0051

					-	Γο 12/31/2021	Date/Time Pre 5/26/2022 1:0	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		206	75, 190	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	
6.00	Hospital Adults & Peds. Swing Bed NF						0	
7.00	Total Adults and Peds. (exclude observation			206	75, 190	0.00	0	7. 00
	beds) (see instructions)	04.00						
8. 00	I NTENSI VE CARE UNI T	31. 00		16	1			
9.00	CORONARY CARE UNIT	32. 00		15	5, 47!	0.00	0	
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT	05.00			,			11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00		18	6, 570	0.00		
13.00	NURSERY	43. 00		055			0	
14. 00	Total (see instructions)			255	93, 07!	0.00		
15. 00	CAH visits						0	
16.00	SUBPROVIDER - I PF	41 00		15	F 47	_		16. 00
17. 00	SUBPROVI DER - I RF	41. 00		15			0	
18.00	SUBPROVI DER	42. 00		0	1)	0	
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00 22. 00	OTHER LONG TERM CARE	101. 00					0	21. 00 22. 00
	HOME HEALTH AGENCY		l				0	23. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	115. 00		0				24.00
	HOSPICE (non-distinct part)	116. 00	1	U	1)		24. 00
24. 10 25. 00	CMHC - CMHC	30. 00						25. 00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)	07.00		270			ľ	27. 00
28. 00	Observation Bed Days			270			0	
29. 00	Ambul ance Tri ps						Ĭ	29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see l'histraction)							31. 00
32. 00	Labor & delivery days (see instructions)			12	4, 380			32.00
32. 01	Total ancillary labor & delivery room			12	7, 300			32. 00
52. 01	outpatient days (see instructions)							32.01
33.00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01
	, , , , , , , , , , , , , , , , , , , ,	'	'		•	1	•	

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO | Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared: | Provider CCN: 15-0051

Component
Note
Name
1.00
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 11,925 14,812 2.00
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 11,925 14,812 2.00
For the portion of LDP room available beds 2.00 3.00 HM0 and other (see instructions) 11,925 14,812 2.00 3.00 4.00 HM0 IRF Subprovi der 0.00
2. 00 HMM and other (see instructions)
3.00 HM0 IPF Subprovi der 4.00 HM0 IRF Subprovi der 5.00 Hospi tal Adul ts & Peds. Swing Bed SNF 6.00 Hospi tal Adul ts & Peds. Swing Bed NF 7.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8.00 INTENSI VE CARE UNI T 9.00 CORONARY CARE UNI T 10.00 BURN INTENSI VE CARE UNI T 11.00 SURGI CAL INTENSI VE CARE UNI T 12.00 NEONATAL INTENSI VE CARE UNI T 13.00 NURSERY 13.00 NURSERY 13.00 Total (see instructions) 18, 789 3, 759 62, 579 0.00 1, 677. 67 14, 00 150 0.00 0.00 0.00 0.00 0.00 0.00 0.
4.00
5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 0 6.00 6.00 6.00 7.0
6.00 Hospital Adults & Peds. Swing Bed NF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
Total Adults and Peds. (exclude observation beds) (see instructions) 15,688 834 47,755 8.00 1 NTENSI VE CARE UNIT 1,512 1,294 4,293 8.00 9.00 1 NTENSI VE CARE UNIT 1,589 0 4,188 9.00 1.000
Beds (see instructions)
8.00 INTÉNSÍVE CARE UNIT 1,512 1,294 4,293 8.00 9.00 CORONARY CARE UNIT 1,589 0 4,188 9.00 10.00 BURN INTENSÍVE CARE UNIT 10.00 11.00 SURGICAL INTENSÍVE CARE UNIT 11.00 12.00 NEONATAL INTENSÍVE CARE UNIT 0 313 3,527 12.00 13.00 NURSERY 1,318 2,816 13.00 14.00 15.00 CAH visits 0 0 0 0 0 15.00 15.00 CAH visits 0 0 0 0 0 15.00 15.00 15.00 SUBPROVÍDER - IPF 0 0 0 0 0 0 0 0 0
9. 00 CORONARY CARE UNIT 1,589 0 4,188 9. 00 10. 00
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 1
11. 00 SURGICAL INTENSIVE CARE UNIT
12.00
13.00 NURSERY 1,318 2,816 13.00 14.00 15.00 16.00 15.00 16.00 15.00 16.00 17.00 16.00 17.00 18.00 18.789
14. 00 Total (see instructions) 18,789 3,759 62,579 0.00 1,677.67 14. 00 15. 00 16. 00 0 0 0 0 0 15. 00 16. 00 16. 00 17. 00 17. 00 18. 00 18. 00 19. 00
15. 00 CAH visits 0 0 0 0 0 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 SUBPROVIDER - I PF 17. 00 SUBPROVIDER - I RF 596 24 1,357 0. 00 0. 00 17. 00 18. 00 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 0 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 20. 00 AMBULATORY SURGICAL CENTER (D. P.) 22. 00 HOSPICE 0 0 0 0 0. 00 0. 00 22. 00 23. 00 24. 00 HOSPICE 0 0 0 0 0. 00 0. 00 24. 00 24. 10 HOSPICE (non-distinct part) 24. 10 HOSPICE (non-distinct part) 24. 10 CMHC - CMHC 25. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 0 0 0 0. 00 0. 00 26. 25 27. 00 Total (sum of lines 14-26)
16. 00 SUBPROVI DER - I PF 16. 00 17. 00 18. 00 17. 00 18. 00 19. 00
17. 00 SUBPROVIDER - IRF 596 24 1,357 0.00 0.00 17. 00 18. 00 SUBPROVIDER 0 0 0.00 0.00 18. 00 19. 00 SKI LLED NURSING FACILITY 20. 00 0.01 17. 00 20. 00 NURSING FACILITY 21. 00 0.01 17. 00 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 0 0 0.00 0.00 22. 00 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 0.00 23. 00 24. 00 HOSPICE 0 0 0 0.00 0.00 24. 00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 25. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 1, 677. 67 27. 00
18. 00 SUBPROVI DER 0 0 0 0 0 0 0 18. 00 19. 0
19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE OTHER LONG TER
20.00 NURSING FACILITY 20.00 21.00 0 0 0 0 0 0 0 22.00 23.00 NURSING FACILITY 0 0 0 0 0 0 0 0 0
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 0 0 0 0 0 0.00 0.00 22.00 24.10 HOSPICE 0 0 0 0 0.00 0.00 24.00 24.10 HOSPICE 0 0 0 0 0.00 0.00 24.00 25.00 CMHC - CMHC 25.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 21.00 0 0 0 0.00 0.00 22.00 22.00 0 0 0 0.00 0.0
22.00
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE
24.00 HOSPICE 0 0 0.00 0.00 24.00 24.10 HOSPICE (non-distinct part) 94 24.10 24.10 25.00 CMHC - CMHC 25.00 26.00 26.00 26.00 26.00 RURAL HEALTH CLINIC 26.00 0 0.00 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 0 0 0.00 1,677.67 27.00
24. 10 HOSPICE (non-distinct part) 94 24. 10 25. 00 CMHC - CMHC 25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 00 0. 00 0. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 1, 677. 67 27. 00
25. 00 CMHC - CMHC 25. 00 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 00 0. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 1, 677. 67 27. 00 27. 00 28. 25 28. 2
26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 00 0. 00 0. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 1, 677. 67 27. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0 0.00 1,677. 67 27. 00
27.00 Total (sum of lines 14-26) 0.00 1,677.67 27.00
28.00 Observation Bed Days 91 3,812 28.00
29.00 Ambul ance Trips 3,333 29.00
30.00 Employee discount days (see instruction) 0 30.00
31.00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions) 0 37 1,463 32.00
32.01 Total ancillary labor & delivery room 0 32.01
outpatient days (see instructions)
33.00 LTCH non-covered days 0 33.00
33.01 LTCH site neutral days and discharges 0 33.01

Provider CCN: 15-0051

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared: |

Full Time Equivalents Nonpaid Workers Title V Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title V Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title V Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title V Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title XVIII Title XIX Total AlI Patients Nonpaid Workers Title XVIII Title XIX Total AlI Nonpaid
Nonpaid Nonpaid Nonpaid Title V Title XVIII Title XIX Total All Patients
No.
11.00 12.00 13.00 14.00 15.00
1.00
Sexclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)
Hospice days) (See instructions for col. 2 for the portion of LDP room available beds)
For the portion of LDP room available beds) 2.00
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults & Peds. Swing Bed NF 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 NEONATAL INTENSIVE CARE UNIT 13.00 NAUSSERY 14.00 Total (see instructions) 15.00 CAR Visits 16.00 NEONATAL INTENSIVE CARE UNIT 17.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 O O O O O O O O O O O O O O O O O O
3. 00
4.00
5.00
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 COROMARY CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 NOROMATAL INTENSIVE CARE UNIT 13.00 Total (see instructions) 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER ON
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURRI NITENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 NEONATAL INTENSIVE CARE UNIT 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 S
beds) (see instructions)
8. 00 INTENSIVE CARE UNIT
9. 00 CORONARY CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 12. 00 NEONATAL INTENSIVE CARE UNIT 12. 00 12. 00 13. 00 14. 00 15. 00 CAH visits 15. 00 CAH visits 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 16. 00 18. 00 19. 00 38 0 89 17. 00 19. 00 19. 00 SKILLED NURSING FACILITY 20. 00 19. 00 SKILLED NURSING FACILITY 20. 00 22. 00 HOME HEALTH AGENCY 20. 00 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC -
10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 NEONATAL INTENSIVE CARE UNIT 13. 00 NURSERY 13. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER FACILITY 19. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 HOSPICE 24. 00 HOSPICE 24. 00 HOSPICE 25. 00 CMC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 29. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 20. 00 Medians A 10. 00 11. 00 11. 00 12. 00
11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 NEONATAL INTENSIVE CARE UNIT 12. 00 12. 00 12. 00 14. 00 15. 00 15. 00 16. 00 16. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00 18. 00 19. 00 18. 00 19. 00 18. 00 19.
12. 00 NEONATAL INTENSIVE CARE UNIT 12. 00 13. 00 14. 00 Total (see instructions) 0. 00 0 3, 650 344 12, 006 14. 00 15. 00 CAH visits 15. 00 16. 00 SUBPROVI DER - IPF 0. 00 0 38 0 89 17. 00 18. 00 19. 00 SKILLED NURSI NG FACILITY 0. 00 SKILLED NURSI NG FACILITY 0. 00 THER LONG TERM CARE 0. 00 0 0 0 0 0 0 0 0
13.00 NURSERY 13.00 14.00 Total (see instructions) 0.00 0 3,650 344 12,006 14.00 15.00 CAH visits 16.00 SUBPROVI DER - IRF 0.00 0 38 0 89 17.00 CAH visits
14.00 Total (see instructions) 0.00 0 3,650 344 12,006 14.00 15.00 16.00 SUBPROVI DER - IPF 0.00 0 38 0 89 17.00 18.00 18.00 19.00 SKI LLED NURSI NG FACI LITY 0.00
15. 00 CAH visits 15. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOME HEALTH AGENCY 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 15. 00 0 0 38 0 89 17. 00 0 0 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 0. 00 0 38 0 89 17. 00 18. 00 SUBPROVI DER 18. 00 0 0 0 0 0 0 0 18. 00 0 0 0 0 0 0 0 0 0
17. 00 SUBPROVIDER - IRF
18. 00 SUBPROVI DER 0. 00 0 18. 00 19.
19. 00
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 21. 00 22. 00 23. 00 24. 00 23. 00 24. 00 25. 00 26. 25 27. 00 28. 00 29. 00 29. 00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 22. 00 23. 00 23. 00 24. 00 24. 00 25. 00 26. 25 27. 00 28. 00 Observation Bed Days 29. 00
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 0. 00 24. 00 HOSPICE 0. 00 00 24. 10 HOSPICE (non-distinct part) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMRAL HEALTH CLINIC 25. 00 EXPALLY QUALIFIED HEALTH CENTER 0. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00
24. 00 HOSPICE
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 24. 10 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 25. 00 26. 25 26. 00 27. 00 28. 00 29. 00 29. 00
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 26. 00 26. 25 27. 00 28. 00 29. 00 Ambulance Trips 26. 00 26. 25 27. 00 28. 00 29. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 27. 00 28. 00 Observation Bed Days 28. 00 Ambulance Trips 29. 00
27. 00 Total (sum of lines 14-26) 0.00 28. 00 Observation Bed Days 28. 00 29. 00 Ambulance Trips 29. 00
28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 28. 00 29. 00
29. 00 Ambul ance Tri ps 29. 00
30.00 Employee discount days (see instruction) 30.00
31.00 Employee discount days - IRF 31.00
32.00 Labor & delivery days (see instructions) 32.00
32.01 Total ancillary labor & delivery room 32.01
outpatient days (see instructions)
33. 00 LTCH non-covered days
33.01 LTCH site neutral days and discharges 0 33.01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0051

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021

					To	o 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	131, 217, 636	-493, 273	130, 724, 363	3, 489, 559. 17	37. 46	1.00
2. 00	instructions) Non-physician anesthetist Part A		0	0	0	0.00	0. 00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0. 00	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 83, 362	_	0 83, 362	0. 00 882. 24		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	o	0	0.00	0. 00	6.00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7.00
7. 01	Contracted interns and residents (in an approved programs)		0	0	О	0.00	0.00	7.0
8. 00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8.00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 14, 046, 642	0 1, 110, 984	0 15, 157, 626	0. 00 473, 413. 61	l .	
11. 00	instructions) OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		1, 785, 664	0	1, 785, 664	21, 628. 00	82. 56	11.00
12. 00	Care Contract labor: Top level		1, 785, 664			0.00		12.00
12.00	management and other management and administrative services		O		J	0.00	0.00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		1, 043, 922	0	1, 043, 922	8, 874. 50	117. 63	13.00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14. 01 14. 02	Home office salaries Related organization salaries		36, 179, 383 0	0	0	0.00	0. 00	
15. 00	Home office: Physician Part A - Administrative		0	_	0	0.00		
16. 00 16. 01	Home office and Contract Physicians Part A - Teaching Home office Physicians Part A		0	_	0	0.00		
16. 02	- Teachi ng		0		0	0.00		16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS						0.00	1
17. 00	Wage-related costs (core) (see instructions)		27, 968, 518	0	27, 968, 518			17. 00
18. 00	Wage-related costs (other) (see instructions)		4 044 042		4 044 040			18.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		4, 064, 943 0	0	4, 064, 943 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 12, 165	0	0 12, 165			22. 0° 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	0	0			24. 00 25. 00
25. 50	Home office wage-related (core)		10, 633, 403	0	10, 633, 403			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 5
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

Provider CCN: 15-0051

					T	12/31/2021	Date/Time Prep 5/26/2022 1:0	
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARII	<u> </u>						
26. 00	Employee Benefits Department	4.00	389, 293	-76, 889	312, 404	8, 210. 34	38. 05	26. 00
27. 00	Administrative & General	5. 00	7, 247, 105	· ·	·	•		
28. 00	Administrative & General under		2, 363, 970		2, 363, 970			
20.00	contract (see inst.)		2, 303, 970		2, 303, 770	12, 740.00	102.00	20.00
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	2, 406, 805	-4, 704	2, 402, 101	84, 964. 82	28. 27	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31. 00
32.00	Housekeepi ng	9. 00	1, 965, 421	-5, 821	1, 959, 600	113, 341. 95	17. 29	32. 00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	2, 120, 708	-572, 397	1, 548, 311	81, 110. 48	19. 09	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	566, 418	566, 418	33, 601. 61	16. 86	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	15, 238, 873	-89, 621	15, 149, 252	212, 935. 04	71. 14	38. 00
39.00	Central Services and Supply	14. 00	-150	150	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	6, 290, 092	-573, 387	5, 716, 705	128, 762. 39	44. 40	40. 00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00		42.00
43.00	Other General Service	18. 00	720, 701	-5, 799	714, 902	33, 659. 71	21. 24	43.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0051 Worksheet S-3 Peri od: From 01/01/2021 To 12/31/2021 Part III Date/Time Prepared: 5/26/2022 1:09 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) Salaries in (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 133, 498, 244 -493, 273 133, 004, 971 3, 501, 622. 93 37. 98 1.00 instructions) 2.00 1, 110, 984 473, 413. 61 32. 02 2.00 Excluded area salaries (see 14, 046, 642 15, 157, 626 instructions) 3.00 Subtotal salaries (line 1 119, 451, 602 -1, 604, 257 117, 847, 345 3, 028, 209. 32 38. 92 3.00

39, 008, 969

38, 601, 921

195, 458, 235

37, 327, 779

Ω

-1, 604, 257

-1, 415, 039

918, 641. 50

3, 946, 850. 82

828, 455. 68

0.00

42.46

32. 76

49 52

45.06

4.00

5.00

6.00

7.00

39, 008, 969

38, 601, 921

197, 062, 492

38, 742, 818

minus line 2)

(see inst.)

instructions)

costs (see inst.)

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

4.00

5.00

6.00

7.00

| Period: | Worksheet S-3 | From 01/01/2021 | Part IV | Date/Time Prepared: | 5/26/2022 1:09 pm

		5/26/2022 1: 09	9 pm
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
. 00	401K Employer Contributions	4, 927, 885	1.
. 00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.
. 00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.
	Qualified Defined Benefit Plan Cost (see instructions)	0	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
	401K/TSA Plan Administration fees	0	5.
. 00	Legal /Accounting/Management Fees-Pension Plan	0	6.
	Employee Managed Care Program Administration Fees	0	7.
	HEALTH AND INSURANCE COST		
	Health Insurance (Purchased or Self Funded)	0	8.
	Health Insurance (Self Funded without a Third Party Administrator)	Ö	8.
	Heal th Insurance (Self Funded with a Third Party Administrator)	16, 395, 267	8.
	Heal th Insurance (Purchased)	0	8.
	Prescription Drug Plan	0	9.
	Dental, Hearing and Vision Plan	0	10.
	Life Insurance (If employee is owner or beneficiary)	369, 893	
	Accident Insurance (If employee is owner or beneficiary)	307, 073	12.
	Disability Insurance (If employee is owner or beneficiary)	445, 655	
	Long-Term Care Insurance (If employee is owner or beneficiary)	445, 055	14.
5. 00	'Workers' Compensation Insurance	488, 802	
6. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	400, 602	16.
6.00	Non cumulative portion)	۷	10.
	TAXES		
	FICA-Employers Portion Only	9, 412, 678	17
	Medicare Taxes - Employers Portion Only	9, 412, 078	18.
	Unemployment Insurance	0	19.
	State or Federal Unemployment Taxes	0	20.
	State of Federal Unemproyment Taxes OTHER	U	20.
	•	0	21
1. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	U	21.
2 00		0	22
	Day Care Cost and Allowances	5, 446	22.
	Tuition Reimbursement	•	
	Total Wage Related cost (Sum of lines 1 -23)	32, 045, 626	24.
	Part B - Other than Core Related Cost		
5.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0051	From 01/01/2021	Worksheet S-3 Part V Date/Time Prepared:

		10 12/31/2021	5/26/2022 1:0	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1, 785, 664	32, 045, 626	1. 00
2.00	Hospi tal	1, 785, 664	27, 968, 518	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	11. 00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18. 00	Other	0	4, 077, 108	18. 00

No.	HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-0051 Period: From 01/01/2/201 To 12/31/2021 Date/Time Prepare 526/2022 1:09 pm Incompensated and Indigent care cost computation 1.00 1.00 Incompensated and Indigent care cost computation 1.00 1.00 1.00 Incompensated and Indigent care cost computation 1.00 1.00 1.00 1.00 Incompensated and Indigent care cost computation 1.00 1.00 1.00 1.00 1.00 Incompensated and Indigent care cost computation 1.00
Incompensated and indigent care cost computation 1.00	Incompensated and indigent care cost computation Incompensated (See instructions for each line) Incompensated (See Instru
	S/26/2022 1:09 pm S/26/2022 1:09 pm I.00 I.
Incorporated and indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I Time 202 column 3 divided by line 202 column 8) 0.179729 1.00	Uncompensated and Indigent care cost computation Control
Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.1797279 1.00	1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.179729 1
Medicald (see Instructions for each line)	Medicald (see instructions for each line) Net revenue from Medicald 10 to you receive DSH or supplemental payments from Medicald? Y 3 to you receive DSH or supplemental payments from Medicald? Y 4 to you receive DSH or supplemental payments from Medicald? Y 4 to you receive DSH or supplemental payments from Medicald? Y 4 to you receive DSH or supplemental payments from Medicald? Y 4 to you receive DSH or supplemental payments from Medicald? Y 4 to you receive DSH or supplemental payments from Medicald? Y 4 to you receive DSH or supplemental payments from Medicald Y Y 4 to you receive DSH or supplemental payments from Medicald Y Y 4 to you receive DSH or supplemental payments from Medicald Y Y 4 to you receive DSH or supplemental payments from Medicald Y Y Y Y Y Y Y Y Y
Net revenue from Medicald	2.00 Metr revenue from Medicaid 63,383,212 2 3.00 1 1 1 1 1 1 1 1 1
Did you receive DSH or supplemental payments from Medicald? Y 4.00 Filine 3 is yes, does line 2 Include all DSH and/or supplemental payments from Medicald? Y 4.00 5.00 Filine 4 is no, then enter DSH and/or supplemental payments from Medicald? Y 4.00 5.00 O Modical did charges 366,093,74 6.00 6.00 Modical did charges 366,093,74 6.00 6.00 Modical did charges 366,093,74 6.00 6.00 Modical did charges 7.00 Medical did did charges 7.00 Medical did did charges 7.00 Medical did did did did did did did did did di	3.00 Did you receive DSH or supplemental payments from Medicaid? Y 3 4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Y 3 4.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid Y O 5 5 5 5 5 5 5 5 5
If	15 10 16 11 11 12 13 14 15 15 15 15 15 15 15
Medical d charges 366,093,746 6.00	6.00 Medicaid charges Medicaid cost (line 1 times line 6) 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2, 414, 451 8 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Medical doost (line 1 times line 6) Medical doost (line 1 times line 6) Medical doost (line 1 times line 6) 2, 414, 451 2, 414, 451 2, 414, 451 2, 414, 451 2, 414, 451 3, 00 2, 2ero then enter zero)	7.00 Medicaid cost* (line 1 times line 6) 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2, 414, 451 8 2 2 2 2 2 2 2 2 4 14, 451 8 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
8.00 On On On On On On On	8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; If 2, 414, 451 8 2 ero then enter zero) 9.00 Net revenue from stand-al one CHIP (see instructions for each line) 9.00 Stand-al one CHIP charges 0 11.00 Stand-al one CHIP (line 1 minus line 9; if < zero then enter zero) 0.11 Oifference between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then enter zero) 0.12 Oither state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (see instructions for each line) 14.00 Charges for patients covered under state or local indigent care program (Not included on lines 2, 5 or 9) 56, 497 13 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 54, 702 16 16 17 2 2 2 2 2 2 2 2 2 2 2 2 3 3 2 2 2 2 2
Second the nether zero)	czero then enter zero Children's Health Insurance Program (CHIP) (see instructions for each line) 9.00 Net revenue from stand-alone CHIP charges 0 10 11.00 Stand-alone CHIP cost (line 1 times line 10) 11.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 13.00 Difference between ret revenue and costs for stand-alone CHIP (line 11 minus line 2, 5 or 9) 56, 497 13.00 Difference between net revenue and costs for stand line 14.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 10 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) 16.00 Difference between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17 18.00 Difference between net revenue and costs for Support of hospital operations 2, 414, 451 19.00 2, 414, 451 19.00 2, 414, 451 19.00 2, 414, 451 2, 4
Children's Health Insurance Program (CHIP) (see instructions for each line)	Children's Health Insurance Program (CHIP) (see instructions for each line) 9.00 Net revenue from stand-al one CHIP 11.00 Stand-al one CHIP cost (line 1 times line 10) 11.00 Difference between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then one of the revenue from state or local indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16) 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2, 414, 451 19, 8, 12 and 16) Uninsured patients 1 patients 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 facility 28,767,041 2,895,879 31,662,920 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5,170,272 2,895,879 8,066,151 21
10.00 Stand-alone CHIP cost (line 1 times line 10) 0 10.00 0 11.00 0 0 11.00 0 11.00 0 11.00 0 11.00 0 11.00 0 0 11.00 0 11.00 0 0 0 0 0 0 0 0 0	10.00 Stand-alone CHIP charges 11.00 Stand-alone CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 16; arants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 17.10
11.00	11. 00 Stand-alone CHIP cost (line 1 times line 10) 12. 00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 lenter zero) Other state or local government indigent care program (see instructions for each line) 13. 00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 land unreimbursed cost for Medicaid indigent care programs (sum of lines 2, 414, 451 land 16) 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 land unreimbursed cost for Medicaid indigent care programs (sum of lines 2, 414, 451 land 16) Uninsured patients 1 patients 2, 414, 451 land 16) Uncompensated Care (see instructions for each line) 20. 00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21. 00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21)
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enter zero	enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 304, 360 lat 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 lateral line) 17.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 lateral lines 0
State or local government indigent care program (See instructions for each line) 13.00 13.00 14.00 14.00 15.00 15.40 13.00 14.00 10.00 1	Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18. 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2, 414, 451 19. Uninsured patients patients 1 Total (col. 1 patients patients patients patients patients 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 facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21.
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 56, 497 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 304, 360 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 54, 702 15.00 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 13: If < zero then enter zero) 6 6 7 7 7 7 15: If < zero then enter zero) 6 7 7 7 7 7 7 7 7 7	13. 00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 304, 360 14 10) 15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2, 414, 451 19 Uninsured Insured Total (col. 1 patients (see instructions) Charity care charges and uninsured discounts for the entire facility 28, 767, 041 2, 895, 879 31, 662, 920 20 Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21)
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15.00 State or local indigent care program cost (line 1 times line 14) 54,702 15.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 16.00 17.	State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18. 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2, 414, 451 19. Uninsured patients patients 2, 414, 451 19. Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility 28, 767, 041 2, 895, 879 31, 662, 920 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21.
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13: if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 18. 00 Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2, 414, 451 19 8, 12 and 16) Uninsured patients Insured patients Total (col. 1 + col. 2)
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17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 19. 00 19. 00 10.	17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2, 414, 451 19.00 Uninsured patients patients 1.00 2.00 3.00 Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21.
18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrel mbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2, 414, 451 19.00	18.00 Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2,414,451 19. Uninsured
19. 00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Insured patients Total (col. 1 + col. 2)	19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients patients + col. 2) Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21.
Uninsured patients Insured patients Total (col. 1 + col. 2)	Uninsured patients Insured patients 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 facility (see instructions) 28,767,041 2,895,879 31,662,920 20,000 20
Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 22.00 23.00 Cost of charity care (line 21 minus line 22) 5, 170, 272 2, 895, 879 8, 066, 151 21.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24.00 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit N 24.00 26.00 Total bad debt expense for the entire hospital complex (see instructions) 12, 853, 010 26.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 13, 370, 141 27.01 28.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10, 609, 505 30.00	Description Patients Patien
Uncompensated Care (see instructions for each line) 20.00 Chari ty care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21.00 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 22.00 charity care (line 21 minus line 22) 5, 170, 272 2, 895, 879 8, 066, 151 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 10.00 20.0	Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21.
20. 00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21. 00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22. 00 Payments received from patients for amounts previously written off as charity care 23. 00 Cost of charity care (line 21 minus line 22) 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program? 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29)	20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21.
(see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 22.00 charity care 23.00 Cost of charity care (line 21 minus line 22) 5,170,272 2,895,879 8,066,151 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 21.00 22.00 22.00 23.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 170, 272 2, 895, 879 8, 066, 151 21.
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22. 00 Payments received from patients for amounts previously written off as charity care 23. 00 Cost of charity care (line 21 minus line 22) 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 01 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24. 00 1. 00 1. 00 24. 00 1. 00 24. 00 1. 00 24. 00 1. 00 25. 00 26. 00 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 29. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29)	
23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 5, 170, 272 2, 895, 879 8, 066, 151 23.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare load debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)	
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26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debts for the entire hospital complex (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10.00 Cost of uncompensated care (line 23 column 3 plus line 29)	25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of 0 25.
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27. 01Medicare allowable bad debts for the entire hospital complex (see instructions)1,370,14127. 0128. 00Non-Medicare bad debt expense (see instructions)11,482,86928. 0029. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)2,543,35429. 0030. 00Cost of uncompensated care (line 23 column 3 plus line 29)10,609,50530. 00	
28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 11, 482, 869 28.00 2, 543, 354 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10, 609, 505 30.00	
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10,609,505 30.00	
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 13,023,956 31.00	31.00 Total universimoursed and uncompensated care cost (fine 19 plus fine 30) [13,023,956] 31.

	Financial Systems	U HEALTH BLOOMING	Provider C		eriod:	u of Form CMS-: Worksheet A	2552-10
RECLAS	STRICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IF EXPENSES	Provider Co	F	rom 01/01/2021		
				T	o 12/31/2021	Date/Time Pre 5/26/2022 1:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	9 piii
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	0.00	2.00	4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	C	6, 858, 404	6, 858, 404	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	d	.,	7, 958, 260	
3.00	00300 OTHER CAP REL COSTS		0	C	0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	389, 293	809, 939			23, 468, 192	
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	7, 247, 105 2, 406, 805	91, 949, 860 17, 714, 182			93, 645, 475 13, 870, 952	
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 400, 803	231, 079			224, 668	
9.00	00900 HOUSEKEEPI NG	1, 965, 421	2, 220, 289	4, 185, 710	-582, 376	3, 603, 334	
10. 00	01000 DI ETARY	2, 120, 708	1, 916, 893	4, 037, 601		2, 494, 755	
11. 00	01100 CAFETERI A	15 220 272	4 205 000	10 444 7/2	1, 019, 965	1, 019, 965	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	15, 238, 873 -150	4, 205, 889 235, 487			16, 980, 551 13, 903, 823	1
15. 00	01500 PHARMACY	6, 290, 092	38, 137, 935			8, 199, 317	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	C	0	0	16. 00
18. 00	01850 SOCIAL SERVICES	0	0	C	0	0	18. 00
18. 01 23. 00	O1851 CENTRAL STERI LI ZATI ON O2301 PARAMED ED PRGM-PHARMACY RESIDENCY	720, 701 127, 654	636, 348			1, 141, 092	
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	127, 034	28, 788	156, 442	204, 265	360, 707	23.00
30.00	03000 ADULTS & PEDI ATRI CS	25, 829, 462	23, 203, 784	49, 033, 246	-6, 493, 192	42, 540, 054	30. 00
31. 00	03100 INTENSIVE CARE UNIT	3, 801, 228	2, 542, 319			5, 277, 722	
32. 00	03200 CORONARY CARE UNIT	3, 205, 928	2, 129, 702		1	4, 382, 378	
35. 00 41. 00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	2, 019, 019 1, 112, 216	1, 281, 952		1	2, 668, 967	1
41.00	04200 SUBPROVI DER	1, 112, 216	624, 115 0	1, 736, 331	-700, 302	968, 029 0	42.00
43. 00	04300 NURSERY	o	0	ď	826, 256	826, 256	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6, 764, 649	31, 277, 382			15, 417, 113	
50. 01 51. 00	05001 CV SURGERY 05100 RECOVERY ROOM	3, 771, 098	1, 512, 255	5, 283, 353	_	0 4, 129, 096	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 957, 963	1, 821, 059			3, 735, 130	
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	3, 580, 848	4, 424, 667			5, 453, 771	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	2, 281, 029	2, 818, 650 0	5, 099, 679	-1, 782, 939 0	3, 316, 740 0	1
57. 00	05700 CT SCAN	634, 664	1, 071, 556	1, 706, 220	-773, 368	932, 852	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	558, 052	385, 409		·	736, 447	
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 429, 967	12, 437, 931			1, 804, 898	1
60. 00 64. 00	06400 I NTRAVENOUS THERAPY	2, 129	16, 997, 368 0	16, 999, 497	259, 530 0	17, 259, 027 0	1
65. 00	06500 RESPIRATORY THERAPY	3, 156, 008	1, 622, 564	4, 778, 572	-1, 269, 200		
66.00	06600 PHYSI CAL THERAPY	6, 534, 888	2, 661, 434	9, 196, 322	-1, 942, 234	7, 254, 088	
	06700 OCCUPATI ONAL THERAPY	0	0	C	0		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	563, 930	527, 920	1, 091, 850	-434, 039	0 657, 811	
70.00	07000 ELECTROENCEPHALOGRAPHY	143, 545	1, 683, 926			1, 723, 632	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	, , , , , , , , , , , , , , , , , , ,	9, 554, 509	9, 554, 509	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	14, 318, 551	14, 318, 551	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	37, 375, 676	37, 375, 676	
73. 01 74. 00	07302 OP PHARMACY 07400 RENAL DI ALYSI S	425, 422 40	1, 382, 800 1, 641, 076		·	1, 678, 757 1, 627, 955	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	1, 041, 070	1, 041, 110	-13, 101	1, 027, 433	1
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	d	0	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	508, 328	142, 351	650, 679	-93, 951	556, 728	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	1 510 544	420 720	1 040 205	221 407	1 417 E00	00 00
90. 00 90. 01	09001 OP ONCOLOGY INFUSION CENTER	1, 510, 546 3, 739, 511	438, 739 1, 995, 279			1, 617, 588 4, 294, 609	
90. 02	09002 WOUND CARE CENTER	564, 810	430, 013			678, 923	
90. 03	09003 PAIN CLINIC	309, 712	740, 794	1, 050, 506		879, 190	
90. 05	09005 OP PSYCH CLINIC	862, 811	783, 328			1, 392, 120	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	5, 636, 559	7, 755, 013	13, 391, 572	-2, 030, 842	11, 360, 730	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	
	09500 AMBULANCE SERVICES	3, 218, 780	1, 968, 000	5, 186, 780	-1, 217, 103	3, 969, 677	
	10000 &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	0		0		100. 00 101. 00
.01.00	SPECIAL PURPOSE COST CENTERS	, J	0		. 0	0	1.51.00
	11300 I NTEREST EXPENSE		0	C			113. 00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C			114. 00 115. 00
	TISOU AMBULATORY SURGICAL CENTER (D. P.)		0				116.00
	1	1 3		'			

Health Financial Systems	J HEALTH BLOOMIN	GTON HOSPITAL		In Lie	u of Form CMS-25	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 01/01/2021	D 1 /T' D	
				o 12/31/2021	Date/Time Prepa 5/26/2022 1:09	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	рііі
5051 501161 50501 F11611	our ur roo	0 (110)	+ col . 2)		Trial Balance	
			,	, , ,	(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	121, 629, 644	284, 388, 075	406, 017, 719	-389, 828	405, 627, 891 1	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	198, 401	138, 105	336, 506	-44, 769	291, 737 1	
190. 01 19001 PROMPTCARE	2, 179, 610	1, 304, 659	3, 484, 269	-814, 233	2, 670, 036 1	190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	2, 927	2, 927 1	
190. 03 19003 0LC0TT	365, 615	187, 109	552, 724	-88, 806	463, 918 1	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0		190. 04
190. 05 19005 FOUNDATI ON	0	0	0	2, 341	2, 341 1	
190. 06 19006 MARKETI NG	0	0	0	0		190. 06
190. 07 19007 HME STORE	0	0	0	0		190. 07
190. 08 19008 UNUSED SPACE	0	0	0	40, 820	40, 820 1	
190. 09 19009 CLI NI CAL TRI ALS	0	0	0	0		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	- 1	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	4, 417, 985	3, 948, 650	8, 366, 635		1, 593, 674 1	
191. 00 19100 RESEARCH	0	0	0	6, 250	6, 250 1	
191. 01 19101 RESEARCH	0	0	0	0		191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	0	0	0	5, 866, 966	5, 866, 966 1	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 416, 574	507, 623	2, 924, 197	-596, 173	2, 328, 024 1	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	872, 924	872, 924 1	
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	1, 785, 797	1, 785, 797 1	
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	- 1	194. 02
194.03 07953 IU HEALTH SIP	3, 902	470	4, 372		135, 585 1	
194. 04 07954 HOME CARE	2, 407	198	,		2, 591 1	
194. 05 07955 H0SPI CE	3, 498	21, 433			22, 477 1	
200.00 TOTAL (SUM OF LINES 118 through 199)	131, 217, 636	290, 496, 322	421, 713, 958	0	421, 713, 958 2	200. 00

Provider CCN: 15-0051

Peri od: From 01/01/2021 To 12/31/2021

In Lieu of Form CMS-2552-10
Worksheet A

2 0.00 0.0000 CAP REL DOSTS-MARIE EQUIP 1,801,946 9,760,206 3.0 3.00 0.0000 CAPITO CAP REL DOSTS - MARIE EQUIP 1,801,946 3.0 3.00 0.0000 CAPITO CAP REL DOSTS - MARIE EQUIP 1,801,740 2,783,740 3.00 0.0000 CAPITO	NEOLA.	STITION AND ADSOSTMENTS OF THE BREAKER O	. EXI ENGES	Trovider of	SIV. 13 0031	From 01/01/2021 To 12/31/2021	Date/Time Pr	epared:
1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0		Cost Center Description					5/26/2022 1:	09 pm
Company Comp								
2.00 00000 CANDER CONTROL EQUIP 1,801,966 9,760,000 3.00 0000 CANDER CONTROL EQUIP 1,801,966 9,760,000 3.00 0000 CANDER CONTROL EQUIP 1,801,900 3.00 0000 CANDER CONTROL EQUIP 1,801,900 1,712,864 7.00 0000 CANDER CONTROL 1,712,864 7.00 0000 CANDER CONTROL 1,801,900 1,712,864 7.00 0000 CANDER CONTROL 1,801,900 1,90		GENERAL SERVICE COST CENTERS	0.00	7.00	I			
3.00 03000 (DIRE CAP BEL COSTS 1,872,208 25,341,487 4.0. 5.00 03000 (DIRES CAP BEL COSTS 1,872,208 25,341,487 4.0. 5.00 03000 (DIRES CAP BEL COSTS 1,872,208 25,341,487 4.0. 5.00 03000 (DIRES CAP BEL COSTS 1,872,208 25,341,487 4.0. 6.00 03000 (DIRES CAP BEL COSTS 1,872,208 4.0. 6.00 03000 (D			1		•			1. 00
4.00 DOMOD IMPLOYEE BERTH IS BENNIHM 1,873,295 25,341,487 4.0 7.00 DOTOD OPTION DOTOD DOTO								2.00
5.00 05000 ADMINISTRATIVE & CENERAL -27, 922, 000 65, 712, 866 5.0 6.00 DOSDOJ ALMERY & LINES SERVICE -41, 008 31, 223, 884 7.0 6.00 DOSDOJ ALMERY & LINES SERVICE -42, 484 815, 101 10.0 6.00 DOSDOJ CHARREY & LINES SERVICE -43, 124 471 10.0 6.00 DOSDOJ CHARREY & LINES SERVICE -43, 124 471 10.0 6.00 DOSDOJ CHARREY & LINES SERVICE -43, 124 471 10.0 6.00 DOSDOJ CHARREY & LINES SERVICE -43, 124 471 10.0 6.00 DOSDOJ CHARREY & LINES SERVICE -43, 124 471 10.0 6.00 DOSDOJ CHARRES & SUPPLY -20, 13, 903, 923 11.0 6.00 DOSDOJ CHARRES & SUPPLY -20, 13, 903, 923 11.0 6.00 DOSDOJ CHARRES & SUPPLY -20, 10.0 0.0 6.00 DOSDOJ CHARRES & SUPPLY -20, 10.0 0.0 6.00 DOSDOJ CHARRES & SUPPLY -20, 10.0 6.00 DOSDOJ CHARRES & SUPP				1				3.00
7. 7. 700 O97700 (PERATLEON OF PLANT)								•
B. DO GORDO LAINDRY & LINEN STRVICE								
9.00 00000 HOUSEKEEPING								8. 00
11.00 0 1100 CAFETERIA -204, 864 815, 101 11.0			-38, 194		•			9. 00
13.00 1300 NURSING ARMINISTRATION -91,731 10,888,820 13.0 13.0 15.0	10.00	01000 DI ETARY	-53, 284	2, 441, 471				10.00
14.00 01400 CENTRAL STRVICES & SUPPLY 0 13, 903, 823 14.0 16.00 16100 CENTRAL STRVICES & LIBRARY 0 0 0 0 16.00 16100 CENTRAL STRVICES & LIBRARY 0 0 0 0 16.00 16100 CENTRAL STRVICES & LIBRARY 0 0 16100 CENTRAL STRVICES & LIBRARY 0 0 16100 CENTRAL STRVICES & LIBRARY 0 0 16100 CENTRAL STRVICES & LIBRARY 16.00 16100 CENTRAL STRVICES & CENTRAL STRVICES & LIBRARY 16.00 16100 CENTRAL STRVICES & CENTRAL STRVICES & LIBRARY &	11.00	01100 CAFETERI A	-204, 864	815, 101				11. 00
15.00 01500			-91, 731		1			13.00
16.00			-		1			14.00
18.00 01850 SOCIAL SERVICES 0 0 1.1,11,092 1.90. 23.00 20.201 PARMED FD PROJ -PHARMACY RESIDENCY 4.4,595 4.05,302 2.2. PARMED FOR DEROJ -PHARMACY RESIDENCY 4.4,595 4.05,302 2.2. PARMED FOR STATE MORTH SERVICE COST CENTERS 3.0. PARMED FOR STATE MORTH SERVICE COST CENTERS 3.0. PARMED FOR STATE MORTH SERVICE COST CENTERS 3.2. PARMED FOR STATE MORTH SERVICE COST CENTE								•
18.01 01851 CENTRAL STERLILIZATION 0 1,141,092 18.0 23.01 02301 PARAMED ED PROMEP PROME PROMEP PROMEP PROMEP PROMEP PROMEP PROMEP PROMEP PROMEP PROME PROMEP PROME PROMEP PROMEP PROMEP PROMEP PROMEP PROMEP PROMEP PROMEP PRO			-	1				•
23.00 0.2001 PARAMED ED PROMI-PHARMACKY RESIDENCY 44, 995 400, 902 23.00 10.00			-					
NATIENT ROUTES SERVICE COST CENTERS 30.00 03000 QUILTS & PEDIATRICS -6, 768, 316 35, 771, 736 31.00 33000 QUILTS & PEDIATRICS -6, 768, 316 35, 771, 736 31.00 33000 QUILTS & PEDIATRICS -6, 768, 316 35, 771, 736 31.00 33000 QUILTS & PEDIATRICS -6, 768, 316 35, 771, 736 31.00 33000 QUILTS & PEDIATRICS -6, 768, 316 35, 771, 778 32.00 33000 QUERNOR -7, 777 -7, 778 -7			-	., ,				
30.00 30.00 ADULTS & PEDIATRICS -6,768,316 35,777,786 31.0 31.00 3310 LITERSILY CARE UNIT -14 4,382,369 32.0 32.00 30.200 CORDINARY CARE UNIT -9 4,382,369 32.0 32.00 30.200 CORDINARY CARE UNIT -17,250 35.0 32.00 30.200 CORDINARY CARE UNIT -17,250 35.0 32.01 30.00 30.00 30.00 30.00 32.0 32.01 30.00 30.00 30.00 32.0 32.02 30.00 30.00 30.00 32.0 32.03 30.00 32.00 32.0 32.04 30.00 30.00 32.0 32.04 30.00 32.0 32.0 32.05 30.00 30.00 32.0 32.07 30.0 32.0 32.00 30.00 30.00 32.0 32.00 30.00 30.00 32.0 32.00 30.00 30.00 32.0 32.00 30.00 30.00 30.00 32.00 30.00 30.00 32.00 30.00 30.00 32.00 30.00	20.00		11,070	100,002				20.00
32.00	30. 00		-6, 768, 318	35, 771, 736				30.00
35.00 02000 NEONATAL INTENSIVE CARE UNIT .197, 250 2, 471, 717 .410, 04100 2019RPOVIDER .1 FF .1 4 968, 015 .412, 00 44300 SUBPROVIDER .0 0 0 .0 0 .22, 256 .42, 00 44300 NURSERY .0 0 826, 256 .42, 00 64300 NURSERY .0 0 826, 256 .42, 00 64300 NURSERY .0 0 9500 DEPRATING ROOM .3, 230, 586 .12, 186, 527 .0 0 .0 0 .0 0 .0 0 .0 0 .0 0 .0 0 .	31.00	03100 INTENSIVE CARE UNIT			•			31.00
41.00 04100 SURPROVIDER - IRF -14 968,015 41.0 04200 04200 04200 04200 04200 04200 04300 NURSERV 0 826,256 43.0 04300 NURSERV 0 826,256 43.0 04300 NURSERV 3.0 05000 0FERATIN REPORT 0 0 05100 RECOVERY ROOM 4.128,726 51.0 05200 081000 081000 081000 081000 081000 081000 0810	32.00	03200 CORONARY CARE UNIT	-9	4, 382, 369				32.00
42.00 04200 SUBPROVI DER 0 0 826,256 43.0			-197, 250					35. 00
43.00 0.0300 NURSERY 0 8.26, 256 43.0			1					41.00
MICLILARY SERVICE COST CENTERS			-					42.00
50.00	43.00		0	826, 256				43.00
50.01 0.5001 (V SURGERY 0 0.50	50 OO		2 220 506	12 104 527	T			F0 00
51.00 05100 RECOVERY ROOM & LABOR ROOM -3.70 4.128, 726 51.0								
52.00 05200 DELIVERY ROOM & LABOR ROOM -8, 137 3, 726, 993 52.0 530, 00			_	1				51.00
53.00 05300 ANESTHESI OLOGY 0 55.0								52. 00
55.00 05500 RADIOLOGY-THERAPLUTIC -352,280 2,964,460 55.00 05600 RADIOLOGY-THERAPLUTIC -352,280 0,90 0 0 0 0 0 0 0 0 0								53.00
56.00 56.00 RADIO ISOTOPE 0 0 0 55.00 57.00	54.00	05400 RADI OLOGY-DI AGNOSTI C	-653, 859	4, 799, 912				54.00
57.00	55.00		-352, 280	2, 964, 460				55. 00
58.00 05800 MARNETIC RESONANCE IMAGING (MRI) -32, 164 704, 283 58.00 5900 CAPOL CARDIAC CARTHETERIZATION -109 1, 804, 789 59.00 05900 CAPOL CARTHETERIZATION -109 1, 804, 789 60.00 06000 LABDRATORY -428, 312 16, 830, 715 60.00 064.00 INTRAVENOUS THERAPY -1.33 3, 509, 3599 65.50 66.00 064.00 INTRAVENOUS THERAPY -1.72, 528 7, 081, 560 66.00 06600 PHSYI CAL THERAPY -1.72, 528 7, 081, 560 0.00 067.00 06600 PHSYI CAL THERAPY -1.72, 528 7, 081, 560 0.00 06900 06900 CEUPATIONAL THERAPY 0.00 0.00 06900 CELECTROCARDIAL THERAPY 0.00 0.00 06900 CELECTROCARDIAL THERAPY 0.00 0.00 06900 CELECTROCARDIOLOGY 0.00 0.00 06900 CELECTROCARDIOLOGY 0.00 0.00 07000 CELECTROCARDIOLOGY 0.00				1				56.00
59.00		1						57. 00
60. 00 06000 LABORATORY -428, 312 16, 830, 715 0.0								•
64.00 06400 INTRAVENDUS THERAPY 0 0 0 64.0								
65. 00 06500 RESPIRATORY THERAPY								
66. 00 06600 PHYSI CAL THERAPY			-					
67. 00 0c700 0cCUPATI ONAL THERAPY 0 0 0 0 6800 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1			66.00
68. 00 06800 SPECH PATHOLOGY 0 0 0 68. 0 06900 CLECTROCARDI OLOGY 2, 665 660, 476 70. 00 07000 CLECTROENCEPHALOGRAPHY -935, 462 788, 170 70. 00 07100 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 9, 554, 509 711. 00 07200 O7200 IMPL DEV CHARGED TO PATIENTS 0 37, 375, 676 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 37, 375, 676 73. 01 07300 DRUGS CHARGED TO PATIENTS 0 37, 375, 676 73. 01 07300 O7400 RENAL DIALYSIS 0 1, 627, 955 74. 0 075. 01 O7500 ASC (NON-DISTINCT PART) 0 0 0 075. 01 O3550 PSYCHIATRI C/PSYCHOLOGI CAL SERVICES 0 0 076. 07 O7697 CARDI AC REHABILITATION 0 556, 728 09. 01 O9000 CLINIC COST CENTERS 09. 01 O9001 OP NOCOLOGY I NFUSION CENTER -2, 827 676, 096 09. 02 O9002 WOUND CARE CENTER -2, 827 676, 096 90. 0 09. 03 O9003 PAIN CLINIC -265, 414 613, 776 90. 0 09. 04 O9003 PSYCH CLINIC -265, 414 613, 776 90. 0 09. 05 O9005 OP PSYCH CLINIC -265, 414 613, 776 90. 0 09. 09 O9003 ONDO EMERGENCY -1, 379, 843 9, 980, 887 90. 0 09. 00 O9000 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 09. 00 O9000 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 09. 00 O9000 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 010. 00 O9000 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 010. 00 O9000 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 010. 00 O1000 Like REGENCY -799, 476 2, 990, 201 0 010. 00 O0000 Like REGENCY -799, 476 2, 990, 201 0 010. 00 O1000 Like REGENCY -799, 476 2, 990, 201 0 011. 00 O1000 Like RESERVICES NOT APPRVD PRGM 0 0 011. 00 O1000 Like RESERVICES NOT APPRVD PRGM 0 0 011. 00 O1000 Like RESERVICES NOT APPRVD PRGM 0 0 011. 00 O1000 Like RESERVICES NOT APPRVD PRGM 0 0 011. 00 O1000 Like RESERVICES NOT APPRVD PRGM 0 0 011. 00 O1000 Like RESERVICES NOT APPRVD PRGM 0 0 011. 00 O1000 Like RESERVIC								67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0	0				68. 00
71. 00 07100 MCDI CAL SUPPLIES CHARGED TO PATIENTS 0 9, 554, 509 71. 07. 07. 07. 07. 07. 07. 07. 07. 07. 07	69.00	06900 ELECTROCARDI OLOGY	2, 665	660, 476				69.00
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 14,318,551 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 37,375,676 73. 01 07302 DRUGS CHARGED TO PATIENTS 0 37,375,676 73. 01 07302 DP PHARMACY -16,616 1,662,141 73. 01 1300 DP PHARMACY -16,616 1,662,141 73. 01 1300 PPARMACY -16,616 1,662,141 73. 01 1400 PPARMACY -16,616 1,662,141 1,662	70.00	07000 ELECTROENCEPHALOGRAPHY	-935, 462	788, 170				70.00
73. 00		1 I	0					71. 00
73. 01 07302 0P PHARMACY			0					72. 00
74. 00			0					
75. 00			-16,616					
75. 01			0	1,027,955				
76. 97 07697 CARDI AC REHABILITATION 0 556, 728 0017PATI ENT SERVICE COST CENTERS 90. 00 9000 CLI NI C 90. 01 90001 DP ONCOLOGY I NFUSI ON CENTER 90. 02 90. 02 90002 WOUND CARE CENTER 90. 03 90. 03 9003 PAIN CLINI C 90. 05 90. 05 90. 05 90. 05 90. 05 90. 06 90. 07 90. 08 90. 07 90. 09 9			0	0				•
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 3.63,335 1,581,253 90. 01 09001 0P ONCOLOGY INFUSION CENTER 0 4,294,609 90. 02 09002 WOUND CARE CENTER -2,827 676,096 90. 03 09003 PAIN CLINIC -265,414 613,776 90. 05 09005 0P PSYCH CLINIC -28,240 1,363,880 90. 09 09000 EMERGENCY -1,379,843 9,980,887 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 94. 00 09500 AMBULANCE SERVICES -979,476 2,990,201 95. 00 100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 113. 00 113.00 11300 INTEREST EXPENSE 0 0 0 113. 00 114. 00 114. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 0				1				76. 97
90. 00 09000 CLINI C -36, 335 1, 581, 253 90. 01 09001 OP ONCOLOGY I NFUSI ON CENTER 0 4, 294, 609 90. 02 09002 WOUND CARE CENTER -2, 827 676, 096 90. 03 09003 PAI N CLINI C -265, 414 613, 776 90. 05 09005 OP PSYCH CLINI C -28, 240 1, 363, 880 90. 05 09005 OP PSYCH CLINI C -28, 240 1, 363, 880 90. 05 09100 EMERGENCY -1, 379, 843 9, 980, 887 91. 00 9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. 00 09500 AMBULANCE SERVI CES -979, 476 2, 990, 201 95. 00 09500 AMBULANCE SERVI CES -979, 476 2, 990, 201 95. 00 00. 00.	2			, 230, ,20				1,
90. 02	90. 00		-36, 335	1, 581, 253				90.00
90. 03	90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	4, 294, 609				90. 01
90. 05					•			90. 02
91. 00								90. 03
92. 00								90.05
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES -979, 476 2, 990, 201 95. 00 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 0 0 113. 00 113. 00 11300 INTEREST EXPENSE 0 0 114. 00 114. 00 11400 UTILI ZATI ON REVIEW-SNF 0 0 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 116. 00			-1, 379, 843	9, 980, 887				
94. 00	92.00	· · · · · · · · · · · · · · · · · · ·						→ 92.00
95. 00	94 00							94 00
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM			· ·	1				95. 00
101. 00			· _	1				100.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 NTEREST EXPENSE 0 0 0 114.00 114.00 114.00 114.00 115.00 115.00 115.00 115.00 116.00			-	1				101.00
113. 00 11300 I NTEREST EXPENSE 0 0 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 116. 00								7 50
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 116. 00 11600 HOSPICE 0 0 116. 0	113. 0		0	0				113.00
116. 00 11600 HOSPI CE 0 0 116. 0	114.0	0 11400 UTILIZATION REVIEW-SNF	0	0				114.00
			0	0				115. 00
118.00			0 00 000	0				116.00
	118. 0	SUBIDIALS (SUM OF LINES 1 through 117)	-38, 965, 434	366, 662, 457	l			118. 00

Health Financial Systems IU HEALTH BLORGE RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Health Financial Systems II	J HEALTH BLOOMI	NGTON HOSPITAL	_	In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 15-0051	Peri od:	Worksheet A
				From 01/01/2021	
				To 12/31/2021	Date/Time Prepared: 5/26/2022 1:09 pm
Cost Center Description	Adjustments	Net Expenses			372072022 1.09 piii
oost contain boscii pti on		For Allocation			
	6.00	7.00	1		
NONREI MBURSABLE COST CENTERS			1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	291, 737	, l		190. 00
190. 01 19001 PROMPTCARE	-25, 650	2, 644, 386			190. 01
190. 02 19002 RENTAL PROPERTIES	0	2, 927	'		190. 02
190. 03 19003 OLCOTT	0	463, 918	3		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0			190. 04
190. 05 19005 FOUNDATI ON	0	2, 341			190. 05
190. 06 19006 MARKETI NG	0	0			190. 06
190. 07 19007 HME STORE	0	0			190. 07
190. 08 19008 UNUSED SPACE	0	40, 820			190. 08
190. 09 19009 CLINICAL TRIALS	0	0			190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0			190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	1, 593, 674	ı		190. 11
191. 00 19100 RESEARCH	0	6, 250			191. 00
191. 01 19101 RESEARCH	0	0			191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	0	5, 866, 966			191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	-2, 328, 024	0			192. 00
193. 00 19300 NONPALD WORKERS	0	0			193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	872, 924			194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	1, 785, 797	'		194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0)		194. 02
194. 03 07953 IU HEALTH SIP	0	135, 585	5		194. 03
194.04 07954 HOME CARE	0	2, 591			194. 04
194. 05 07955 HOSPI CE	0	22, 477	<u>'</u>		194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	-41, 319, 108	380, 394, 850)		200. 00

IU HEALTH BLOOMINGTON HOSPITAL

Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm

					5/26/2022 1:	09 pm
	Cost Center	Increases Line #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - BENEFITS	2, 22				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	21, 681, 396		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	6		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0. 00 0. 00	0	0		5. 00
6. 00 7. 00		0.00	o	0		6. 00 7. 00
8. 00		0.00	o	0		8. 00
9. 00		0.00	o	Ö		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 15. 00		0. 00 0. 00	0	0 0		14. 00 15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	Ö	O		17. 00
18. 00		0.00	O	0		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		0.00	0	0		22. 00
23. 00		0. 00 0. 00	0	0 0		23. 00 24. 00
24. 00 25. 00		0.00	0	0		25. 00
26. 00		0.00	o	0		26. 00
27. 00		0.00	o	0		27. 00
28.00		0.00	О	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00		0.00	0	0		30. 00
31.00		0.00	0	0		31. 00
32. 00 33. 00		0. 00 0. 00	0	0 0		32. 00 33. 00
34. 00		0.00	o	0		34.00
35. 00		0.00	o	0 0		35. 00
36.00		0.00	О	0		36. 00
37.00		0.00	0	0		37. 00
38. 00		0. 00	0	0		38. 00
39. 00		0.00	0	0		39. 00
40. 00 41. 00		0. 00 0. 00	0	0 0		40. 00
41.00		0.00	0	0		41. 00 42. 00
43. 00		0.00	o	0		43. 00
44. 00		0.00	o	Ö		44. 00
	0 — — — — —			21, 681, 402		
	B - CAPITAL RELATED					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	5, 590, 963		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	7, 759, 492		2. 00 3. 00
3. 00 4. 00		0.00	0	0 0		4. 00
5. 00		0.00	o	0		5. 00
6. 00		0.00	Ö	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0 0		11.00
12. 00 13. 00		0. 00 0. 00	o	0		12. 00 13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	o	Ö		15. 00
16.00		0.00	0	0		16. 00
17. 00		0. 00	О	0		17. 00
18. 00		0.00	0	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0 0		21. 00 22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	Ö	O		25. 00
26.00		0.00	0	0		26. 00
27. 00		0.00	O	0		27. 00

IU HEALTH BLOOMINGTON HOSPITAL

Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm

					5/26/2022 1:09 pm
	2 1 2 1	Increases	6.1	0.11	
	Cost Center 2.00	Li ne # 3. 00	Sal ary 4. 00	0ther 5.00	
28. 00	2.00	0.00	4.00		28. 00
29. 00		0.00	0		29.00
30. 00		0.00	0		30.00
31. 00		0.00	0		31. 00
32. 00		0.00	0		32.00
33. 00		0.00	0		33.00
34.00		0.00	0		34.00
35. 00		0.00	0		35. 00
36.00		0.00	0		36.00
37.00		0.00	0	0	37. 00
38.00		0.00	0	0	38. 00
39.00		0.00	0	0	39. 00
	0		0	13, 350, 455	
	C - BILLABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00		9, 554, 509	1. 00
	PATI ENTS	55.00		504	
2.00	RADI OLOGY-THERAPEUTI C	55.00		521	2.00
3.00	AMBULANCE SERVICES	95.00	0	3, 316	3.00
4. 00 5. 00		0. 00 0. 00	0		4.00
6.00		0.00	0		5. 00 6. 00
7. 00		0.00	0		7.00
8. 00		0.00	0		8.00
9. 00		0.00	0		9.00
10. 00		0.00	0		10.00
11. 00		0.00	0		11.00
12. 00		0.00	0		12. 00
13.00		0.00	0		13. 00
14.00		0.00	0		14. 00
15.00		0.00	0	0	15. 00
16.00		0.00	0	0	16. 00
17.00		0.00	0	0	17. 00
18.00		0.00	0		18. 00
19.00		0.00	0		19. 00
20.00		0.00	0		20. 00
21.00		0. 00	0	0	21. 00
22.00		0.00	0		22. 00
23.00		0.00	0		23. 00
24.00		0.00	0		24. 00
25. 00		0. 00	0		25. 00
26. 00		0. 00	0		26. 00
27. 00		0.00	0		27. 00
28. 00		0.00	0		28. 00
29. 00		0.00	0		29.00
30.00		0.00	0		30.00
31. 00 32. 00		0. 00 0. 00	0		31. 00 32. 00
33. 00		0.00	0		33.00
34. 00		0.00	0	0	34.00
34.00			— — <u> </u>	9, 558, 346	34.00
	D - NONBILLABLE MEDICAL SUPPL	.I ES		77 0007 010	
1.00	CENTRAL SERVICES & SUPPLY	14. 00		13, 629, 580	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00		169, 101	2. 00
3.00	OPERATION OF PLANT	7. 00		98, 423	3. 00
4.00	DI ETARY	10.00		1, 384	4. 00
5.00	CENTRAL STERILIZATION	18. 01		9, 719	5. 00
6.00	RADI OLOGY-THERAPEUTI C	55. 00		29, 003	6. 00
7.00	MAGNETIC RESONANCE I MAGING	58. 00		897	7. 00
	(MRI)				
8.00	LABORATORY	60.00		4, 335	8. 00
9.00	OP PSYCH CLINIC	90. 05		39	9. 00
10. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	_	29	10.00
11. 00		0.00	0		11.00
12.00		0.00	0		12.00
13.00		0.00	0		13.00
14.00		0.00	0		14.00
15.00		0.00	0		15. 00
16.00		0.00	0		16.00
17.00		0. 00 0. 00	0		17. 00 18. 00
18. 00 19. 00		0.00	0		19. 00
20. 00		0.00	0		20.00
21. 00		0.00	0		21.00
22. 00		0.00	0		22. 00
		1		1	

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm Provider CCN: 15-0051

					5/26/2022 1	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
00.00	2. 00	3. 00	4.00	5. 00		00.00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0			25. 00
26. 00		0. 00 0. 00	0	0		26. 00
27. 00 28. 00		0.00	0			27. 00 28. 00
29. 00		0.00	0			29. 00
30.00		0.00	0			30.00
31. 00		0.00	0	- 1		31.00
31.00	<u> </u>		— — <u> </u>			31.00
	E - IMPLANTS SUPPLIES			13, 742, 310		
1.00	I MPL. DEV. CHARGED TO	72.00	0	14, 318, 551		1.00
	PATI ENTS		_	, ,		
2.00	EMERGENCY	91.00	0	504		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0			8. 00
9.00		0.00	0			9. 00
10. 00	L	0.00	0			10. 00
	0		0	14, 319, 055		
4 00	F - LEASE EXPENSE	4 00		4 440 ((0)		4 00
1.00	CAP REL COSTS-BLDG & FLXT	1.00		1, 440, 663		1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	59, 669		2.00
3. 00 4. 00		0. 00 0. 00	0	l I		3.00
5. 00		0.00	0			4. 00 5. 00
6. 00		0.00	0	l I		6. 00
7. 00		0.00	0			7. 00
8. 00		0.00	0	l I		8. 00
9. 00		0.00	0			9. 00
10. 00		0.00	0	l I		10.00
11. 00		0.00	0	l I		11. 00
12. 00		0.00	0	l I		12. 00
13. 00		0.00	0			13. 00
14. 00		0.00	0			14. 00
15. 00		0.00	0	1		15. 00
16.00		0.00	0			16. 00
17. 00		0.00	0	1		17. 00
18.00		0.00	0	0		18. 00
	0			1, 500, 332		
	G - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0			1. 00
2.00		0.00	0			2. 00
3.00		0.00	0			3. 00
4.00		0.00	0	-		4. 00
5.00		0.00	0			5. 00
6.00		0.00	0			6. 00
7.00		0.00	0			7. 00
8. 00 9. 00		0. 00 0. 00	0			8. 00 9. 00
10. 00		0.00	0			10.00
11. 00		0.00	0			11.00
12. 00		0.00	0			12. 00
13. 00		0.00	0			13. 00
14. 00		0.00	0			14. 00
15. 00		0.00	0	Ö		15. 00
16. 00		0.00	0			16. 00
17. 00		0.00	0			17. 00
18. 00		0.00	0			18. 00
19. 00		0.00	0			19. 00
20. 00		0.00	0			20. 00
21. 00		0.00	0			21. 00
22.00		0.00	0			22. 00
23.00		0.00	0	0		23. 00
24.00		0.00	0			24. 00
25.00		0.00	0	0		25. 00
26.00		0.00	0			26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0			28. 00
29. 00		0.00	0			29. 00
30. 00	<u> </u>	0.00	0	0		30. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm Provider CCN: 15-0051

Increases	
Cost Center Line # Salary Other 2.00 3.00 4.00 5.00	
31.00 0.00 0 0	31.00
32.00	32. 00
33.00 0.00 0 0	33.00
34.00 0.00 0	34.00
35.00 0.00 0	35. 00
36.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	36. 00
0	
1. 00 PHARMACY 15. 00 0 1, 438, 295	1.00
2.00 0.00 0 0	2. 00
3.00 0.00 0	3. 00
4.00 0.00 0 0	4. 00
5. 00 0.00 0	5. 00
6. 00	6. 00 7. 00
8.00	8.00
9.00	9. 00
10.00 0.00 0	10.00
11.00	11.00
12.00	12.00
13. 00	13. 00 14. 00
15.00	15.00
16. 00	16. 00
17. 00	17. 00
18.00 0.00 0 0	18. 00
19.00 0.00 0	19. 00
20.00 0 0 0	20.00
21. 00	21. 00 22. 00
23.00	23.00
24.00	24. 00
25. 00 0. 00 0	25. 00
26. 00 0. 00 0	26. 00
27.000	27. 00
0 0 1, 438, 295 J - INTEREST EXPENSE	
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 595	1.00
0 595	
K - PHARMACY RESIDENCY	1.00
1.00 PARAMED ED PRGM-PHARMACY 23.00 200, 113 15, 309 RESI DENCY	1.00
2. 00 NLST DENCT 0. 00 0 0	2. 00
0 200, 113 15, 309	
L - PSYCH ADMIN	
1. 00 OP PSYCH CLI NI C 90. 05 87, 332 39, 728 87, 332 39, 728	1.00
M - SOFTWARE LICENSE	
1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 233, 548	1.00
2.00 0.00 0	2. 00
3.00 0.00 0	3.00
4. 00	4. 00 5. 00
6.00	6.00
7.00	7. 00
8.00	8. 00
9.00 0.00 0	9. 00
10.00 0 0 0	10. 00
11.00	11.00
12. 00	12. 00 13. 00
14.00	14.00
15. 00	15. 00
16. 00 0. 00 0 0	16. 00
17. 00 0. 00 0 0	17. 00
18.00 0.00 0	18.00
19.00	19.00
20. 00	20. 00 21. 00
22.00	21.00
23. 00 0. 00 0	23. 00
24. 00 0. 00 0	24. 00
25. 00 0. 00 0	25. 00
26.00 0.00 0	26. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: | 5/26/2022 1:09 pm Provider CCN: 15-0051

					10 12/31/2	5/26/2022 1: 09 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5 00		
27. 00	2.00	3.00	4. 00	5. 00		27. 00
28. 00		0.00	Ö	ő		28.00
	0			233, 548		
	N - CAFETERIA					
1.00	CAFETERI A	1100	56 <u>6, 4</u> 18	45 <u>3, 5</u> 47		1. 00
	O CHORT TERM DISABILITY/FLM	Λ	566, 418	453, 547		
1. 00	O - SHORT TERM DISABILITY/FLM. ADMINISTRATIVE & GENERAL	5.00	0	7, 914		1.00
2. 00	OPERATION OF PLANT	7. 00	o	4, 704		2.00
3.00	HOUSEKEEPI NG	9. 00	Ö	5, 821		3.00
4.00	DI ETARY	10.00	О	5, 979		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	14, 685		5. 00
6.00	PHARMACY	15. 00	0	8, 701		6. 00
7.00	CENTRAL STERILIZATION	18. 01	0	5, 799		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	76, 257		8.00
9. 00 10. 00	INTENSIVE CARE UNIT	31. 00 32. 00	0	30, 837 23, 861		9.00
11. 00	NEONATAL INTENSIVE CARE UNIT	35.00	Ö	26, 852		11.00
12. 00	SUBPROVI DER - I RF	41. 00	o	16, 471		12. 00
13.00	OPERATING ROOM	50.00	O	15, 477		13.00
14.00	RECOVERY ROOM	51.00	0	17, 517		14. 00
15. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	20, 819		15. 00
16.00	RADI OLOGY THE PARELLE C	54.00	0	19, 166		16.00
17.00	RADI OLOGY-THERAPEUTI C	55. 00 57. 00	0	9, 942		17. 00
18. 00 19. 00	CT SCAN CARDIAC CATHETERIZATION	57. 00 59. 00	0	2, 107 10, 625		18. 00 19. 00
20. 00	RESPIRATORY THERAPY	65. 00	Ö	17, 733		20.00
21. 00	PHYSI CAL THERAPY	66.00	o	40, 502		21. 00
22. 00	ELECTROCARDI OLOGY	69.00	O	560		22. 00
23.00	CLINIC	90.00	O	472		23. 00
24.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	17, 631		24. 00
25. 00	WOUND CARE CENTER	90. 02	0	3, 773		25. 00
26. 00	PAIN CLINIC OP PSYCH CLINIC	90. 03 90. 05	0	19, 514		26. 00
27. 00 28. 00	EMERGENCY	91.00	0	3, 129 22, 376		27. 00 28. 00
29. 00	AMBULANCE SERVICES	95.00	0	14, 546		29.00
30. 00	PROMPTCARE	190. 01	o	7, 540		30.00
31.00	OLCOTT	190. 03	O	10, 570		31.00
32.00	COMMUNITY HEALTH SERVICES	190. 11	0	5, 275		32.00
33. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0_	6, 268		33. 00
	P - UTILITIES EXPENSE		0	493, 423		
1. 00	OPERATION OF PLANT	7.00	0	293, 278		1.00
2.00	0. 2.0 61. 61. 1. 2.0	0.00	o	0		2.00
3.00		0.00	O	0		3.00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6.00
7. 00 8. 00		0. 00 0. 00	0	0 0		7. 00 8. 00
9. 00		0.00	0	0		9.00
10. 00		0.00	o	Ö		10.00
11. 00		0.00	O	0		11. 00
12.00		0.00	O	0		12. 00
13. 00		0.00	0	0		13. 00
14.00		0.00	0	0		14.00
15.00		0. 00 0. 00	0	0		15. 00
16. 00 17. 00		0.00	0	0		16. 00 17. 00
17.00		0.00	0	0		18.00
19. 00		0.00	Ö	Ö		19. 00
20. 00		0.00	ō	0		20. 00
21.00		0.00	o	0		21.00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
20.00				0 293, 278		26.00
	Q - BCC DEPRECIATION		٧,			
1.00	RENTAL PROPERTIES	190. 02	0	2, 927		1.00
2.00	FOUNDATI ON	190. 05	0	2, 341		2. 00
3. 00	UNUSED SPACE	1 <u>90.</u> 08	•	4 <u>0, 820</u>		3.00
	0		U	46, 088		

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: | 5/26/2022 1:09 pm Provider CCN: 15-0051

					10 12/31/20	5/26/2022 1: 09 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	R - OCCUPATIONAL HEALTH ADMIN					
1.00	ADMI NI STRATI VE & GENERAL		25 <u>5, 6</u> 39	0		1.00
	0		255, 639	0		
	S - NURSERY					
1.00	NURSERY	43. 00	692, 507	133, 749		1.00
2.00		0.00	0	0		2. 00
	0		692, 507	133, 749		
	T - BEDFORD ALLOCATION					
1.00	IU HEALTH BEDFORD HOSPITAL	194. 01	1, 100, 943	684, 854		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		000	0	0		6. 00
	0		1, 100, 943	684, 854		
	U - PAOLI ALLOCATION					
1.00	IU HEALTH PAOLI HOSPITAL	194. 00	539, 867	333, 057		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	О		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	0	0		7. 00
	0		539, 867	333, 057		
	V - LIBERTY BUILDING DEPRECIA	TION				
1.00	IU HEALTH SIP	194. 03	0	131, 369		1.00
2.00		0.00	0	o		2. 00
		T		131, 369		
	X - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		739, 601		1. 00
2.00	OPERATION OF PLANT	7.00		12, 421		2. 00
3.00	HOUSEKEEPI NG	9.00		12, 521		3. 00
4.00	INTENSIVE CARE UNIT	31.00		23, 458		4. 00
5.00	SUBPROVI DER - I RF	41.00		31, 318		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00		28, 968		6. 00
7. 00	MAGNETIC RESONANCE I MAGING	58. 00		5, 472		7. 00
,, 00	(MRI)	55.55		3,2		7.55
8.00	PHYSI CAL THERAPY	66.00		72, 806		8.00
9.00	ELECTROENCEPHALOGRAPHY	70.00		3, 446		9. 00
10.00	CARDI AC REHABI LI TATI ON	76. 97		1, 847		10.00
11. 00	WOUND CARE CENTER	90. 02		9, 674		11.00
12. 00	PAIN CLINIC	90. 03		5, 320		12. 00
13. 00	GIFT, FLOWER, COFFEE SHOP &	190.00		597		13. 00
10.00	CANTEEN	170.00		377		10.00
14. 00	OLCOTT	190. 03		2, 616		14. 00
15. 00	PHYSICIANS' PRIVATE OFFICES	192. 00		83, 965		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	o	Ö		18. 00
19. 00		0.00	ő	o		19.00
20. 00		0.00	0	0		20.00
21. 00		0.00	0	0		21.00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	o o		23. 00
24. 00		0.00	0	0		24.00
25. 00		0.00	0	Ö		25. 00
20.00				1,034,030		25.00
	Y - REHAB - COVI D		9	., 551, 555		
1.00	ADULTS & PEDIATRICS	30.00	413, 630	134, 935		1.00
	0		413, 630	134, 935		
	Z - CENTRAL SUPPLY SALARY		, 666	. 5 . 7 , 5 5		
1.00	CENTRAL SERVICES & SUPPLY	14. 00	150	0		1.00
50	TOTALS		150	0		1.00
	AA - BLOOD STORAGE		130	3		
1.00	LABORATORY	60.00		4, 448		1.00
2.00	2.5010110111	0.00	o	4, 448		2.00
2.00	TOTALS — — — —			 0		2.00
	AB - PACU RECLASS		υĮ	4, 440		
1 00	ADULTS & PEDIATRICS	20.00	00 450	14 424		1.00
1. 00	TOTALS	30.00	9 <u>9, 450</u> 99, 450	$- \frac{14,434}{14,434}$		1.00
			99, 450	14, 434		
1 00	AC - GRANT	101 00		4 250		1 00
1.00	RESEARCH	191. 00	2 010 240	6, 250		1.00
2.00	OTHER SPONSORED ACTIVITIES	191. 02	2, 819, 349	3, 047, 617		2.00
3. 00		0. 00	이	0		3.00

IU HEALTH BLOOMINGTON HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0051

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 1:09 pm

					37 207 2022 1. 07 pili	_
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	TOTALS		2, 819, 349	3, 053, 867		
	AD - PHYSICIAN					
1.00	ADULTS & PEDIATRICS	30.00	0	94, 944	1.0)()
2.00	OPERATING ROOM	50.00	0	1, 729, 545	2.0)()
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	518, 874	3.0)()
4.00	RADI OLOGY-THERAPEUTI C	55.00	0	14, 080	4.0)()
5.00	LABORATORY	60.00	0	282, 854	5.0)()
6.00	RESPIRATORY THERAPY	65.00	0	15, 600	6.0)()
7.00	ELECTROCARDI OLOGY	69.00	0	16, 500	7.0)()
	TOTALS		0	2, 672, 397		
500.00	Grand Total: Increases		6, 775, 398	122, 938, 727	500. 0)()

Health Financial Systems RECLASSIFICATIONS IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0051

					1	o 12/31/2021 Date/lime Pri 5/26/2022 1:	
		Decreases		1			
	Cost Center	Li ne #	Sal ary	Other 0.00	Wkst. A-7 Ref.		
	A - BENEFITS	7. 00	8. 00	9. 00	10. 00		
1.00	ADMINISTRATIVE & GENERAL	5.00		629, 319	0		1.00
2.00	OPERATION OF PLANT	7. 00		514, 582	0		2. 00
3.00	HOUSEKEEPI NG	9. 00		579, 809	0		3. 00
4.00	DI ETARY	10. 00		463, 155			4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00		1, 927, 101	0		5. 00
6.00	PHARMACY	15.00		901, 445			6.00
7. 00 8. 00	CENTRAL STERILIZATION PARAMED ED PRGM-PHARMACY	18. 01 23. 00		128, 115 10, 908			7. 00 8. 00
0.00	RESI DENCY	23.00		10, 700			0.00
9.00	ADULTS & PEDIATRICS	30.00		4, 400, 437	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00		560, 854	0		10.00
11. 00	CORONARY CARE UNIT	32. 00		430, 955			11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35.00		412, 774			12. 00
13.00	SUBPROVI DER – I RF	41.00		203, 730			13.00
14. 00 15. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00		1, 276, 481			14. 00 15. 00
16. 00	DELIVERY ROOM & LABOR ROOM	52.00		666, 414 546, 319			16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00		644, 145			17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55. 00		381, 721			18. 00
19.00	CT SCAN	57. 00		102, 891	0		19. 00
20.00	MAGNETIC RESONANCE IMAGING	58. 00		94, 384	0		20. 00
04 00	(MRI)	50.00		040 040			04.00
21. 00	CARDI AC CATHETERI ZATI ON	59.00		213, 943			21. 00
22. 00 23. 00	LABORATORY RESPIRATORY THERAPY	60. 00 65. 00		90 454, 301			22. 00 23. 00
24. 00	PHYSICAL THERAPY	66.00		1, 101, 451	0		24. 00
25. 00	ELECTROCARDI OLOGY	69.00		120, 451			25. 00
26.00	ELECTROENCEPHALOGRAPHY	70.00		35, 607	0		26. 00
27.00	OP PHARMACY	73. 01		88, 135	0		27. 00
28. 00	RENAL DIALYSIS	74. 00		2	0		28. 00
29. 00	CARDI AC REHABI LI TATI ON	76. 97		88, 886			29. 00
30.00	CLINIC	90.00		277, 998			30.00
31. 00 32. 00	OP ONCOLOGY INFUSION CENTER WOUND CARE CENTER	90. 01 90. 02		639, 529 120, 526			31. 00 32. 00
33. 00	PAIN CLINIC	90.02		68, 771	0		33. 00
34. 00	OP PSYCH CLINIC	90.05		287, 704			34. 00
35.00	EMERGENCY	91.00		761, 256			35. 00
36.00	AMBULANCE SERVICES	95. 00		687, 798			36. 00
37.00	GIFT, FLOWER, COFFEE SHOP &	190. 00		42, 378	0		37. 00
20.00	CANTEEN PROMPTCARE	100.01		220 120			20.00
38. 00 39. 00	OLCOTT	190. 01 190. 03		328, 138 85, 018			38. 00 39. 00
40.00	COMMUNITY HEALTH SERVICES	190.03		993, 654			40.00
41. 00	PHYSICIANS' PRIVATE OFFICES	192.00		407, 603			41. 00
42.00	IU HEALTH SIP	194. 03		156			42. 00
43.00	HOME CARE	194. 04		14			43. 00
44. 00	HOSPICE	194.05		2, 454			44. 00
	O CARLEAL BELATER		0	21, 681, 402			
1. 00	B - CAPITAL RELATED EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 513	O		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0				2.00
3. 00	OPERATION OF PLANT	7. 00	0	· ·			3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0		0		4. 00
5.00	HOUSEKEEPI NG	9. 00	0				5. 00
6.00	DIETARY	10.00	0	1			6. 00
7.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00	0				7. 00
8. 00 9. 00	PHARMACY	14. 00 15. 00	0	1			8. 00 9. 00
10. 00	CENTRAL STERILIZATION	18. 01	0	1			10.00
11. 00	ADULTS & PEDIATRICS	30.00	0	1			11. 00
12. 00	INTENSIVE CARE UNIT	31. 00	0	1			12. 00
13.00	CORONARY CARE UNIT	32. 00	0	60, 473	0		13. 00
14. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0				14. 00
15.00	OPERATING ROOM	50.00	0	1			15. 00
16.00	RECOVERY ROOM	51.00	0				16.00
17. 00 18. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00	0				17. 00 18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	55.00	0				19. 00
20. 00	CT SCAN	57. 00	0				20.00
21. 00	MAGNETIC RESONANCE I MAGING	58.00	0				21. 00
	(MRI)						
22. 00	CARDI AC CATHETERI ZATI ON	59.00	0				22. 00
23. 00	RESPIRATORY THERAPY	65.00	0	133, 501	0		23. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provider CCN: 15-0051

						o 12/31/2021 Date/lime Pr 5/26/2022 1:	
		Decreases		<u>'</u>			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
24. 00	PHYSI CAL THERAPY	66.00	0				24. 00
25. 00 26. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0				25. 00 26. 00
27. 00	OP PHARMACY	73. 01	0				27. 00
28. 00	CARDI AC REHABI LI TATI ON	76. 97	0	6, 107			28. 00
29. 00	CLINIC	90.00	0				29. 00
30.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	41, 119	0		30.00
31.00	WOUND CARE CENTER	90. 02	0	22, 755	0		31.00
32.00	PAIN CLINIC	90. 03	0	26, 254			32. 00
33. 00	OP PSYCH CLINIC	90. 05	0	.,			33. 00
34. 00	EMERGENCY	91.00	0	269, 460			34. 00
35. 00 36. 00	AMBULANCE SERVICES GIFT. FLOWER. COFFEE SHOP &	95. 00 190. 00	0	260, 847			35. 00 36. 00
30.00	CANTEEN	190.00	U	2, 988	U		36.00
37. 00	PROMPTCARE	190. 01	0	8, 363	0		37. 00
38. 00	OLCOTT	190. 03	0	1			38. 00
39.00	COMMUNITY HEALTH SERVICES	190. 11	0	8, 867	0		39. 00
	0		0	13, 350, 455			
	C - BILLABLE MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		311	0		1.00
2.00	OPERATION OF PLANT	7. 00		198			2.00
3. 00 4. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00		62	0		3. 00 4. 00
5. 00	NURSING ADMINISTRATION	13. 00		23, 713			5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00		3, 247			6. 00
7. 00	PHARMACY	15. 00		2, 887			7. 00
8.00	CENTRAL STERILIZATION	18. 01		2, 744			8. 00
9.00	ADULTS & PEDIATRICS	30.00		395, 615	0		9. 00
10.00	INTENSIVE CARE UNIT	31. 00		51, 386			10. 00
11. 00	CORONARY CARE UNIT	32. 00		33, 160			11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35.00		6, 378			12.00
13.00	SUBPROVI DER - I RF	41.00		8, 926			13.00
14. 00 15. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00		3, 428, 646 11, 017	0		14. 00 15. 00
16. 00	DELIVERY ROOM & LABOR ROOM	52. 00		67, 146			16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00		1, 231, 857			17. 00
18. 00	CT SCAN	57. 00		3, 819			18. 00
19. 00	MAGNETIC RESONANCE IMAGING	58. 00		432			19. 00
	(MRI)						
20. 00	CARDI AC CATHETERI ZATI ON	59. 00		4, 042, 188			20. 00
21. 00	RESPIRATORY THERAPY	65.00		552			21. 00
22. 00 23. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00		10, 608			22. 00 23. 00
24. 00	ELECTROCARDIOLOGY	70.00		2, 273 224			24. 00
25. 00	RENAL DIALYSIS	74.00		2, 453			25. 00
26. 00	CARDI AC REHABI LI TATI ON	76. 97		42			26. 00
27.00	CLINIC	90.00		1, 054	0		27. 00
28. 00	OP ONCOLOGY INFUSION CENTER	90. 01		78, 435	0		28. 00
29. 00	WOUND CARE CENTER	90. 02		60, 125			29. 00
30. 00	PAIN CLINIC	90. 03		1, 028			30.00
31. 00	OP PSYCH CLINIC	90.05		36			31. 00
32. 00 33. 00	EMERGENCY PROMPTCARE	91. 00 190. 01		82, 032 E 174			32. 00 33. 00
34. 00	COMMUNITY HEALTH SERVICES	190. 01		5, 176 575			34.00
34.00	0	190.11	— — ₀				34.00
	D - NONBILLABLE MEDICAL SUPPL	I ES		., .,			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		5, 031	0		1. 00
2.00	HOUSEKEEPI NG	9. 00		3, 240			2. 00
3.00	NURSING ADMINISTRATION	13. 00		65, 319			3. 00
4.00	PHARMACY	15. 00		156, 808			4. 00
5.00	ADULTS & PEDIATRICS	30. 00		1, 010, 910			5. 00
6. 00 7. 00	INTENSIVE CARE UNIT	31. 00 32. 00		289, 331 218, 744			6. 00 7. 00
7. 00 8. 00	NEONATAL INTENSIVE CARE UNIT	35. 00 35. 00		109, 666			8. 00
9. 00	SUBPROVI DER - I RF	41. 00		30, 550			9. 00
10. 00	OPERATING ROOM	50.00		8, 778, 028			10.00
11. 00	RECOVERY ROOM	51. 00		168, 544			11. 00
12.00	DELIVERY ROOM & LABOR ROOM	52. 00		161, 580	0		12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00		554, 089			13. 00
14.00	CT SCAN	57. 00		55, 800			14. 00
15. 00	CARDI AC CATHETERI ZATI ON	59. 00		962, 499			15. 00
16. 00 17. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00		609, 828			16. 00 17. 00
17.00	ELECTROCARDI OLOGY	69. 00		7, 294 14, 223		1	17.00
-5.00	L===011100/1101 0E001	07.00		14,223	1		1 10.00

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/26/2022 1:09 pm

						5/26/2022 1:0	J9 DIII
		Decreases		1			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
19. 00	ELECTROENCEPHALOGRAPHY	70. 00		5, 050			19. 00
20.00	OP PHARMACY	73. 01		1, 607			20. 00
21. 00	RENAL DIALYSIS	74. 00		2, 006	0		21. 00
22.00	CARDIAC REHABILITATION	76. 97		316	0		22. 00
23.00	CLINIC	90.00		4, 415	0		23. 00
24.00	OP ONCOLOGY INFUSION CENTER	90. 01		117, 762	0		24. 00
25.00	WOUND CARE CENTER	90. 02		18, 135	0		25. 00
26.00	PAIN CLINIC	90. 03		13, 869	1		26. 00
27.00	EMERGENCY	91.00		461, 531	o		27. 00
28. 00	AMBULANCE SERVICES	95.00		87, 086	0		28. 00
29. 00	PROMPTCARE	190. 01		17, 209			29. 00
30.00	OLCOTT	190. 03		2, 593			30.00
31. 00	COMMUNITY HEALTH SERVICES	190. 03		9, 447			31.00
31.00	O DELLA PER		— — — _ō				31.00
	E - IMPLANTS SUPPLIES		0	13, 742, 310			ł
1 00		14 00		F 77/			1 00
1.00	CENTRAL SERVICES & SUPPLY	14.00		5, 776			1.00
2.00	ADULTS & PEDIATRICS	30.00		6, 838			2.00
3. 00	CORONARY CARE UNIT	32.00		167	0		3. 00
4.00	OPERATING ROOM	50.00		8, 072, 192	0		4. 00
5. 00	DELIVERY ROOM & LABOR ROOM	52. 00		10, 819			5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00		23, 145			6. 00
7.00	CT SCAN	57. 00		1, 415			7. 00
8.00	MAGNETIC RESONANCE IMAGING	58. 00		66	0		8. 00
	(MRI)						
9.00	CARDIAC CATHETERIZATION	59. 00		6, 195, 718	0		9. 00
10.00	OP ONCOLOGY INFUSION CENTER	90. 01		2, 919	0		10.00
	0 — — — — — —		<u> </u>	14, 319, 055			
	F - LEASE EXPENSE						1
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00		31, 140	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		13, 569			2. 00
3.00	OPERATION OF PLANT	7. 00		257, 974			3. 00
4.00	NURSING ADMINISTRATION	13. 00		20, 330			4. 00
5. 00	OPERATING ROOM	50.00		4, 576			5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54. 00		9, 196			6. 00
7. 00	RADI OLOGY-THERAPEUTI C	55. 00		1, 925			7. 00
8. 00	LABORATORY	60.00		31, 757	0		8. 00
9. 00	RESPIRATORY THERAPY	65. 00		1, 524			9. 00
							1
10.00	PHYSI CAL THERAPY	66.00		622, 159			10.00
11. 00	ELECTROENCEPHALOGRAPHY	70.00		45			11.00
12.00	OP ONCOLOGY INFUSION CENTER	90. 01		92, 673			12.00
13. 00	WOUND CARE CENTER	90. 02		92, 775			13. 00
14. 00	PAIN CLINIC	90. 03		48, 030	1		14. 00
15. 00	OP PSYCH CLINIC	90. 05		86, 319	1		15. 00
16.00	AMBULANCE SERVICES	95. 00		68, 020			16. 00
17. 00	PROMPTCARE	190. 01		41, 693	0		17. 00
18.00	COMMUNITY HEALTH SERVICES	190. 11		76, 627	0		18. 00
	0		0	1, 500, 332			
	G - BILLABLE DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		13, 608	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00		8, 870	0		2. 00
3.00	OPERATION OF PLANT	7. 00		25, 355			3. 00
4.00	NURSING ADMINISTRATION	13. 00		30, 925	0		4. 00
5. 00	CENTRAL SERVICES & SUPPLY	14. 00		1, 308			5. 00
6. 00	PHARMACY	15. 00		35, 593, 727			6. 00
7. 00	CENTRAL STERILIZATION	18. 01		48	I I		7. 00
8. 00	ADULTS & PEDIATRICS	30.00		118, 549			8. 00
9. 00	INTENSIVE CARE UNIT	31.00		20, 270			9. 00
10. 00	CORONARY CARE UNIT	32.00		13, 045			10.00
11. 00	NEONATAL INTENSIVE CARE UNIT	35. 00 35. 00		15, 045			11.00
12.00		41.00					1
	SUBPROVI DER - I RF	41.00 50.00		3, 172			12.00
13.00	OPERATING ROOM			203, 984			13.00
14. 00	RECOVERY ROOM	51.00		30, 267			14.00
15. 00	DELIVERY ROOM & LABOR ROOM	52.00		26, 566	0		15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54.00		68, 747			16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55.00		271, 925			17. 00
18. 00	CT SCAN	57. 00		237, 515	1		18. 00
19. 00	MAGNETIC RESONANCE IMAGING	58. 00		50, 724	0		19. 00
	(MRI)						
20.00	CARDI AC CATHETERI ZATI ON	59. 00		88, 929			20. 00
21. 00	LABORATORY	60.00		260			21. 00
22. 00	RESPIRATORY THERAPY	65. 00		23, 464	0		22. 00
23.00	PHYSI CAL THERAPY	66.00		182	0		23. 00
24.00	ELECTROCARDI OLOGY	69. 00		133, 811	0		24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00		7			25. 00
							·

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm Provider CCN: 15-0051

					'	5/26/2022 1	
		Decreases		,	'		
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9. 00	10.00		
26. 00	RENAL DIALYSIS	74.00		5, 817	0		26. 00
27. 00	CARDIAC REHABILITATION	76. 97		1	0		27. 00
28. 00	CLINIC	90.00		14, 210	0		28. 00
29. 00	OP ONCOLOGY INFUSION CENTER	90. 01		146, 379	0		29. 00
30. 00	WOUND CARE CENTER	90. 02		11, 033	0		30.00
31. 00	PAIN CLINIC	90. 03		10, 385	0		31.00
32. 00	OP PSYCH CLINIC	90.05		89	o O		32. 00
33. 00	EMERGENCY	91.00		57, 558	0		33. 00
34. 00	AMBULANCE SERVICES	95. 00		22, 309	0		34.00
35. 00	PROMPTCARE	190. 01		84, 342	0		35. 00
36. 00	COMMUNITY HEALTH SERVICES	190. 01		43, 276	0		36.00
30.00	COMMUNITY HEALTH SERVICES			4 <u>3, 2</u> 7 <u>0</u> 37, 375, 676			30.00
	H - NON-BILLABLE DRUGS		υĮ	37, 373, 070			
1.00	ADMI NI STRATI VE & GENERAL	5. 00		468	0		1.00
2.00	NURSING ADMINISTRATION	13. 00		1, 269	0		2. 00
3.00		•			0		3. 00
	CENTRAL SERVICES & SUPPLY	14.00		7, 331	0		1
4.00	ADULTS & PEDIATRICS	30.00		230, 874	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00		114, 725			5. 00
6.00	CORONARY CARE UNIT	32.00		40, 825	0		6. 00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00		15, 050	0		7. 00
8.00	SUBPROVI DER – I RF	41.00		4, 635	0		8. 00
9.00	OPERATING ROOM	50.00		120, 544	0		9. 00
10. 00	RECOVERY ROOM	51.00		88, 431	0		10. 00
11. 00	DELIVERY ROOM & LABOR ROOM	52.00		38, 381	0		11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54. 00		63, 862	0		12. 00
13. 00	RADI OLOGY-THERAPEUTI C	55. 00		6, 646	0		13. 00
14. 00	CT SCAN	57. 00		19, 930	0		14. 00
15. 00	MAGNETIC RESONANCE I MAGING	58. 00		11, 041	0		15. 00
	(MRI)						
16. 00	CARDIAC CATHETERIZATION	59. 00		41, 481	0		16. 00
17. 00	RESPIRATORY THERAPY	65. 00		84	0		17. 00
18.00	PHYSI CAL THERAPY	66.00		270	0		18. 00
19.00	ELECTROCARDI OLOGY	69. 00		3, 218	0		19. 00
20.00	RENAL DIALYSIS	74.00		2, 849	0		20. 00
21.00	CLINIC	90.00		2, 681	0		21. 00
22.00	OP ONCOLOGY INFUSION CENTER	90. 01		253, 457	0		22. 00
23.00	WOUND CARE CENTER	90. 02		225	0		23. 00
24.00	PAIN CLINIC	90. 03		540	0		24. 00
25.00	EMERGENCY	91.00		352, 086	0		25. 00
26.00	AMBULANCE SERVICES	95.00		17, 360	0		26. 00
27. 00	PROMPTCARE	190. 01		32	0		27. 00
				1, 438, 295			
	J - INTEREST EXPENSE	'	<u> </u>				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	595	11		1. 00
	0		0	595			
	K - PHARMACY RESIDENCY						
1.00	PHARMACY	15. 00	187, 488	14, 343	0		1. 00
2.00	CLINIC	90.00	12, 625	966	0		2. 00
	0		200, 113	15, 309			
	L - PSYCH ADMIN						
1.00	ADULTS & PEDIATRICS	30.00	87, 332	39, 728	0		1. 00
	0		87, 332	39, 728			
	M - SOFTWARE LICENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	977	14		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 065	0		2. 00
3.00	OPERATION OF PLANT	7. 00	0	3, 251	0		3. 00
4.00	DI ETARY	10.00	0	8, 696	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	15, 527	0		5. 00
6.00	PHARMACY	15. 00	0	986	0		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	6, 238	0		7. 00
8.00	INTENSIVE CARE UNIT	31.00	О	191	0		8. 00
9.00	OPERATING ROOM	50.00	o	51, 244	0		9. 00
10.00	RECOVERY ROOM	51.00	O	2, 253	0		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	O	34	0		11. 00
12. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	391	0		12. 00
13. 00	CT SCAN	57. 00	O	3, 310			13. 00
14. 00	CARDIAC CATHETERIZATION	59.00	O	61, 741	0		14. 00
15. 00	RESPIRATORY THERAPY	65. 00	o	34	0		15. 00
16. 00	PHYSI CAL THERAPY	66.00	ő	1, 378	0		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	ő	54	0		17. 00
18. 00	OP PHARMACY	73. 01	ol o	11, 458	0		18. 00
19. 00	RENAL DIALYSIS	74.00	0	34	0		19. 00
20. 00	CARDI AC REHABI LI TATI ON	74.00 76.97	o	446	0		20.00
21. 00	CLINIC	90.00	o	635			21. 00
00	1	, , , , , ,	<u> </u>	555	1	I	1 21.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm Provider CCN: 15-0051

					10	22 1: 09 pm
		Decreases				
	Cost Center	Li ne #	Sal ary		kst. A-7 Ref.	
00.00	6.00	7. 00	8.00	9. 00	10. 00	 00.00
22. 00 23. 00	OP ONCOLOGY INFUSION CENTER PAIN CLINIC	90. 01 90. 03	0	1, 326 733	0	22. 00 23. 00
24. 00	EMERGENCY	91.00	0	4, 026	o	24. 00
25. 00	AMBULANCE SERVICES	95.00	0	159	o	25. 00
26. 00	PROMPTCARE	190. 01	o	48, 640	o	26. 00
27. 00	COMMUNITY HEALTH SERVICES	190. 11	O	6, 657	O	27. 00
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	64	0	28. 00
	0		0	233, 548		
	N - CAFETERIA	10.00	= (450 547		
1. 00	DI ETARY		566, 418	453, 547	0	1. 00
	O - SHORT TERM DISABILITY/FLM	Λ	566, 418	453, 547		
1. 00	ADMI NI STRATI VE & GENERAL	5.00	7, 914	0	0	1. 00
2. 00	OPERATION OF PLANT	7. 00	4, 704	o	o	2. 00
3.00	HOUSEKEEPI NG	9.00	5, 821	Ö	Ö	3. 00
4.00	DI ETARY	10. 00	5, 979	0	0	4. 00
5.00	NURSING ADMINISTRATION	13. 00	14, 685	0	0	5. 00
6.00	PHARMACY	15. 00	8, 701	0	0	6. 00
7.00	CENTRAL STERILIZATION	18. 01	5, 799	0	0	7. 00
8. 00 9. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	76, 257	0	0	8. 00 9. 00
10. 00	CORONARY CARE UNIT	32.00	30, 837 23, 861	0	0	10.00
11. 00	NEONATAL INTENSIVE CARE UNIT	35.00	26, 852	o	o	11. 00
12. 00	SUBPROVI DER - I RF	41.00	16, 471	Ö	Ö	12. 00
13.00	OPERATING ROOM	50.00	15, 477	0	O	13. 00
14.00	RECOVERY ROOM	51.00	17, 517	0	0	14. 00
15.00	DELIVERY ROOM & LABOR ROOM	52. 00	20, 819	0	0	15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54.00	19, 166	0	0	16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55.00	9, 942	0	0	17. 00
18. 00 19. 00	CT SCAN CARDI AC CATHETERI ZATI ON	57. 00 59. 00	2, 107	0	0	18. 00 19. 00
20. 00	RESPIRATORY THERAPY	65. 00	10, 625 17, 733	0	ol Ol	20. 00
21. 00	PHYSI CAL THERAPY	66.00	40, 502	o	o	21. 00
22. 00	ELECTROCARDI OLOGY	69. 00	560	Ö	o	22. 00
23.00	CLINIC	90.00	472	0	O	23. 00
24.00	OP ONCOLOGY INFUSION CENTER	90. 01	17, 631	0	0	24. 00
25. 00	WOUND CARE CENTER	90. 02	3, 773	0	0	25. 00
26. 00	PAIN CLINIC	90. 03	19, 514	0	0	26. 00
27. 00	OP PSYCH CLINIC	90.05	3, 129	0	0	27. 00
28. 00 29. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	22, 376 14, 546	0	0	28. 00 29. 00
30.00	PROMPTCARE	190. 01	7, 540	Ö	0	30.00
31. 00	OLCOTT	190. 03	10, 570	Ö	Ö	31. 00
32.00	COMMUNITY HEALTH SERVICES	190. 11	5, 275	0	0	32. 00
33.00	PHYSICIANS' PRIVATE OFFICES	192.00	6, 268	0	0	33. 00
	0		493, 423	0		
4 00	P - UTILITIES EXPENSE	4 00		2.1		4.00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36	0	1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL HOUSEKEEPING	5. 00 9. 00	0	1, 545 3, 452	0	2. 00 3. 00
4. 00	NURSI NG ADMI NI STRATI ON	13. 00	0	579	o	4.00
5. 00	PHARMACY	15. 00	o	70	Ö	5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	993	O	6. 00
7.00	INTENSIVE CARE UNIT	31.00	0	132	0	7. 00
8.00	CORONARY CARE UNIT	32. 00	0	179	0	8. 00
9.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	42	0	9. 00
10.00	SUBPROVI DER – I RF	41.00	0	42	0	10.00
11. 00 12. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	899 81	0	11. 00 12. 00
13. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	85	ol O	13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54. 00	o	16, 572	o	14. 00
15.00	RADI OLOGY-THERAPEUTI C	55.00	O	186, 974	O	15. 00
16.00	MAGNETIC RESONANCE IMAGING	58. 00	O	88	0	16. 00
	(MRI)					
17. 00	CARDI AC CATHETERI ZATI ON	59.00	0	590	0	17. 00
18.00	RESPIRATORY THERAPY	65.00	0	121	0	18. 00
19.00	PHYSI CAL THERAPY	66.00	O	26, 209	0	19.00
20. 00 21. 00	OP ONCOLOGY INFUSION CENTER	69. 00 90. 01	0	78 129	0	20. 00 21. 00
21.00	PAIN CLINIC	90.01	O	7, 026	0	22.00
23. 00	OP PSYCH CLINIC	90.05	ŏl	47	0	23. 00
24. 00	AMBULANCE SERVICES	95.00	Ö	15, 514	Ö	24. 00
25. 00	PROMPTCARE	190. 01	O	36	0	25. 00
26. 00	COMMUNITY HEALTH SERVICES	190. 11	0	31, 759	0	 26. 00

Provider CCN: 15-0051

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm

						5/26/2022 1:	
		Decreases					
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	0.00	7.00	0.00	293, 278			_
	Q - BCC DEPRECIATION		-1				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	46, 088			1.00
2. 00 3. 00		0. 00 0. 00	0	0			2. 00 3. 00
3.00				46, 088			3.00
	R - OCCUPATIONAL HEALTH ADMIN			,			
1.00	PROMPTCARE	190. 01	<u>255, 6</u> 39	0			1. 00
	0 S - NURSERY		255, 639	0			_
1.00	ADULTS & PEDIATRICS	30.00	665, 042	125, 550	O		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	27, 465	8, 199			2. 00
	0		692, 507	133, 749			
4 00	T - BEDFORD ALLOCATION	4 00	50 (40	22 275			4
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	50, 643 601, 305	33, 375 471, 102	l .		1. 00 2. 00
3. 00	NURSI NG ADMI NI STRATI ON	13. 00	55, 419	14, 802	- 1		3. 00
4.00	PHARMACY	15. 00	285, 973	131, 429	o		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	17, 658	13, 323	l .		5. 00
6. 00	PHYSICAL THERAPY	6600	89, 945 1, 100, 943	<u>20, 823</u> 684, 854			6. 00
	U - PAOLI ALLOCATION		1, 100, 943	004, 034			-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	26, 246	17, 297	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	299, 409	238, 701			2. 00
3.00	NURSI NG ADMI NI STRATI ON	13.00	19, 517	5, 205			3. 00
4. 00 5. 00	PHARMACY RADI OLOGY-DI AGNOSTI C	15. 00 54. 00	91, 225 9, 151	42, 969 6, 905			4. 00 5. 00
6. 00	PHYSI CAL THERAPY	66.00	89, 945	20, 823			6. 00
7. 00	CLINIC	90.00	4, 374	1, 157			7. 00
	0		539, 867	333, 057			_
1 00	V - LIBERTY BUILDING DEPRECIA CAP REL COSTS-BLDG & FIXT		ما	127 720	9		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	1. 00 2. 00	0	127, 729 3, 640			1.00
2.00	0			131, 369			2.00
	X - ACCRUED PTO	T			TT		4
1. 00 2. 00	ADMINISTRATIVE & GENERAL DIETARY	5. 00 10. 00		60, 220	l .		1.00
3.00	NURSING ADMINISTRATION	13. 00		15, 211 99, 834	- 1		3. 00
4. 00	PHARMACY	15. 00		30, 954			4. 00
5.00	CENTRAL STERILIZATION	18. 01		4, 715	0		5. 00
6. 00	PARAMED ED PRGM-PHARMACY	23. 00		249	0		6. 00
7. 00	RESIDENCY ADULTS & PEDIATRICS	30. 00		75, 707	o		7. 00
8. 00	CORONARY CARE UNIT	32.00		155, 704	l .		8. 00
9.00	NEONATAL INTENSIVE CARE UNIT	35.00		21, 850	o		9. 00
10.00	OPERATING ROOM	50.00		95, 950			10.00
11.00	RECOVERY ROOM	51.00		66, 205 41, 276	I .		11.00
12. 00 13. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-THERAPEUTIC	52. 00 55. 00		41, 276 8, 526	- 1		12. 00 13. 00
14. 00	CT SCAN	57.00		6, 932			14. 00
15. 00	CARDIAC CATHETERIZATION	59. 00		70, 393			15. 00
16.00	RESPIRATORY THERAPY	65. 00		61, 391			16.00
17. 00 18. 00	ELECTROCARDI OLOGY OP PHARMACY	69. 00 73. 01		3, 335 12, 146			17. 00 18. 00
19. 00	CLI NI C	90.00		4, 110			19. 00
20. 00	OP ONCOLOGY INFUSION CENTER	90. 01		66, 453			20.00
21. 00	OP PSYCH CLINIC	90. 05		2, 519			21. 00
22. 00	EMERGENCY	91.00		43, 397			22. 00
23. 00 24. 00	AMBULANCE SERVICES PROMPTCARE	95. 00 190. 01		61, 326 24, 965			23. 00 24. 00
25. 00	COMMUNITY HEALTH SERVICES	190. 11		662			25. 00
	0			1, 034, 030			
4 00	Y - REHAB - COVI D		440 (0-1	40.4 0			4
1. 00	SUBPROVI DER - I RF	41.00	41 <u>3, 6</u> 30 413, 630	13 <u>4, 9</u> 35 134, 935			1.00
	Z - CENTRAL SUPPLY SALARY		413,030	134, 935			-
1.00	CENTRAL SERVICES & SUPPLY	1400	0	150			1.00
	TOTALS		o	150			_
1. 00	AA - BLOOD STORAGE ELECTROCARDI OLOGY	69.00		30	O		1.00
2.00	COMMUNITY HEALTH SERVICES	190. 11		30 4, 418			2.00
	TOTALS	+		4, 448			1

Health Financial Systems RECLASSIFICATIONS IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0051

						5/26/2022 1:0	09 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	AB - PACU RECLASS						
1.00	RECOVERY ROOM	51.00	99, 450	14, 434	C		1. 00
	TOTALS		99, 450	14, 434			
	AC - GRANT						
1.00	COMMUNITY HEALTH SERVICES	190. 11	2, 819, 349	2, 777, 670	C		1. 00
2.00	OLCOTT	190. 03	0	3, 697	C		2. 00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	272, 500	C		3. 00
	TOTALS		2, 819, 349	3, 053, 867			
	AD - PHYSICIAN						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 672, 397	C		1. 00
2.00		0.00	0	0	C		2. 00
3.00		0.00	0	0	C		3. 00
4.00		0.00	0	0	C		4. 00
5.00		0.00	0	0	C		5. 00
6.00		0.00	0	0	C		6. 00
7.00		0.00	0	0	C		7. 00
	TOTALS	- $ +$		2, 672, 397		1	
500.00	Grand Total: Decreases		7, 268, 671	122, 445, 454		7	500.00

Provider CCN: 15-0051

					To 12/31/2021	Date/Time Prep 5/26/2022 1:09	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET				_		
1.00	Land	19, 741, 447	0		0	0	1. 00
2.00	Land Improvements	2, 058, 207	0		0	0	2. 00
3.00	Buildings and Fixtures	150, 733, 671	346, 440, 250		0 346, 440, 250	0	3. 00
4.00	Building Improvements	11, 327, 645	3, 673, 354		0 3, 673, 354	0	4. 00
5.00	Fi xed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	139, 282, 710	107, 666, 652		0 107, 666, 652	10, 458, 786	6.00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	323, 143, 680	457, 780, 256		0 457, 780, 256	10, 458, 786	8.00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	323, 143, 680	457, 780, 256		0 457, 780, 256	10, 458, 786	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1.00	Land	19, 741, 447	0				1. 00
2.00	Land Improvements	2, 058, 207	2, 047, 204				2. 00
3.00	Buildings and Fixtures	497, 173, 921	143, 654, 369				3. 00
4.00	Building Improvements	15, 000, 999	9, 163, 727				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	236, 490, 576	97, 455, 921				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	770, 465, 150	252, 321, 221				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	770, 465, 150	252, 321, 221				10. 00

Heal th	Financial Systems I	U HEALTH BLOOMII	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part II Date/Time Pre 5/26/2022 1:0	pared:
		SUMMARY OF CAPITAL					
	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 WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FLXT	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 OF	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	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				3. 00

Heal th	n Financial Systems II	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/26/2022 1:09	
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1. 00	2.00	3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	5.00	
1. 00	CAP REL COSTS-BLDG & FIXT	533, 974, 573		533, 974, 57	0. 693055	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	236, 490, 577		236, 490, 57			2. 00
3.00	Total (sum of lines 1-2)	770, 465, 150		770, 465, 15			3. 00
0.00	Total (Sam of Titles 1 2)		TION OF OTHER (_	F CAPITAL	0.00
		, ALLOON	THOM OF OTHER V	5711 1 171 <u>C</u>	JOHNIN II C	7 O/11 1 1/1E	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 7, 859, 939		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		9, 557, 798	-31, 140	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 17, 417, 737	1, 409, 523	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (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 COSTS CE				_		
1.00	CAP REL COSTS-BLDG & FLXT	-611, 302	0	l .	0	8, 689, 300	1. 00
2 00	CAD DEL COSTS MADLE FOLLID		l 0		0 222 540	0.760.206	2 00

0 -611, 302

0 0 0

233, 548 233, 548

8, 689, 300 9, 760, 206 18, 449, 506

2. 00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0051 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -123, 514 CAP REL COSTS-BLDG & FLXT 1. 00 1.00 11 Α COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 Provider-based physician A-8-2 -18 414 000 10.00 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 36, 737, 292 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -204, 864 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines 20.00 0.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review OUTILIZATION REVIEW-SNF 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 *** Cost Center Deleted *** 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00

-2 050 EMPLOYEE BENEFITS DEPARTMENT

4.00

0 33.00

33. 00 MI SCELLANEOUS INCOME

Depreciation and Interest

В

Provider CCN: 15-0051 Peri od: Worksheet A-8 From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				T	o 12/31/2021	Date/Time Pre 5/26/2022 1:0	
				Expense Classification on	Worksheet A	372072022 1.0	y pili
				To/From Which the Amount is			
		5 , (0 , (0)			"		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
33. 01	MI SCELLANEOUS I NCOME	1. 00 B	2.00	3. 00 ADMI NI STRATI VE & GENERAL	4. 00 5. 00	5. 00 0	33. 01
33. 01	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7. 00	0	
33. 03	MI SCELLANEOUS I NCOME	В		HOUSEKEEPI NG	9. 00	0	
33. 04	MI SCELLANEOUS I NCOME	В	· ·	DI ETARY	10. 00	0	33. 04
33. 05	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00	0	
33. 06	MI SCELLANEOUS I NCOME	В		PHARMACY	15. 00	0	33. 06
33. 07	MI SCELLANEOUS I NCOME	В	-13, 875	ADULTS & PEDIATRICS	30.00	0	33. 07
33. 10	MI SCELLANEOUS I NCOME	В	-32, 139	MAGNETIC RESONANCE IMAGING	58. 00	0	33. 10
				(MRI)			
33. 11	MI SCELLANEOUS I NCOME	В		LABORATORY	60.00	0	
33. 12	MI SCELLANEOUS I NCOME	В		PHYSI CAL THERAPY	66. 00	0	33. 12
33. 13	MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	69. 00	0	
33. 14	MI SCELLANEOUS I NCOME	В		ELECTROENCEPHALOGRAPHY	70.00	0	33. 14
33. 15	MI SCELLANEOUS I NCOME	В		OP PHARMACY	73. 01	0	33. 15
33. 16	MI SCELLANEOUS I NCOME	В	-35, 161		90.00	0	33. 16
33. 17 33. 19	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B	· ·	AMBULANCE SERVICES PROMPTCARE	95. 00 100. 01	0	33. 17 33. 19
33. 19	MI SCELLANEOUS I NCOME	В	· ·	PHYSICIANS' PRIVATE OFFICES	190. 01 192. 00	0	33. 19
33. 20	UNNECESSARY BORROWING	A		CAP REL COSTS-BLDG & FIXT	1, 00	11	
33. 21	TELEPHONE EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 23	TELEPHONE EXPENSE	A		OPERATION OF PLANT	7. 00	0	33. 23
33. 24	TELEPHONE EXPENSE	A		HOUSEKEEPI NG	9. 00	0	33. 24
33. 25	TELEPHONE EXPENSE	A		NURSING ADMINISTRATION	13. 00	0	33. 25
33. 26	TELEPHONE EXPENSE	A		ADULTS & PEDIATRICS	30.00	0	33. 26
33. 27	TELEPHONE EXPENSE	A		INTENSIVE CARE UNIT	31.00	0	33. 27
33. 28	TELEPHONE EXPENSE	A	-9	CORONARY CARE UNIT	32.00	0	33. 28
33. 29	TELEPHONE EXPENSE	A	-14	NEONATAL INTENSIVE CARE UNIT	35. 00	0	33. 29
33. 30	TELEPHONE EXPENSE	A	-14	SUBPROVIDER - IRF	41.00	0	33. 30
33. 31	TELEPHONE EXPENSE	A		OPERATING ROOM	50.00	0	33. 31
33. 32	TELEPHONE EXPENSE	A		RECOVERY ROOM	51. 00	0	33. 32
33. 33	TELEPHONE EXPENSE	A		DELIVERY ROOM & LABOR ROOM	52. 00	0	33. 33
33. 34	TELEPHONE EXPENSE	A		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 34
33. 35	TELEPHONE EXPENSE	A	-25	MAGNETIC RESONANCE IMAGING	58. 00	0	33. 35
22.27	TELEBLIONE EVDENCE	Δ.	100	(MRI)	FO 00	_	22.24
33. 36 33. 37	TELEPHONE EXPENSE TELEPHONE EXPENSE	A A		CARDIAC CATHETERIZATION RESPIRATORY THERAPY	59. 00 65. 00	0	33. 36 33. 37
33. 37	TELEPHONE EXPENSE	A		PHYSICAL THERAPY	66.00	0	33. 38
33. 39	TELEPHONE EXPENSE	A		ELECTROCARDI OLOGY	69. 00	0	1
33. 40	TELEPHONE EXPENSE	A		OP PSYCH CLINIC	90. 05	0	
33. 41	PHYSI CI AN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 42	PHYSICIAN RECRUITMENT	A	· ·	ADULTS & PEDIATRICS	30. 00	0	1
33. 43	HAF FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 44	WEGMILLER CAPITALIZED INTEREST	A		CAP REL COSTS-BLDG & FIXT	1.00	11	33. 44
33. 45	1983 CAPITALIZED INTEREST	A		CAP REL COSTS-BLDG & FIXT	1.00	11	1
33. 46	OTHER CARRYFORWARD ADJUSTMENTS	A	· ·	CAP REL COSTS-BLDG & FIXT	1. 00	9	
33. 47	START UP COSTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 48	NEW HOSPITAL START UP -	A	593, 286	ADMINISTRATIVE & GENERAL	5. 00	0	33. 48
22 40	AMORTI ZATI ON		007.050	ADMINISTRATIVE A CENEDAL	F	_	22.40
33. 49	NONALLOWABLE MARKETING	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 50	NONALLOWABLE MARKETING	A		OPERATING ROOM	50.00	0	
33. 51	SIP PHARMACY RESIDENCY	A	44, 595	PARAMED ED PRGM-PHARMACY RESIDENCY	23. 00	0	33. 51
33. 52	BENEFIT EXPENSE	А	-21 767 208	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 52
33. 53	CONTRI BUTI ON EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 54	CONTRIBUTION EXPENSE	A		OPERATION OF PLANT	7. 00	0	1
33. 55	CONTRI BUTI ON EXPENSE	A		AMBULANCE SERVICES	95. 00	Ö	1
33. 56	UNWONTED SITUATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 57	UNWONTED SITUATIONS	Α		NURSING ADMINISTRATION	13. 00	0	
50.00	TOTAL (sum of lines 1 thru 49)		-41, 319, 108				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0051
From 01/01/2021
To 12/31/2021
Date/Time Prepared: 5/26/2022 1:09 pm

				12/31/2021	5/26/2022 1:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00		CAP REL COSTS-BLDG & FIXT	HO ALLOCATION	2, 343, 866	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO ALLOCATION	1, 801, 946	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO ALLOCATION	23, 642, 553	0	3.00
3.01	5. 00	ADMINISTRATIVE & GENERAL	HO ALLOCATION	63, 536, 109	59, 028, 933	3. 01
3.02	30.00	ADULTS & PEDIATRICS	HO ALLOCATION	o	36, 148	3. 02
3.03	54.00	RADI OLOGY-DI AGNOSTI C	HO ALLOCATION	o	57, 387	3. 03
3.04	90.00	CLINIC	HO ALLOCATION	0	1, 174	3.04
4.00	91.00	EMERGENCY	SIP ER	6, 603, 885	2, 067, 425	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	138, 814	138, 814	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	266, 283	266, 283	4. 02
4.03	13. 00	NURSING ADMINISTRATION	SHARED EMPLOYEES	70	70	4.03
4.04	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	5, 585, 427	5, 585, 427	4.04
4.05	35. 00	NEONATAL INTENSIVE CARE UNIT	SHARED EMPLOYEES	340, 898	340, 898	4. 05
4.06	50.00	OPERATING ROOM	SHARED EMPLOYEES	2, 007, 595	2, 007, 595	4.06
4.07	55. 00	RADI OLOGY-THERAPEUTI C	SHARED EMPLOYEES	431, 798	431, 798	4. 07
4.08	57. 00	CT SCAN	SHARED EMPLOYEES	17, 500	17, 500	4. 08
4.09	59. 00	CARDIAC CATHETERIZATION	SHARED EMPLOYEES	464	464	4. 09
4. 10	60.00	LABORATORY	SHARED EMPLOYEES	16, 032, 143	16, 032, 143	4. 10
4. 11	70.00	ELECTROENCEPHALOGRAPHY	SHARED EMPLOYEES	1, 439, 334	1, 439, 334	4. 11
4. 12	90. 01	OP ONCOLOGY INFUSION CENTER	SHARED EMPLOYEES	162, 520	162, 520	4. 12
4. 13	90. 02	WOUND CARE CENTER	SHARED EMPLOYEES	2, 314	2, 314	4. 13
4. 14	90. 03	PAIN CLINIC	SHARED EMPLOYEES	2, 314	2, 314	4. 14
4. 16	95. 00	AMBULANCE SERVICES	SHARED EMPLOYEES	265, 341	265, 341	4. 16
4. 17	190. 01	PROMPTCARE	SHARED EMPLOYEES	398, 374	398, 374	4. 17
4. 18	190. 11	COMMUNITY HEALTH SERVICES	SHARED EMPLOYEES	54, 674	54, 674	4. 18
5.00	0		0	125, 074, 222	88, 336, 930	5. 00

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

mao mo t	has not been posted to not keneet N, cordinate a diagram and a diagram of the part.							
				Related Organization(s) and/	or Home Office			
						i		
						i		
						ĺ		
	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 the information requested under Part B of this worksheet.

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

6. 00	С		O. OO LU HEALTH SLP	0.00	6. 00
7.00	С		O.OOIU HEALTH PAOLI	0.00	7. 00
8.00	В	IU HEALTH	0. 00	0.00	8. 00
9.00			0. 00	0.00	9. 00
10.00			0. 00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

					To 12/31/2021	Date/Time Prepared: 5/26/2022 1:09 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED OF	RGANIZATIONS OR (CLAI MED
	HOME OFFICE CO					
1. 00	2, 343, 866					1.00
2.00	1, 801, 946					2.00
3.00	23, 642, 553					3.00
3. 01	4, 507, 176					3. 01
3. 02	-36, 148					3. 02
3.03	-57, 387	0				3. 03
3.04	-1, 174					3. 04
4.00	4, 536, 460	0				4.00
4.01	0	0				4. 01
4.02	0	0				4. 02
4.03	0	0				4. 03
4.04	0	0				4. 04
4.05	0	0				4. 05
4.06	0	0				4.06
4.07	0	0				4. 07
4.08	0	0				4. 08
4.09	0	0				4. 09
4. 10	0	0				4. 10
4. 11	0	0				4. 11
4. 12	0	0				4. 12
4. 13	0	0				4. 13
4. 14	0	0				4. 14
4. 16	0	0				4. 16
4. 17	0	0				4. 17
4. 18	0	0				4. 18
5.00	36, 737, 292					5. 00

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

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

1 6	HIDUI	Selliett under title Aviii.		
		PHYSICIAN GROUP		6. 00
7.	00	HOSPI TAL		7. 00
	00			8. 00
9.	00			9. 00
10	0. 00		10	0.00
10	00.00		100	0.00

- (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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2021 To 12/31/2021 Date/Time Prepared: Provider CCN: 15-0051

							5/26/2022 1:0)9 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		ldenti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	6, 795, 431	6, 624, 478		211, 500	781	1. 00
2.00		NEONATAL INTENSIVE CARE UNIT	327, 285				1, 594	2. 00
3.00		OPERATING ROOM	3, 224, 873			246, 400	0	
4.00		DELIVERY ROOM & LABOR ROOM	8, 112				0	
5.00		RADI OLOGY-DI AGNOSTI C	596, 297				0	
6.00		RADI OLOGY-THERAPEUTI C	352, 280				0	
7. 00		CT SCAN	62, 631	62, 631		,	0	
8. 00		PHYSI CAL THERAPY	172, 412			,	0	8. 00
9. 00		ELECTROENCEPHALOGRAPHY	870, 962				0	9. 00
10.00		WOUND CARE CENTER	2, 827	2, 827			0	
11. 00		PAIN CLINIC	265, 414				0	
12.00		OP PSYCH CLINIC	28, 226			181, 300	0	12. 00
13. 00		EMERGENCY	5, 916, 303			,	0	13. 00
14. 00	95. 00	AMBULANCE SERVICES	410			211, 500	0	14. 00
200.00			18, 623, 463	18, 238, 950			2, 375	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	79, 414				14.00	1. 00
2. 00		NEONATAL INTENSIVE CARE UNIT	130, 049				0	
3. 00		OPERATING ROOM	130,047				0	
4. 00		DELIVERY ROOM & LABOR ROOM	l ő			l	0	
5. 00		RADI OLOGY-DI AGNOSTI C	l o				0	5. 00
6. 00		RADI OLOGY-THERAPEUTI C	0		1		0	
7. 00		CT SCAN	0		-		0	0.00
8. 00		PHYSI CAL THERAPY	0				0	
9. 00		ELECTROENCEPHALOGRAPHY	0		0	0	0	9. 00
10. 00		WOUND CARE CENTER	0		o o	l o	0	10.00
11. 00	90. 03	PAIN CLINIC	0		o o	0	0	11. 00
12.00	90. 05	OP PSYCH CLINIC	0		o o	0	0	12. 00
13.00	91.00	EMERGENCY	0		o o	0	0	13. 00
14.00	95.00	AMBULANCE SERVICES	0	1 0	o	0	0	14. 00
200.00			209, 463	10, 473	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
1 00	1.00	2.00	15. 00	16. 00	17. 00	18.00		1 00
1.00		ADULTS & PEDIATRICS	0			6, 716, 017		1.00
2.00		NEONATAL INTENSIVE CARE UNIT OPERATING ROOM	0			197, 236		2.00
3. 00 4. 00		DELIVERY ROOM & LABOR ROOM			1			3. 00 4. 00
4. 00 5. 00		RADI OLOGY-DI AGNOSTI C						5. 00
		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C			-			
6.00		CT SCAN			J			6. 00 7. 00
7. 00 8. 00					-	,		8. 00
8. 00 9. 00		PHYSI CAL THERAPY ELECTROENCEPHALOGRAPHY			9			9. 00
9. 00 10. 00		WOUND CARE CENTER			J	2,827		10.00
11. 00		PAIN CLINIC						11. 00
12.00		OP PSYCH CLINIC			-	,		12.00
12.00		EMERGENCY						12.00
14. 00		AMBULANCE SERVICES	0			3, 910, 303		14. 00
200.00	75.00	MINDOLANGE SERVICES		209, 463	1			200.00
200.00	I	l	1	207, 403	175,050	10,414,000	I	200.00

		U HEALTH BLOOMI		011 45 0054 5		u of Form CMS-2	2552-10
COSTA	ALLOCATION - GENERAL SERVICE COSTS		Provi der C		eriod: rom 01/01/2021	Worksheet B Part I	
					o 12/31/2021	Date/Time Pre	pared:
			CADITAL DE	ATED COCTO		5/26/2022 1:0	9 pm
			CAPITAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	5551 5511tol. 55551. pt. 6.1	for Cost	5250 a 11711		BENEFI TS	oub to tu.	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)					
	OFNEDAL CEDIU OF COCT OFNEDO	0	1. 00	2.00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	8, 689, 300	8, 689, 300				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	9, 760, 206	0,007,300	9, 760, 206			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	25, 341, 487	56, 366				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	65, 712, 866				70, 684, 751	5. 00
7.00	00700 OPERATION OF PLANT	13, 223, 854				16, 693, 149	1
8.00	00800 LAUNDRY & LINEN SERVICE	224, 668	14, 858	17, 569		257, 095	
9.00	00900 HOUSEKEEPI NG	3, 565, 140		38, 892		4, 019, 558	
10.00	01000 DI ETARY	2, 441, 471	90, 296			2, 940, 864	
11.00	01100 CAFETERI A	815, 101	55, 468			1, 046, 757	
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	16, 888, 820 13, 903, 823	160, 252			20, 196, 635 14, 013, 155	
14. 00 15. 00	01500 PHARMACY	8, 199, 073	50, 096 41, 988			9, 406, 964	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0, 177, 0/3	33, 640			73, 418	
18. 00	01850 SOCI AL SERVI CES	0	00,010	0,,,,,		75, 116	
18. 01	01851 CENTRAL STERI LI ZATI ON	1, 141, 092	28, 667			1, 343, 250	
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	405, 302				489, 112	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	35, 771, 736				43, 301, 181	1
31. 00	03100 INTENSIVE CARE UNIT	5, 277, 708	98, 903			6, 229, 773	
32. 00	03200 CORONARY CARE UNIT	4, 382, 369	148, 290			5, 327, 342	1
35. 00 41. 00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	2, 471, 717	64, 035			3, 000, 465	
41.00	04200 SUBPROVI DER	968, 015	71, 564	84, 621		1, 257, 391 0	1
43. 00	04300 NURSERY	826, 256	41, 349	-		1, 051, 718	
10.00	ANCILLARY SERVICE COST CENTERS	020,200	11,017	107070	100/220	1,001,710	10.00
50.00	05000 OPERATING ROOM	12, 186, 527	477, 790	564, 965	1, 317, 857	14, 547, 139	50.00
50. 01	05001 CV SURGERY	0	0	0	0	0	50. 01
51. 00	05100 RECOVERY ROOM	4, 128, 726	43, 945			4, 938, 147	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 726, 993	325, 546	1	568, 150	5, 005, 632	
53.00	05300 ANESTHESI OLOGY	4 700 010	101 770	0	(00, 22)	0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	4, 799, 912 2, 964, 460	181, 770 226, 054			5, 886, 843 3, 901, 270	
56. 00	05600 RADI OLOGI - THERAPEUTI C	2, 704, 400	220,034	207, 299	443, 437	3, 901, 270	1
57. 00	05700 CT SCAN	870, 221	17, 115	20, 237	123, 514	1, 031, 087	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	704, 283	19, 461			855, 722	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 804, 789	74, 669	88, 293	277, 144	2, 244, 895	59. 00
60.00	06000 LABORATORY	16, 830, 715	165, 284	195, 441	416	17, 191, 856	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0		0	
	06500 RESPI RATORY THERAPY	3, 509, 359				4, 148, 710	
	06600 PHYSI CAL THERAPY	7, 081, 560	96, 367	113, 949	1, 232, 981	8, 524, 857	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	660, 476	23, 225	27, 463	110, 005	821, 169	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	788, 170	39, 911	47, 193		903, 303	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 554, 509	0	0	0	9, 554, 509	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 318, 551	0	0	0	14, 318, 551	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	37, 375, 676	0	0	0	37, 375, 676	
73. 01	07302 OP PHARMACY	1, 662, 141	0		83, 069	1, 745, 210	1
74.00	07400 RENAL DI ALYSI S	1, 627, 955	7, 369	8, 714	8	1, 644, 046	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
75. 01 76. 97	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON	556, 728	34, 958	41, 336	99, 257	0 732, 279	
70. 77	OUTPATIENT SERVICE COST CENTERS	330,728	34, 730	41, 330	77, 237	132, 214	70. 77
90. 00	09000 CLINIC	1, 581, 253	212, 744	251, 560	291, 541	2, 337, 098	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	4, 294, 609	188, 120			5, 431, 915	
90. 02	09002 WOUND CARE CENTER	676, 096	46, 631	55, 139	109, 549	887, 415	90. 02
90. 03	09003 PAIN CLINIC	613, 776	29, 955	35, 421	56, 665	735, 817	
90. 05	09005 OP PSYCH CLINIC	1, 363, 880	121, 080			1, 813, 048	
91. 00	09100 EMERGENCY	9, 980, 887	268, 680	317, 703	1, 096, 237	11, 663, 507	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		0	0	n n	0	94.00
	09500 AMBULANCE SERVICES	2, 990, 201	74, 879			3, 779, 286	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	_		100.00
	10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
440 -	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113.00
114.00	7 11700 UTLLZATION KEVIEW-SINF	1	<u> </u>	I	l l		114. 00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051 Peri od: Worksheet B From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115. 00 0 116.00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 366, 662, 457 7, 915, 612 9, 359, 854 23, 327, 651 363, 351, 565 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 349, 458 190. 00 291 737 8, 697 10 284 38 740 190. 01 19001 PROMPTCARE 3, 158, 846 190. 01 2,644,386 64, 264 75, 990 374, 206 190. 02 19002 RENTAL PROPERTIES 2,927 177, 306 0 180, 233 190. 02 190. 03 19003 OLCOTT 0 560, 704 190. 03 463, 918 27, 459 69, 327 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 190, 04 190. 05 19005 FOUNDATION 2, 341 11, 982 0 0 14, 323 190. 05 190. 06 19006 MARKETI NG 0 0 0 190.06 C 190. 07 19007 HME STORE 0 0 0 190. 07 0 190. 08 19008 UNUSED SPACE 0 40, 820 190. 08 40.820 Ω 190. 09 19009 CLINICAL TRIALS 0 0 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 1, 593, 674 0 2, 046, 816 190. 11 142, 019 311, 123 0 191. 00 19100 RESEARCH 6, 250 6, 250 191. 00 191. 01 19101 RESEARCH 0 0 191. 01 191. 02 19102 OTHER SPONSORED ACTIVITIES 5, 866, 966 0 0 550, 512 6, 417, 478 191. 02 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 470, 641 192. 00 0 470, 641 C 193.00 19300 NONPALD WORKERS O 0 193. 00 194.00 07950 IU HEALTH PAOLI HOSPITAL 872, 924 89,886 106, 287 105, 416 1, 174, 513 194. 00 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 2, 384, 289 194. 01 1, 785, 797 175, 729 207, 791 214, 972 0 194. 02 194. 02 07952 I U HEALTH MORGAN HOSPITAL 0 194. 03 07953 IU HEALTH SIP 135, 585 4, 493 0 762 140, 840 194. 03 194. 04 07954 HOME CARE 2, 591 23, 964 0 470 27, 025 194. 04 0 194. 05 07955 HOSPI CE 22, 477 47, 889 683 71, 049 194. 05 200.00 0 200. 00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201. 00 380, 394, 850 8, 689, 300 202.00 TOTAL (sum lines 118 through 201) 9, 760, 206 25, 464, 503 380, 394, 850 202. 00

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared:
5/26/2022 1:09 pm

				''	0 12/31/2021	5/26/2022 1:0	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	2.22	10.00	
	CENEDAL CEDVICE COST CENTEDS	5.00	7. 00	8.00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					ı	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					ı	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	70, 684, 751				ı	5. 00
7.00	00700 OPERATION OF PLANT	3, 809, 861	20, 503, 010			ı	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	58, 677	54, 691	370, 463		ı	8. 00
9.00	00900 HOUSEKEEPI NG	917, 380	121, 070	1	5, 058, 009	ı	9. 00
10. 00		671, 190	332, 372	1	15, 697	3, 960, 123	10.00
11. 00		238, 900	204, 172	1	7, 558	0	11. 00
13. 00		4, 609, 458	589, 875		·	0	13. 00
14. 00		3, 198, 208	184, 398		139, 531	0	14. 00
15. 00		2, 146, 942	154, 553	1	l	0	15.00
16.00		16, 756	123, 826	1	,	0	16.00
18. 00 18. 01	01850 SOCIAL SERVICES 01851 CENTRAL STERILIZATION	306, 569	105, 522	0 621	0	0	18. 00 18. 01
23. 00	1	111, 630	33, 410	1	0	0	23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	111,030	33, 410) ₁	<u> </u>		23.00
30. 00		9, 882, 507	4, 296, 688	106, 083	2, 508, 077	3, 283, 657	30.00
31. 00	1	1, 421, 815	364, 054	1		295, 189	31.00
32. 00	1	1, 215, 854	545, 843	1	· · ·	287, 969	32.00
35.00	1	684, 793	235, 707	1	l .	0	35. 00
41.00	04100 SUBPROVI DER - I RF	286, 973	263, 420	10, 386	o	93, 308	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00		240, 033	152, 201	4, 172	80, 812	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	1	3, 320, 079	1, 758, 708	1	465, 104	0	50.00
50. 01		0	0	0	0	0	50. 01
51. 00		1, 127, 028	161, 757	1		0	51.00
52.00		1, 142, 430	1, 198, 311	20, 367	195, 925	0	52.00
53. 00 54. 00		1, 343, 548	669, 081	30, 578	139, 531	0	53. 00 54. 00
55. 00		890, 383	832, 088		139, 331	0	55.00
56. 00		090, 303	032,000		0	0	56.00
57. 00		235, 324	62, 997			0	57.00
58. 00		195, 301	71, 635	1	0	0	58.00
59. 00		512, 350	274, 851	1	0	0	59.00
60. 00		3, 923, 680	608, 399		l I	0	60.00
64. 00		0	0	0	0	0	64. 00
65.00		946, 856	44, 804	. 0	О	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 945, 620	354, 719	0	52, 324	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0	0	O	0	67. 00
68. 00		0	0	0	0	0	68. 00
69. 00	1	187, 415	85, 491		139, 531	0	69. 00
70. 00	1	206, 160	146, 908	0	0	0	70. 00
71. 00	1	2, 180, 616	0	0	0	0	71.00
72. 00		3, 267, 909	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	8, 530, 213	0	0	0	0	73.00
73. 01		398, 308	27 125	0	0	0	73. 01
74. 00 75. 00		375, 219	27, 125		0	0	74. 00 75. 00
75. 00 75. 01		0	0		0	0	75. 00
76. 97	1	167, 127	128, 678			0	76. 97
70. 71	OUTPATIENT SERVICE COST CENTERS	107, 127	120, 070	, 0	<u> </u>	0	, 3. ,,
90. 00		533, 394	783, 094	0	ol	0	90.00
90. 01		1, 239, 721	692, 457		o	0	90. 01
90. 02		202, 534	171, 644		34, 883	0	90. 02
90. 03	09003 PAIN CLINIC	167, 935	110, 264	0	o	0	90. 03
90. 05		413, 790	445, 686	0	o	0	90. 05
91. 00	09100 EMERGENCY	2, 661, 951	988, 993	51, 959	906, 953	0	91. 00
92. 00							92. 00
_	OTHER REIMBURSABLE COST CENTERS						
94. 00		0	0	0	·	0	94. 00
	09500 AMBULANCE SERVI CES	862, 543	275, 623	25, 734	0	0	95. 00
	0 10000 I&R SERVICES-NOT APPRVD PRGM	0	Ü	0	0		100.00
101.0	0 10100 HOME HEALTH AGENCY	0	0)[0	0	0	101. 00
112 0	SPECIAL PURPOSE COST CENTERS 0 11300 INTEREST EXPENSE						113. 00
	0 11300 TNTEREST EXPENSE 0 11400 UTILIZATION REVIEW-SNF					ı	114. 00
	0 11400 011E1ZATTON REVIEW-SINF 0 11500 AMBULATORY SURGICAL CENTER (D. P.)		0			n	115.00
	0 11600 H0SPICE		0				116.00
118. 0	1	66, 794, 980	17, 655, 115	370, 463	5, 005, 685	3, 960, 123	
	NONREI MBURSABLE COST CENTERS		, 222, 110			.,, .20	
190. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	79, 756	32, 013	0	0	0	190. 00
		· · · · · · · · · · · · · · · · · · ·			· · · · · · · · · · · · · · · · · · ·		

| Period: | Worksheet B | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: | 5/26/2022 | 1:09 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051

					5/26/2022 1:09 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5.00	7. 00	8. 00	9. 00	10. 00
190. 01 19001 PROMPTCARE	720, 940	236, 553	0	0	0 190. 01
190. 02 19002 RENTAL PROPERTI ES	41, 134	652, 652	0	0	0 190. 02
190. 03 19003 OLCOTT	127, 969	101, 075	0	0	0 190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	3, 269	44, 106	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190.07 19007 HME STORE	0	0	0	52, 324	0 190. 07
190. 08 19008 UNUSED SPACE	9, 316	0	0	0	0 190. 08
190. 09 19009 CLINICAL TRIALS	0	0	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	467, 143	522, 761	0	0	0 190. 11
191. 00 19100 RESEARCH	1, 426	0	0	0	0 191. 00
191. 01 19101 RESEARCH	0	0	0	0	0 191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	1, 464, 655	0	0	0	0 191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	107, 414	0	0	0	0 192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	268, 058	330, 865	0	0	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	544, 164	646, 844	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194.03 07953 IU HEALTH SIP	32, 144	16, 540	0	0	0 194. 03
194.04 07954 HOME CARE	6, 168	88, 211	0	0	0 194. 04
194. 05 07955 HOSPI CE	16, 215	176, 275	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	70, 684, 751	20, 503, 010	370, 463	5, 058, 009	3, 960, 123 202. 00

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/26/2022 1:09 pm	

				12/31/2021	5/26/2022 1:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON			RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
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 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A	1, 497, 387					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	100, 764	25, 496, 793				13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	0	17, 535, 292			14. 00
15. 00 01500 PHARMACY	60, 932	О	76, 884	11, 899, 749		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	237, 255	16. 00
18. 00 01850 SOCIAL SERVICES	0	0	0	0	0	18. 00
18. 01 01851 CENTRAL STERILIZATION	15, 928	0	6, 100	0	0	18. 01
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY	3, 971	0	0	0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	336, 970	10, 064, 851	451, 026	70, 508	24, 849	30.00
31. 00 03100 NTENSI VE CARE UNIT	45, 691	1, 571, 537	139, 335	35, 181	3, 702	31.00
32. 00 03200 CORONARY CARE UNIT	36, 976	1, 263, 587	99, 933	12, 519	3, 318	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	22, 861	800, 462	53, 975	4, 615	2, 026	35. 00
41. 00 04100 SUBPROVI DER - RF	8, 841	276, 058	8, 948	907	408	41.00
42. 00 04200 SUBPROVI DER	0	0	0	О	0	42. 00
43. 00 04300 NURSERY	6, 603	228, 515	29, 336	1, 715	500	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	85, 722	2, 058, 082	4, 114, 390	36, 966	28, 719	50.00
50. 01 05001 CV SURGERY 51. 00 05100 RECOVERY ROOM	0 47, 077	1, 556, 970	0 78, 705	26, 390	0 4, 400	50. 01 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	30, 100	1, 028, 761	84, 325	11, 588	4, 400	52.00
53. 00 05300 ANESTHESI OLOGY	30, 100	1, 020, 701	04, 323	11, 500	4, 043	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	44, 449	302, 614	283, 518	19, 584	6, 178	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	30, 450	149, 928	9, 232	2, 038	11, 671	55. 00
56. 00 05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	8, 243	18	38, 216	6, 112	4, 453	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 603	72	1, 631	3, 386	1, 111	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	16, 117	455, 805	621, 274	12, 720	8, 718	59.00
60. 00 06000 LABORATORY 64. 00 06400 INTRAVENOUS THERAPY	54, 397 0	0	0	0	15, 198 0	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	35, 603	4, 633	284, 039	26	2, 556	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	81, 347	4, 033	5, 758	83	3, 768	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	01, 017	o	0, 700	0	0, 700	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	O	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	9, 825	4, 760	7, 782	987	3, 381	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 663	0	2, 709	0	922	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4, 316, 259	0	10, 676	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	6, 468, 402	0	17, 719	
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07302 OP PHARMACY	4 403	U E41	1 145	11, 461, 466	39, 712	
73. 01 07302 0P PHARMACY 74. 00 07400 RENAL DI ALYSI S	4, 602	541	1, 145 2, 288	874	224 529	73. 01 74. 00
75. 00 07500 ASC (NON-DI STINCT PART)	0	0	2, 200	0/4	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	o	O	o	0	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	7, 418	98, 473	472	O	340	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	19, 707	274, 002	2, 640	822	311	90. 00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	51, 079	1, 488, 893	55, 202	77, 724	5, 186	90. 01
90. 02 09002 WOUND CARE CENTER	8, 834	229, 579	12, 079	69	988	90. 02
90. 03 09003 PAIN CLINIC	5, 669	78, 389	7, 270	166	210	90. 03
90. 05 09005 0P PSYCH CLINIC 91. 00 09100 EMERGENCY	17, 306 79, 425	163, 918 2, 660, 732		107, 969	508 26, 878	90. 05 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	17,425	2,000,732	213, 790	107, 909	20, 676	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	O	0	O	0	94. 00
95. 00 09500 AMBULANCE SERVICES	61, 552	34, 020	41, 866	5, 324	3, 451	95. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	o	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	o	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0				0	114. 00 115. 00
116. 00 11600 H0SPICE	0	0		٥		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 347, 725	24, 795, 200	17, 518, 776	11, 899, 739	237, 255	

Provider CCN: 15-0051

			10	12/ 31/ 2021	5/26/2022 1:09 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
		ADMI NI STRATI ON	SERVICES &		RECORDS &
			SUPPLY		LI BRARY
	11. 00	13. 00	14. 00	15. 00	16. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 846		0	0	0 190. 00
190. 01 19001 PROMPTCARE	24, 796	207, 963	10, 221	10	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0 190. 02
190. 03 19003 OLCOTT	5, 169	117, 873	1, 185	0	0 190. 03
190. 04 19004 PHYSICIAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	0	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0 190. 08
190. 09 19009 CLINICAL TRIALS	0	0	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	72, 185	356, 340	5, 110	0	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
191. 01 19101 RESEARCH	0	0	0	0	0 191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	0	0	0	0	0 191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	27, 041	1, 983	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	4, 744		0	0	0 194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	9, 720	0	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194. 03 07953 IU HEALTH SIP	58	2, 218	0	0	0 194. 03
194. 04 07954 HOME CARE	34	0	0	0	0 194. 04
194. 05 07955 HOSPI CE	69	0	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 497, 387	25, 496, 793	17, 535, 292	11, 899, 749	237, 255 202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

				Т	o 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		OTHER GENE	RAL SERVICE			372072022 1.0	7 DIII
	Cost Center Description	SOCI AL SERVI CES	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		18. 00	18. 01	23. 00	24.00	25.00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 18. 01 23. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01850 SOCIAL SERVICES 01851 CENTRAL STERILIZATION 02301 PARAMED ED PRGM-PHARMACY RESIDENCY INPATIENT ROUTINE SERVICE COST CENTERS		1, 777, 990	638, 123		0	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 18. 01 23. 00
31. 00 32. 00 35. 00 41. 00 42. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER		0 0 0 0 0 0	000000000000000000000000000000000000000	10, 342, 050 8, 806, 573 4, 807, 999 2, 206, 640	0 0 0 0	31. 00 32. 00 35. 00 41. 00 42. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	(0	0	1, 795, 605	0	43. 00
50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00	05001 CV SURGERY 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI)			1	0 7, 973, 070 8, 722, 084 0 8, 725, 924 5, 827, 060	0 0 0	50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00
60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07300 P PHARMACY 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)			638, 123	21, 816, 849 0 5, 467, 227 10, 968, 476 0 1, 265, 122 1, 262, 665 16, 062, 060 24, 072, 581	0 0 0 0 0 0 0 0	60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 01 74. 00 75. 01
76. 97	07697 CARDIAC REHABILITATION	(0	1, 134, 787	0	76. 97
90. 00 90. 01 90. 02 90. 03 90. 05 91. 00 92. 00	09001 OP ONCOLOGY INFUSION CENTER 09002 WOUND CARE CENTER 09003 PAIN CLINIC 09005 OP PSYCH CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	()	0 0 0	000000000000000000000000000000000000000	3, 951, 068 9, 047, 894 1, 548, 025 1, 105, 720 2, 854, 503 19, 362, 157	0 0 0	90. 00 90. 01 90. 02 90. 03 90. 05 91. 00 92. 00
95. 00 100. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 0 10000 & SERVI CES - NOT APPRVD PRGM 0 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	()	0	000000000000000000000000000000000000000	5, 089, 399 0 0	0	94. 00 95. 00 100. 00 101. 00
	D 11300 I NTEREST EXPENSE D 11400 UTI LI ZATI ON REVI EW-SNF						113. 00 114. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

			To	12/31/2021	Date/Time Prepared: 5/26/2022 1:09 pm
	OTHER GENER	DAL SEDVICE			372872022 1.09 pill
	OTTICK GENER	AL SERVICE			
Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &
5550 5511011 B5551 1 p 11 511	SERVI CES		PRGM-PHARMACY		Residents Cost
			RESI DENCY		& Post
					Stepdown
					Adjustments
	18. 00	18. 01	23. 00	24.00	25. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115.00
116. 00 11600 HOSPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 777, 990	638, 123	355, 693, 794	0 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	482, 289	
190. 01 19001 PROMPTCARE	0	0	0	4, 359, 329	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	874, 019	
190. 03 19003 OLCOTT	0	0	0	913, 975	
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	61, 698	
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	0	0	0	52, 324	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	50, 136	
190. 09 19009 CLINI CAL TRI ALS	0	0	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0	0	3, 470, 355	
191. 00 19100 RESEARCH	0	0	0	7, 676	
191. 01 19101 RESEARCH	0	0	0	0	0 191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	0	0	0	7, 882, 133	0 191. 02
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	607, 079	0 192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	1, 778, 180	0 194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	3, 585, 017	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194.03 07953 IU HEALTH SIP	0	0	0	191, 800	0 194. 03
194. 04 07954 HOME CARE	0	0	0	121, 438	0 194. 04
194. 05 07955 HOSPI CE	0	0	0	263, 608	0 194. 05
200.00 Cross Foot Adjustments			0	0	0 200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	o	1, 777, 990	638, 123	380, 394, 850	0 202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/26/2022 1:09 pm	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

			5/26/2022 1:0	
	Cost Center Description	Total		
-	ENEDAL CEDILICE COCT CENTEDO	26. 00		
	ENERAL SERVICE COST CENTERS 10100 CAP REL COSTS-BLDG & FLXT			1.00
1	10200 CAP REL COSTS-MVBLE EQUIP			2. 00
1	0400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
	0500 ADMINISTRATIVE & GENERAL			5. 00
7.00 0	0700 OPERATION OF PLANT			7. 00
8.00 0	0800 LAUNDRY & LINEN SERVICE			8. 00
	10900 HOUSEKEEPI NG			9. 00
1	1000 DI ETARY			10.00
1	11100 CAFETERI A			11.00
1	11300 NURSI NG ADMI NI STRATI ON			13.00
1	11400 CENTRAL SERVI CES & SUPPLY 11500 PHARMACY			14. 00 15. 00
	11600 MEDI CAL RECORDS & LI BRARY			16. 00
1	11850 SOCIAL SERVICES			18. 00
	1851 CENTRAL STERILIZATION			18. 01
	2301 PARAMED ED PRGM-PHARMACY RESIDENCY			23. 00
_	NPATIENT ROUTINE SERVICE COST CENTERS			
30.00 0	3000 ADULTS & PEDIATRICS	74, 326, 397		30. 00
31.00 0	3100 INTENSIVE CARE UNIT	10, 342, 050		31. 00
	3200 CORONARY CARE UNIT	8, 806, 573		32. 00
	2060 NEONATAL INTENSIVE CARE UNIT	4, 807, 999		35. 00
1	4100 SUBPROVI DER – I RF	2, 206, 640		41.00
1	4200 SUBPROVI DER	0		42.00
	14300 NURSERY	1, 795, 605		43. 00
_	NCILLARY SERVICE COST CENTERS 15000 OPERATING ROOM	28, 230, 687		50.00
	15001 CV SURGERY	20, 230, 667		50. 00
1	5100 RECOVERY ROOM	7, 973, 070		51. 00
	5200 DELIVERY ROOM & LABOR ROOM	8, 722, 084		52.00
	5300 ANESTHESI OLOGY	0, 722, 004		53. 00
1	5400 RADI OLOGY-DI AGNOSTI C	8, 725, 924		54. 00
1	5500 RADI OLOGY-THERAPEUTI C	5, 827, 060		55. 00
1	5600 RADI OI SOTOPE	0		56. 00
1	5700 CT SCAN	1, 386, 450		57. 00
1	5800 MAGNETIC RESONANCE IMAGING (MRI)	1, 135, 461		58. 00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	4, 153, 960		59. 00
60.00 0	6000 LABORATORY	21, 816, 849		60.00
64. 00 0	6400 I NTRAVENOUS THERAPY	0		64.00
65.00 0	6500 RESPI RATORY THERAPY	5, 467, 227		65. 00
	6600 PHYSI CAL THERAPY	10, 968, 476		66. 00
	6700 OCCUPATI ONAL THERAPY	0		67. 00
	6800 SPEECH PATHOLOGY	0		68. 00
	6900 ELECTROCARDI OLOGY	1, 265, 122		69. 00
	17000 ELECTROENCEPHALOGRAPHY	1, 262, 665		70.00
	17100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 062, 060		71.00
	17200 IMPL. DEV. CHARGED TO PATIENTS 17300 DRUGS CHARGED TO PATIENTS	24, 072, 581		72.00
	17300 DRUGS CHARGED TO PATTENTS	58, 045, 190		73. 00 73. 01
	17302 OF PHARMACT	2, 150, 030 2, 050, 081		74.00
	17500 ASC (NON-DISTINCT PART)	2, 030, 081		75. 00
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		75. 01
	17697 CARDI AC REHABI LI TATI ON	1, 134, 787		76. 97
	UTPATIENT SERVICE COST CENTERS	.,,		1
90.00 0	9000 CLI NI C	3, 951, 068		90.00
	9001 OP ONCOLOGY INFUSION CENTER	9, 047, 894		90. 01
	9002 WOUND CARE CENTER	1, 548, 025		90. 02
	9003 PAIN CLINIC	1, 105, 720		90. 03
	9005 OP PSYCH CLINIC	2, 854, 503		90. 05
	9100 EMERGENCY	19, 362, 157		91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
_	THER REIMBURSABLE COST CENTERS	21		04.00
	19400 HOME PROGRAM DIALYSIS	0		94.00
	19500 AMBULANCE SERVICES	5, 089, 399		95. 00
	0000 I &R SERVICES-NOT APPRVD PRGM	0		100. 00 101. 00
	0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	0		1101.00
	1300 I NTEREST EXPENSE			113. 00
	1400 UTI LI ZATI ON REVI EW-SNF			114. 00
	1500 AMBULATORY SURGICAL CENTER (D. P.)	o		115. 00
	1600 HOSPICE	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	355, 693, 794		118. 00
_	ONREI MBURSABLE COST CENTERS	333, 370, 774		1
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	482, 289		190. 00
	9001 PROMPTCARE	4, 359, 329		190. 01

| Peri od: | Worksheet B | From 01/01/2021 | Part | | Date/Time Prepared: | 5/26/2022 1:09 pm

		5/26/2022 1:09 pm
Cost Center Description	Total	
	26.00	
190. 02 19002 RENTAL PROPERTI ES	874, 019	190. 02
190. 03 19003 OLCOTT	913, 975	190. 03
190. 04 19004 PHYSICIAN RECRUITMENT	0	190. 04
190. 05 19005 FOUNDATI ON	61, 698	190. 05
190. 06 19006 MARKETI NG	0	190. 06
190. 07 19007 HME STORE	52, 324	190. 07
190. 08 19008 UNUSED SPACE	50, 136	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	3, 470, 355	190. 11
191. 00 19100 RESEARCH	7, 676	191. 00
191. 01 19101 RESEARCH	0	191. 01
191.02 19102 OTHER SPONSORED ACTIVITIES	7, 882, 133	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	607, 079	192. 00
193. 00 19300 NONPALD WORKERS	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	1, 778, 180	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	3, 585, 017	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	194. 02
194.03 07953 IU HEALTH SIP	191, 800	194. 03
194.04 07954 HOME CARE	121, 438	194. 04
194. 05 07955 HOSPI CE	263, 608	194. 05
200.00 Cross Foot Adjustments	0	200.00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	380, 394, 850	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

			Τ̈́	0 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		CAPI TAL REI	LATED COSTS		372072022 1.0) piii
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New Capital				BENEFI TS	
	Related Costs				DEPARTMENT	
GENERAL SERVICE COST CENTERS	0	1.00	2. 00	2A	4. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP		· ·		400.044		2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL	0	56, 366 1, 688, 147				4. 00 5. 00
7. 00 00700 OPERATION OF PLANT	0	1, 374, 716				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	14, 858			0	8. 00
9. 00 00900 HOUSEKEEPI NG	0	32, 891	38, 892		1, 848	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	90, 296 55, 468			1, 460 534	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	160, 252			14, 286	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	50, 096			0	14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	41, 988				15. 00 16. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 18. 00 01850 SOCI AL SERVI CES	0	33, 640 0	39, 778 (73, 418 0	0	18.00
18. 01 01851 CENTRAL STERILIZATION	0	28, 667	33, 898	62, 565	674	18. 01
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY	0	9, 077	10, 733	19, 810	309	23. 00
30.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	0	1, 167, 284	1, 380, 261	2, 547, 545	24, 098	30. 00
31. 00 03100 NTENSI VE CARE UNI T	0	98, 903			3, 555	31.00
32. 00 03200 CORONARY CARE UNIT	0	148, 290				32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVI DER - IRF	0	64, 035			1, 879 643	35. 00 41. 00
41.00 04100 SUBPROVIDER - TRF 42.00 04200 SUBPROVIDER	0	71, 564 0	84, 621	156, 185 0	043	41.00
43. 00 04300 NURSERY	0	41, 349	48, 893	90, 242	653	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	ΙΟ	477, 790	564, 965	1, 042, 755	6, 364	50.00
50. 01 05001 CV SURGERY	0	477, 790	304, 903		0, 304	50. 00
51. 00 05100 RECOVERY ROOM	0	43, 945			3, 446	51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	325, 546	384, 943	710, 489	2, 744 0	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	181, 770	214, 935	396, 705		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	226, 054			2, 142	55. 00
56. 00 05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	17, 115 19, 461	20, 237 23, 012		597 526	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	74, 669			1, 338	59. 00
60. 00 06000 LABORATORY	0	165, 284	195, 441	360, 725	2	60. 00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0 12, 172	14, 393	0 26, 565	0 2, 959	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	96, 367				66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0	C	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	07.44	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	23, 225 39, 911	27, 463 47, 193		531 135	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	0	.,,,,,	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07302 OP PHARMACY	0	0		0	0 401	73. 00 73. 01
74. 00 07400 RENAL DIALYSIS	0	7, 369	8, 714	16, 083	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97 07697 CARDI AC REHABI LI TATI ON	0	0 34, 958	41, 336	0 76, 294	0 479	75. 01 76. 97
OUTPATIENT SERVICE COST CENTERS	0	34, 730	41, 330	70, 294	477	70. 77
90. 00 09000 CLI NI C	0	212, 744			1, 408	90. 00
90. 01 09001 0P ONCOLOGY INFUSION CENTER 90. 02 09002 WOUND CARE CENTER	0	188, 120 46, 631			3, 510 529	90. 01 90. 02
90. 03 09003 PAIN CLINIC	0	29, 955				90. 02
90. 05 09005 OP PSYCH CLINIC	0	121, 080	143, 172	264, 252	893	90. 05
91. 00 09100 EMERGENCY	0	268, 680	317, 703	586, 383	5, 294	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92. 00
94.00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	74, 879	88, 541	163, 420		95. 00
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0) 0 0		0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0	0		0	n	114. 00 115. 00
	1	·	1	<u> </u>	·	1

Provider CCN: 15-0051

			To	12/31/2021	Date/Time Pre 5/26/2022 1:0	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 915, 612	9, 359, 854	17, 275, 466	112, 696	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 697	10, 284	18, 981		190. 00
190. 01 19001 PROMPTCARE	0	64, 264	75, 990	140, 254	·	190. 01
190. 02 19002 RENTAL PROPERTI ES	0	177, 306	0	177, 306		190. 02
190. 03 19003 OLCOTT	0	27, 459	0	27, 459		190. 03
190. 04 19004 PHYSI CI AN RECRUITMENT	0	0	0	0		190. 04
190. 05 19005 FOUNDATI ON	0	11, 982	0	11, 982		190. 05
190. 06 19006 MARKETI NG	0	0	0	0		190. 06
190. 07 19007 HME STORE	0	0	0	0		190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0		190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	0	0	0		190. 09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	140.010	0	140.010		190. 10
190. 11 19011 COMMUNI TY HEALTH SERVI CES	0	142, 019	0	142, 019		190. 11
191. 00 19100 RESEARCH	0	0	0	0		191. 00
191. 01 19101 RESEARCH	0	0	0	0		191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	O O	·	191. 02
192. 00 19200 PHYSICIANS PRIVATE OFFICES 193. 00 19300 NONPAID WORKERS		0	0	O O		192. 00 193. 00
193.00 19300 NONPALD WORKERS 194.00 07950 IU HEALTH PAOLI HOSPITAL		89, 886	106, 287	196, 173		193.00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL		175, 729		383, 520		194. 00
194.02 07952 IU HEALTH MORGAN HOSPITAL		173, 729	207, 791	363, 320		194. 01
194. 03 07953 I U HEALTH SIP		4, 493	0	4, 493		194. 02
194. 04 07954 HOME CARE		23, 964	0	23, 964		194. 03
194. 05 07955 HOSPI CE		47, 889	0	47, 889		194. 04
200.00 Cross Foot Adjustments	١	47,009	U	47,009		200. 00
201.00 Negative Cost Centers		n	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	8, 689, 300	9, 760, 206	18, 449, 506	123, 016	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				1	0 12/31/2021	Date/lime Pre 5/26/2022 1:0	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2 (00 522					4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	3, 690, 523 198, 916	3, 201, 437	,			5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	3, 064	3, 201, 437 8, 540				8.00
9.00	00900 HOUSEKEEPI NG	47, 897	18, 904	1	140, 432		9. 00
10.00	01000 DI ETARY	35, 043	51, 898	0	436	285, 904	10. 00
11.00	01100 CAFETERI A	12, 473	31, 880	1	210	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	240, 663	92, 106		2 074	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	166, 981 112, 093	28, 793 24, 133	1	3, 874 1, 453	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	875	19, 335		646	0	16.00
18. 00	01850 SOCIAL SERVICES	0	0	o o	0	0	18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	16, 006	16, 477	74	0	0	18. 01
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	5, 828	5, 217	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F1F 004	470.000	12 (00	40 422	227.047	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	515, 994 74, 234	670, 908 56, 845	1		237, 067 21, 311	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	63, 481	85, 230			20, 790	32.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	35, 754	36, 804			0	35. 00
41.00	04100 SUBPROVI DER - I RF	14, 983	41, 132	1		6, 736	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300 NURSERY	12, 532	23, 765	496	2, 244	0	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	172 244	274 (12	4 401	12 012	0	 E0 00
50. 00 50. 01	05000 OPERATI NG ROOM 05001 CV SURGERY	173, 344	274, 613 0		12, 913	0	50. 00 50. 01
51. 00	05100 RECOVERY ROOM	58, 843	25, 258	1	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	59, 647	187, 110		5, 440	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	70, 148	104, 473	3, 634	3, 874	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	46, 488	129, 926		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	12, 286	9, 837		0	0	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	10, 197 26, 750	11, 185 42, 917		0	0	58. 00 59. 00
60.00	06000 LABORATORY	204, 858	94, 998		646	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	49, 436	6, 996	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	101, 582	55, 387	' o	1, 453	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0		0	68. 00
69.00	06900 ELECTROCARDI OLOGY	9, 785	13, 349		3, 874	0	69. 00 70. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 764 113, 852	22, 939		0	0	70.00
71.00	1	170, 620	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	445, 369	Ö	o o	0	Ö	73. 00
73. 01		20, 796	0	0	0	0	73. 01
74.00		19, 590	4, 235	5 O	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 704	0	0	0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	8, 726	20, 092	2 0	0	0	76. 97
90. 00		27, 849	122, 276	0	n	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	64, 727	108, 123	1		0	90. 01
90. 02		10, 574	26, 801			0	90. 02
90. 03	09003 PAIN CLINIC	8, 768	17, 217	' O	0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	21, 604	69, 592	1	0	0	90. 05
91. 00	09100 EMERGENCY	138, 982	154, 426	6, 175	25, 181	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S				0	0	94. 00
	09500 AMBULANCE SERVICES	45, 034	43, 037	3, 059	0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM	13,034	43, 037	0,007	0		100.00
	10100 HOME HEALTH AGENCY	0	O	o	0		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF	_	=	_		_	114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116. 00 118. 00) 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	3, 487, 436	2, 756, 754	0 44, 031	0 138, 979	0 285, 904	116.00
110.00	NONREI MBURSABLE COST CENTERS	5, 407, 430	2, 750, 754	1 44, 031	130, 7/7	200, 704	110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 164	4, 999	0	0	0	190. 00
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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

					5/26/2022 1:09 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10.00
190. 01 19001 PROMPTCARE	37, 641	36, 936	0	0	0 190. 01
190. 02 19002 RENTAL PROPERTIES	2, 148	101, 908	0	0	0 190. 02
190. 03 19003 OLCOTT	6, 681	15, 782	0	0	0 190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	171	6, 887	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190.07 19007 HME STORE	0	0	0	1, 453	0 190. 07
190. 08 19008 UNUSED SPACE	486	0	0	0	0 190. 08
190. 09 19009 CLINICAL TRIALS	0	0	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	24, 390	81, 626	0	0	0 190. 11
191. 00 19100 RESEARCH	74	0	0	0	0 191. 00
191. 01 19101 RESEARCH	0	0	0	0	0 191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	76, 471	0	0	0	0 191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5, 608	0	0	0	0 192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	13, 995	51, 663	0	0	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	28, 411	101, 001	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194.03 07953 IU HEALTH SIP	1, 678	2, 583	0	0	0 194. 03
194.04 07954 HOME CARE	322	13, 774	0	0	0 194. 04
194. 05 07955 HOSPI CE	847	27, 524	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 690, 523	3, 201, 437	44, 031	140, 432	285, 904 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

| Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 1:09 pm

				12/31/2021	5/26/2022 1:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11.00	13.00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	1 00	10.00	11100	10.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	166, 153					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	11, 181		200 000			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	(7/1	1	308, 980	242.050		14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	6, 761	1	1, 355 0	242, 959	94, 274	15. 00 16. 00
18. 00 01850 SOCIAL SERVICES		1	0	0	94, 274	18. 00
18. 01 01851 CENTRAL STERI LI ZATI ON	1, 767	1	107	0	0	18. 00
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY	441		0	0	0	23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	1 111	·	o _l	<u> </u>		23.00
30. 00 03000 ADULTS & PEDI ATRI CS	37, 388	279, 475	7, 947	1, 440	9, 940	30. 00
31. 00 03100 I NTENSI VE CARE UNIT	5, 070		2, 455	718	1, 481	31.00
32. 00 03200 CORONARY CARE UNIT	4, 103		1, 761	256	1, 327	32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	2, 537	22, 227	951	94	810	35. 00
41. 00 04100 SUBPROVI DER - I RF	981	7, 665	158	19	163	41.00
42. 00 04200 SUBPROVI DER	C	o o	0	0	0	42.00
43. 00 04300 NURSERY	733	6, 345	517	35	200	43.00
ANCILLARY SERVICE COST CENTERS		, ,				
50. 00 05000 OPERATI NG ROOM	9, 512		72, 497	755	11, 488	50. 00
50. 01 05001 CV SURGERY	5 00	1	0	0	0	50. 01
51. 00 05100 RECOVERY ROOM	5, 224		1, 387	539	1, 760	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	3, 340		1, 486	237	1, 858	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	4, 932	1	0 4, 996	0	2 471	53. 00 54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	3, 379		163	400 42	2, 471 4, 668	55. 00
56. 00 05600 RADI 01 SOTOPE	3, 3/7		0	0	4, 000	56. 00
57. 00 05700 CT SCAN	915	1 1	673	125	1, 781	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	733	1	29	69	444	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 788	1	10, 947	260	3, 487	59. 00
60. 00 06000 LABORATORY	6, 036		0	ol	6, 079	60. 00
64.00 06400 INTRAVENOUS THERAPY	C		0	o	0	64.00
65. 00 06500 RESPIRATORY THERAPY	3, 951	129	5, 005	1	1, 022	65. 00
66.00 06600 PHYSI CAL THERAPY	9, 026	6 o	101	2	1, 507	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	o o	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	C	이	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 090		137	20	1, 353	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	296	1	48	0	369	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		76, 054	0	4, 271	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	C		113, 977	0		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	514	1	0	234, 008	15, 259	73.00
73. 01 07302 0P PHARMACY	511	1	20	0	90	73. 01
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)		1	40	18	212	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 75. 01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES			0	0	0	75. 00 75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	823	2, 734	8	0	136	76. 97
OUTPATIENT SERVICE COST CENTERS	023	2, 734	0	<u> </u>	130	70. 77
90. 00 09000 CLI NI C	2, 187	7, 608	47	17	124	90. 00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	5, 668		973	1, 587	2, 074	90. 01
90. 02 09002 WOUND CARE CENTER	980		213	1	395	90. 02
90. 03 09003 PAIN CLINIC	629		128	3	84	90. 03
90.05 09005 OP PSYCH CLINIC	1, 920	4, 552	4	o	203	90. 05
91. 00 09100 EMERGENCY	8, 813	73, 882	3, 767	2, 204	10, 751	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S		0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	6, 830	. 1	738	109	1, 380	95.00
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM			0	0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		0	0	0	0	101. 00
113.00 11300 I NTEREST EXPENSE		I	I	T		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	(ol ol	n	n	n	115. 00
116. 00 11600 HOSPI CE	0	ol ol	Ö	ol		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	149, 545	688, 502	308, 689	242, 959		
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ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0051

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/26/2022 1:09 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & LI BRARY SUPPLY 11. 00 13.00 15.00 16.00 14.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 423 190. 01 19001 PROMPTCARE 2, 751 5, 775 180 0 190. 01 0 190. 02 190. 02 19002 RENTAL PROPERTIES 0 0 190. 03 19003 OLCOTT 21 0 190. 03 574 3, 273 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 0 190. 04 190. 05 19005 FOUNDATION 0 0 190. 05 0 0 190. 06 19006 MARKETI NG 0 190, 06 0 0 0 190. 07 19007 HME STORE 0 0 190. 07 0 190. 08 19008 UNUSED SPACE 0 0 0 0 190. 08 190. 09 19009 CLINICAL TRIALS 0 0 0 190. 09 0 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 0 190. 11 19011 COMMUNITY HEALTH SERVICES 8,010 9, 895 90 0 190. 11 191. 00 19100 RESEARCH 0 191.00 191. 01 19101 RESEARCH 0 0 191. 01 0 0 191. 02 19102 OTHER SPONSORED ACTIVITIES 0 191.02 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 3,001 55 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194.00|07950|IU HEALTH PAOLI HOSPITAL 0 0 194.00 0 526 194.01 07951 IU HEALTH BEDFORD HOSPITAL 1,079 0 0 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPI TAL 0 0 0 194. 02 0 194. 03 07953 IU HEALTH SIP 0 0 194. 03 62 6 194.04 07954 HOME CARE 0 0 194. 04 4 C 194. 05 07955 HOSPI CE 8 C 0 0 0 194. 05 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 O 0 201.00 707, 985 308, 980 242, 959 202.00 TOTAL (sum lines 118 through 201) 166, 153 94, 274 202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				To	12/31/2021	Date/Time Pre 5/26/2022 1:0	
		OTHER GENE	RAL SERVICE			3/20/2022 1.0	y piii
	Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &	
		SERVI CES	STERILIZATION	PRGM-PHARMACY RESI DENCY		Residents Cost & Post	
				RESI DENCY		Stepdown	
						Adjustments	
		18. 00	18. 01	23. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	OO4OO						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY			•		•	16. 00
18. 00	01850 SOCIAL SERVICES	C					18. 00
18. 01	01851 CENTRAL STERILIZATION	C	97, 670				18. 01
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	C	0	31, 605			23. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		_	1		1	
30. 00	03000 ADULTS & PEDIATRICS	C	l control of the cont		4, 414, 043	l	30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT		-		433, 057 540, 245	l	31. 00 32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT				241, 177	l .	35. 00
41. 00	04100 SUBPROVI DER – I RF	l c	o o		229, 899		41. 00
42.00	04200 SUBPROVI DER	C	0		C	0	42. 00
43.00	04300 NURSERY	C	0		137, 762	0	43. 00
	ANCILLARY SERVICE COST CENTERS	_				_	
50.00	05000 OPERATING ROOM	C			1, 763, 550		50.00
50. 01 51. 00	05001 CV SURGERY 05100 RECOVERY ROOM	C	1		239, 472	0	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		1		1, 003, 338	l .	52. 00
53. 00	05300 ANESTHESI OLOGY		ol o		1, 000, 000	ő	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	0		603, 369	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	0		684, 324	0	55. 00
56. 00	05600 RADI 0I SOTOPE	C	0		C	0	56. 00
57. 00	05700 CT SCAN	C	0		63, 567	l	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION				65, 658 263, 965	l	58. 00 59. 00
60. 00	06000 LABORATORY				673, 352		60.00
64. 00	06400 I NTRAVENOUS THERAPY		ol o	l .	070,002	Ö	64. 00
65. 00	06500 RESPI RATORY THERAPY	C	0		96, 064	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	C	0		385, 329	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	0	1	C	0	67. 00
	06800 SPEECH PATHOLOGY	C	0		01 533	0	00.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY				81, 527 121, 655		69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				194, 177		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	C	o o		291, 684		72.00
	07300 DRUGS CHARGED TO PATIENTS	C	0		694, 636		73. 00
	07302 OP PHARMACY	C	0		21, 833		73. 01
	07400 RENAL DI ALYSI S	C	0		40, 178		74. 00
	07500 ASC (NON-DISTINCT PART)	C	0		C	0	75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON				109, 292	0	75. 01 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS)		107, 272	0	70. 77
90. 00	09000 CLINIC	C	0		625, 820	0	90. 00
	09001 OP ONCOLOGY INFUSION CENTER		o o		639, 249	1	90. 01
90. 02	09002 WOUND CARE CENTER	c	0		148, 606	l .	90. 02
	09003 PAIN CLINIC	C	0		94, 656	l .	90. 03
	09005 OP PSYCH CLINIC	<u> </u>	0		363, 020	l .	90. 05
	09100 EMERGENCY	C	0	1	1, 015, 858	l	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92.00
94.00	09400 HOME PROGRAM DIALYSIS	0) 0		0	0	94. 00
	09500 AMBULANCE SERVICES		o o		267, 574		95. 00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	C	0		· C	0	100. 00
101.00	10100 HOME HEALTH AGENCY	C	0		C	0	101. 00
110.00	SPECIAL PURPOSE COST CENTERS		1	1		T	112 00
	11300 INTEREST EXPENSE 11400 UTI LI ZATION REVIEW-SNF						113. 00 114. 00
114.00	11700 OTILIZATION NEVIEW-SIN	l	1	I I		<u>I</u>	114.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

			T	o 12/31/2021	Date/Time Prepared:
	OTHER GENER	DAL SEDVICE			5/26/2022 1:09 pm
	OTHER GENER	KAL SERVICE			
Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &
cost center bescription	SERVI CES		PRGM-PHARMACY		Residents Cost
	02.111.020	0122.2	RESI DENCY		& Post
					Stepdown
					Adjustments
	18. 00	18. 01	23.00	24. 00	25. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0 115. 00
116. 00 11600 HOSPI CE	0	0		0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	97, 670	0	16, 547, 936	0 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		29, 403	0 190. 00
190. 01 19001 PROMPTCARE	0	0		225, 344	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0		281, 362	0 190. 02
190. 03 19003 OLCOTT	0	0		54, 125	0 190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0		0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0		19, 040	0 190. 05
190. 06 19006 MARKETI NG	0	0		0	0 190. 06
190. 07 19007 HME STORE	0	0		1, 453	0 190. 07
190. 08 19008 UNUSED SPACE	0	0		486	0 190. 08
190. 09 19009 CLINI CAL TRI ALS	0	0		0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0		0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0		267, 533	0 190. 11
191. 00 19100 RESEARCH	0	0		74	0 191. 00
191. 01 19101 RESEARCH	0	0		0	0 191. 01
191.02 19102 OTHER SPONSORED ACTIVITIES	0	0		79, 130	0 191. 02
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		10, 937	0 192. 00
193.00 19300 NONPALD WORKERS	0	0		0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0		262, 866	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0		515, 049	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0		0	0 194. 02
194.03 07953 IU HEALTH SIP	0	0		8, 826	0 194. 03
194.04 07954 HOME CARE	0	0		38, 066	0 194. 04
194. 05 07955 HOSPI CE	0	0		76, 271	0 194. 05
200.00 Cross Foot Adjustments			31, 605	31, 605	0 200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	0	97, 670	31, 605	18, 449, 506	0 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared:
5/26/2022 1:09 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				5/26/2022 1:0	
		Cost Center Description	Total		
	loenes.	AL 050// 05 0007 05//7500	26. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP			2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	1	ADMINISTRATIVE & GENERAL			5. 00
7.00	1	OPERATION OF PLANT			7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING			8. 00 9. 00
10.00	1	DI ETARY			10.00
11. 00	1	CAFETERI A			11.00
13.00		NURSING ADMINISTRATION			13. 00
14.00	1	CENTRAL SERVICES & SUPPLY			14. 00
15.00	1	PHARMACY			15. 00
16. 00 18. 00	1	MEDICAL RECORDS & LIBRARY			16. 00 18. 00
18. 00	1	SOCIAL SERVICES CENTRAL STERILIZATION			18. 01
23. 00	1	PARAMED ED PRGM-PHARMACY RESIDENCY			23. 00
		IENT ROUTINE SERVICE COST CENTERS	<u>'</u>		
30. 00	1	ADULTS & PEDIATRICS	4, 414, 043		30. 00
31.00	1	INTENSIVE CARE UNIT	433, 057		31.00
32. 00 35. 00		CORONARY CARE UNIT NEONATAL INTENSIVE CARE UNIT	540, 245		32. 00 35. 00
41. 00	1	SUBPROVIDER - IRF	241, 177 229, 899		41. 00
42. 00	1	SUBPROVI DER	0		42. 00
43.00	1	NURSERY	137, 762		43. 00
		LARY SERVICE COST CENTERS			
50.00	1	OPERATING ROOM	1, 763, 550		50.00
50. 01	1	CV SURGERY	0 220 472		50. 01 51. 00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	239, 472 1, 003, 338		51.00
53. 00	1	ANESTHESI OLOGY	0		53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	603, 369		54.00
55. 00	05500	RADI OLOGY-THERAPEUTI C	684, 324		55. 00
56. 00	1	RADI OI SOTOPE	0		56. 00
57. 00	1	CT SCAN	63, 567		57. 00
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	65, 658 263, 965		58. 00 59. 00
60.00	1	LABORATORY	673, 352		60.00
64. 00	1	INTRAVENOUS THERAPY	0		64. 00
65.00	06500	RESPI RATORY THERAPY	96, 064		65. 00
66. 00		PHYSI CAL THERAPY	385, 329		66. 00
67.00	1	OCCUPATIONAL THERAPY	0		67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	81, 527		68. 00 69. 00
70.00	1	ELECTROENCEPHALOGRAPHY	121, 655		70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	194, 177		71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	291, 684		72. 00
	1	DRUGS CHARGED TO PATIENTS	694, 636		73. 00
		OP PHARMACY	21, 833		73. 01
74. 00 75. 00	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)	40, 178 0		74. 00 75. 00
75. 00		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		75. 00
	1	CARDI AC REHABI LI TATI ON	109, 292		76. 97
		TIENT SERVICE COST CENTERS			
90.00	1	CLINIC	625, 820		90.00
90. 01 90. 02		OP ONCOLOGY INFUSION CENTER WOUND CARE CENTER	639, 249		90. 01 90. 02
90. 02		PAIN CLINIC	148, 606 94, 656		90. 02
90. 05		OP PSYCH CLINIC	363, 020		90. 05
91.00		EMERGENCY	1, 015, 858		91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
		REIMBURSABLE COST CENTERS			
		HOME PROGRAM DIALYSIS AMBULANCE SERVICES	247 574		94. 00 95. 00
	1	I&R SERVICES-NOT APPRVD PRGM	267, 574 0		100.00
		HOME HEALTH AGENCY	o		101. 00
250		AL PURPOSE COST CENTERS	<u> </u>]
	11300	INTEREST EXPENSE			113. 00
		UTI LI ZATI ON REVI EW-SNF			114. 00
	1	AMBULATORY SURGICAL CENTER (D. P.)	0		115.00
116.00		HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	16, 547, 936		116. 00 118. 00
110.00		IMBURSABLE COST CENTERS	10, 547, 730		1, 10. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 403		190. 00
190. 01	19001	PROMPTCARE	225, 344		190. 01

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 1:09 pm |

		5/26/2022 1: 09 pm
Cost Center Description	Total	
	26. 00	
190. 02 19002 RENTAL PROPERTI ES	281, 362	190. 02
190. 03 19003 OLCOTT	54, 125	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	190. 04
190. 05 19005 FOUNDATI ON	19, 040	190. 05
190. 06 19006 MARKETI NG	0	190. 06
190. 07 19007 HME STORE	1, 453	190. 07
190. 08 19008 UNUSED SPACE	486	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	267, 533	190. 11
191. 00 19100 RESEARCH	74	191. 00
191. 01 19101 RESEARCH	0	191. 01
191.02 19102 OTHER SPONSORED ACTIVITIES	79, 130	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10, 937	192. 00
193. 00 19300 NONPALD WORKERS	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	262, 866	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	515, 049	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	194. 02
194.03 07953 IU HEALTH SIP	8, 826	194. 03
194.04 07954 HOME CARE	38, 066	194. 04
194. 05 07955 HOSPI CE	76, 271	194. 05
200.00 Cross Foot Adjustments	31, 605	200.00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	18, 449, 506	202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SOUARE FEET) (SOUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 870 222 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 826, 646 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5,645 5, 645 130, 411, 959 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 6 594 116 -70, 684, 751 309 710 099 5 00 169 066 169, 066 7.00 00700 OPERATION OF PLANT 137,676 137, 676 2, 402, 101 16, 693, 149 7.00 1, 488 8.00 00800 LAUNDRY & LINEN SERVICE 1, 488 257, 095 8.00 00900 HOUSEKEEPI NG 3, 294 3, 294 1, 959, 600 0 4, 019, 558 9.00 9.00 01000 DI ETARY 9 043 1, 548, 311 0 9,043 2, 940, 864 10 00 10 00 11.00 01100 CAFETERI A 5, 555 5, 555 566, 418 0 1, 046, 757 11.00 01300 NURSING ADMINISTRATION 16, 049 20, 196, 635 13.00 16,049 15, 149, 252 0 13.00 01400 CENTRAL SERVICES & SUPPLY 5,017 14, 013, 155 14.00 5.017 14.00 4, 205 4, 205 9, 406, 964 15.00 01500 PHARMACY 5, 716, 705 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 369 3, 369 0 73, 418 16.00 C 01850 SOCIAL SERVICES 0 18.00 0 18.00 01851 CENTRAL STERILIZATION 2, 871 2, 871 o 714.902 1, 343, 250 18.01 18.01 |02301| PARAMED ED PRGM-PHARMACY RESIDENCY 23.00 909 909 327, 767 0 489, 112 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 116, 902 116, 902 25, 513, 911 0 43, 301, 181 30.00 03100 INTENSIVE CARE UNIT 0 31.00 9.905 9.905 3, 770, 391 6, 229, 773 31.00 32.00 03200 CORONARY CARE UNIT 14, 851 14, 851 3, 182, 067 5, 327, 342 32.00 6, 413 0 02060 NEONATAL INTENSIVE CARE UNIT 1, 992, 167 3,000,465 35.00 6,413 35.00 04100 SUBPROVIDER - IRF 682, 115 41.00 1, 257, 391 41.00 7.167 7.167 42.00 04200 SUBPROVI DER 0 42.00 C 0 04300 NURSERY 43.00 4, 141 4, 141 692, 507 1, 051, 718 43.00 ANCILLARY SERVICE COST CENTERS 14, 547, 139 50.00 05000 OPERATING ROOM 47, 850 47, 850 6, 749, 172 0 50.00 05001 CV SURGERY 0 50.01 50.01 05100 RECOVERY ROOM 4, 401 4, 401 0 4, 938, 147 51.00 3, 654, 131 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 32,603 32, 603 2, 909, 679 0 5, 005, 632 52.00 05300 ANESTHESI OLOGY 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 18.204 18, 204 3, 534, 873 5, 886, 843 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 22, 639 22, 639 2, 271, 087 0 0 0 3, 901, 270 55.00 05600 RADI OI SOTOPE 56.00 56.00 1, 031, 087 05700 CT SCAN 632, 557 57.00 1,714 1, 714 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,949 1, 949 558, 052 855, 722 58.00 59.00 05900 CARDIAC CATHETERIZATION 7,478 7,478 1, 419, 342 0 0 0 2, 244, 895 59.00 06000 LABORATORY 16, 553 2, 129 60 00 16, 553 17, 191, 856 60 00 64.00 06400 INTRAVENOUS THERAPY 64.00 1, 219 65.00 06500 RESPIRATORY THERAPY 1, 219 3, 138, 275 4, 148, 710 65.00 66.00 06600 PHYSI CAL THERAPY 9,651 9, 651 6, 314, 496 0 8, 524, 857 66.00 06700 OCCUPATIONAL THERAPY 67 00 67 00 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 2, 326 2, 326 563, 370 821, 169 69.00 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 3, 997 3, 997 143.545 903, 303 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 554, 509 71 00 0 C 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 14, 318, 551 72.00 C 07300 DRUGS CHARGED TO PATIENTS 0 73.00 37, 375, 676 73.00 07302 OP PHARMACY 1, 745, 210 73.01 0 C 425, 422 73.01 07400 RENAL DIALYSIS 74.00 738 738 40 1, 644, 046 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75 01 C 75 01 07697 CARDIAC REHABILITATION 3,501 3, <u>5</u>01 508, 328 732, 279 76.97 76.97 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 21, 306 21, 306 1, 493, 075 0 2, 337, 098 90.00 0 09001 OP ONCOLOGY INFUSION CENTER 90.01 18.840 18.840 3, 721, 880 5, 431, 915 90.01 09002 WOUND CARE CENTER 4,670 90.02 4.670 561, 037 887, 415 90 02 90.03 09003 PAIN CLINIC 3,000 3,000 290, 198 0 735, 817 90.03 09005 OP PSYCH CLINIC 90.05 12, 126 12, 126 947, 014 1, 813, 048 90.05 26, 908 09100 EMERGENCY 26, 908 91.00 91.00 5, 614, 183 11, 663, 507 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 n 94.00 09500 AMBULANCE SERVICES 7, 499 7, 499 3, 204, 234 95.00 0 3, 779, 286 95.00 100.00 10000 I&R SERVICES-NOT APPRVD PRGM C 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00

Health Financ	ciai Systems – it) HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	<u> 2552-10</u>
COST ALLOCAT	ION - STATISTICAL BASIS		Provi der CO		eriod: rom 01/01/2021	Worksheet B-1	
				Т	o 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	300 CONTON BOOM PT 011	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
		,	, ,	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1. 00	2. 00	4. 00	5A	5. 00	
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	_	_	_	115. 00
116. 00 11600		0	0	0	Į		116. 00
	SUBTOTALS (SUM OF LINES 1 through 117)	792, 738	792, 738	119, 468, 449	-70, 684, 751	292, 666, 814	118. 00
	MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	871	871	100 401		240.450	100.00
190. 00 19000		6, 436		198, 401 1, 916, 431			
	RENTAL PROPERTIES	17, 757	0, 430	1, 910, 431	0	-, ,	
190. 03 19003		2, 750	0	355, 045	_		
	PHYSI CLAN RECRUI TMENT	2,730	0	333, 043	0		190. 04
190. 05 19005		1, 200	O O	0	0	14, 323	
190. 06 19006		0	0	0	0		190. 06
190. 07 19007		0	o	Ö	0		190. 07
190. 08 19008		0	0	O	0	40, 820	190. 08
190. 09 19009	CLINICAL TRIALS	0	0	0	0	0	190. 09
190. 10 19010	MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	190. 10
190. 11 19011	COMMUNITY HEALTH SERVICES	14, 223	0	1, 593, 361	0	2, 046, 816	190. 11
191. 00 19100		0	0	0	0	6, 250	191. 00
191. 01 19101		0	0	0	0	_	191. 01
191. 02 19102	OTHER SPONSORED ACTIVITIES	0	0	2, 819, 349		0,,	
	PHYSICIANS' PRIVATE OFFICES	0	0	2, 410, 306	0	470, 641	
	NONPALD WORKERS	0	0	0	0		193. 00
	IU HEALTH PAOLI HOSPITAL	9, 002		·		.,,	
	IU HEALTH BEDFORD HOSPITAL IU HEALTH MORGAN HOSPITAL	17, 599 0	17, 599 0	1, 100, 943 0		_, _,	194. 01
	TO HEALTH MORGAN HOSPITAL TU HEALTH SIP	450		3, 902	_	140, 840	
194. 04 07954		2, 400	- 1	2, 407			194. 03
194. 05 07955		4, 796		3, 498			194. 05
	Cross Foot Adjustments	1,770	J	0, 170	J	, 1, 017	200. 00
1 1	Negative Cost Centers						201. 00
	Cost to be allocated (per Wkst. B,	8, 689, 300	9, 760, 206	25, 464, 503		70, 684, 751	
	Part I)	.,,	,	.,,		, , , , ,	
203.00	Unit cost multiplier (Wkst. B, Part I)	9. 985153	11. 806996	0. 195262		0. 228229	203. 00
204.00	Cost to be allocated (per Wkst. B,			123, 016		3, 690, 523	204. 00
	Part II)						
	Unit cost multiplier (Wkst. B, Part II)			0. 000943		0. 011916	205. 00
	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						207.00
1 1		!		1	1	1	1

	LLOCATION - STATISTICAL BASIS	J HEALTH BECOME	Provider Co		Peri od:	Worksheet B-1	
				F	rom 01/01/2021		
				'	o 12/31/2021	Date/Time Pre 5/26/2022 1:0	parea: 9 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, p
		PLANT	LINEN SERVICE	(HOURS OF	(PATIENT DAYS)	(MANHOURS)	
		(SQUARE FEET)	(POUNDS OF	SERVI CE)			
		7.00	LAUNDRY) 8.00	9.00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	FE7 02E					5. 00 7. 00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	557, 835 1, 488					8.00
9. 00	00900 HOUSEKEEPING	3, 294		8, 700			9. 00
10.00	01000 DI ETARY	9, 043	0	27	57, 593		10.00
11.00	01100 CAFETERI A	5, 555		13		3, 164, 294	
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	16, 049 5, 017				212, 935 0	1
15. 00	01500 PHARMACY	4, 205				128, 762	1
	01600 MEDICAL RECORDS & LIBRARY	3, 369		40		0	1
18. 00	01850 SOCIAL SERVICES	0	0	C	o	0	
	01851 CENTRAL STERILIZATION	2, 871		C		33, 660	•
23.00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY INPATIENT ROUTINE SERVICE COST CENTERS	909	0	<u> </u>	0	8, 392	23. 00
30. 00	03000 ADULTS & PEDIATRICS	116, 902	347, 169	4, 314	47, 755	712, 091	30.00
31. 00	03100 NTENSI VE CARE UNI T	9, 905		380		96, 554	1
32.00		14, 851	43, 304	C	4, 188	78, 137	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 413			_	48, 311	1
41. 00 42. 00	04100 SUBPROVI DER - I RF	7, 167	33, 991		.,	18, 682	1
42.00	04200 SUBPROVI DER 04300 NURSERY	4, 141	13, 654		1	0 13, 953	
10.00	ANCI LLARY SERVI CE COST CENTERS	1, 111	10,001	107	<u> </u>	10, 700	10.00
	05000 OPERATING ROOM	47, 850	123, 667	800	0	181, 149	
50. 01	05001 CV SURGERY	0		C		0	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	4, 401				99, 484	
53. 00	05300 ANESTHESI OLOGY	32, 603	66, 655 0	337		03, 006	52. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C	18, 204	100, 072		-	93, 930	
55.00	05500 RADI OLOGY-THERAPEUTI C	22, 639	0	C		64, 347	1
	05600 RADI OI SOTOPE	0	0	C		0	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 714 1, 949				17, 419 13, 953	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 478				34, 058	
60.00	06000 LABORATORY	16, 553	210			114, 953	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	_	C		0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 219 9, 651		90		75, 237 171, 903	
67. 00	06700 OCCUPATI ONAL THERAPY	0,031				0	1
68. 00	06800 SPEECH PATHOLOGY	0	0	C	o	0	68. 00
	06900 ELECTROCARDI OLOGY	2, 326		240			69. 00
	07000 ELECTROENCEPHALOGRAPHY	3, 997	0	C		•	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73. 00
73. 01	07302 OP PHARMACY	0	0	C	o	9, 726	1
	07400 RENAL DIALYSIS	738	0	C	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	C	_	0	
75. 01 76. 97	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON	3, 501	0			15, 675	75. 01 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	3,301			γ	13, 073	70. 77
90.00	09000 CLI NI C	21, 306	0	C	0	41, 645	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	18, 840		C	_	107, 940	
90. 02	09002 WOUND CARE CENTER	4, 670		60		18, 668	1
90. 03 90. 05	O9003 PAIN CLINIC O9005 OP PSYCH CLINIC	3, 000 12, 126				11, 979 36, 572	1
91. 00	09100 EMERGENCY	26, 908		1, 560	_	167, 841	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		·				92. 00
	OTHER REIMBURSABLE COST CENTERS	1 -	T	T			
94.00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	7, 499	0 84, 219			0 130, 073	
	10000 I &R SERVICES-NOT APPRVD PRGM	7,499	04, 219				100.00
	10100 HOME HEALTH AGENCY	0	0	d			101. 00
	SPECIAL PURPOSE COST CENTERS	1					
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF	-					113. 00 114. 00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(o l	Ω	115.00
116.00	11600 HOSPI CE	0	0	c	o	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	480, 351	1, 212, 391	8, 610	57, 593	2, 848, 027	118. 00
							

Health Financial Systems I	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-0051	Peri od:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narodi
				10 12/31/2021	5/26/2022 1:0	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, p
, , , , , , , , , , , , , , , , , , ,	PLANT	LINEN SERVICE	(HOURS OF	(PATIENT DAYS)	(MANHOURS)	
	(SQUARE FEET)	(POUNDS OF	SERVI CE)			
		LAUNDRY)				
	7.00	8. 00	9. 00	10.00	11. 00	
NONREI MBURSABLE COST CENTERS	1	_	1	_		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	871			0		190. 00
190. 01 19001 PROMPTCARE	6, 436		1	0		190. 01
190. 02 19002 RENTAL PROPERTI ES	17, 757			0		190. 02
190. 03 19003 OLCOTT	2, 750	l l		0		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	C	1		0		190. 04
190. 05 19005 FOUNDATI ON	1, 200	l l		0		190. 05
190. 06 19006 MARKETI NG	C	0	1	0		190. 06
190. 07 19007 HME STORE	C	0	9			190. 07
190. 08 19008 UNUSED SPACE	C	0		0		190. 08
190. 09 19009 CLINICAL TRIALS	C	0		0		190. 09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	C	΄Ι ΄		0		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	14, 223	8 0		0	152, 542	
191. 00 19100 RESEARCH	C	0		0		191. 00
191. 01 19101 RESEARCH	C	0	1	0	_	191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	C	0	1	0	0	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	C	1		0		192. 00
193. 00 19300 NONPALD WORKERS	C	1		0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	9, 002		1	0		194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	17, 599	 	1	0		194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	C	1)	0		194. 02
194. 03 07953 IU HEALTH SIP	450	l .)	0		194. 03
194. 04 07954 HOME CARE	2, 400		1	0		194. 04
194. 05 07955 HOSPI CE	4, 796	0	1	0	146	194. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	20, 503, 010	370, 463	5, 058, 00	9 3, 960, 123	1, 497, 387	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)			l .			
204.00 Cost to be allocated (per Wkst. B,	3, 201, 437	44, 031	140, 43	2 285, 904	166, 153	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	5. 739039	0. 036317	16. 14160	9 4. 964214	0. 052509	205. 00
						00/ 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						207.00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	I		I			

	•	U HEALTH BLOOMI		N 15 0051 B		Wardiahaat D. 1	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 01/01/2021	Worksheet B-1	
					o 12/31/2021		
						5/26/2022 1:0	9 pm
						OTHER GENERAL	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SERVI CE SOCI AL	
	cost center bescription	ADMI NI STRATI ON		(COSTED	RECORDS &	SERVI CES	
		ADMINI STRATTON	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT NURS.	(COSTED	REGOT 5.)	(GROSS	(TTIME SI EIVI)	
		HRS.)	REQUISITIONS)		CHARGES)		
		13.00	14.00	15. 00	16.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT						7. 00 8. 00
9. 00	OO8OO LAUNDRY & LINEN SERVICE OO9OO HOUSEKEEPING						9.00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 414, 223					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	38, 816, 319				14. 00
15.00	01500 PHARMACY	0	170, 190	38, 804, 902			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	C	1, 979, 057, 736		16. 00
18. 00	01850 SOCIAL SERVICES	0	0	C	0	0	18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	0	13, 504	C	0	•	
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	0	0	C	0	0	23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	550.074	000 004	200 001	007 07/ 040		00.00
30.00	03000 ADULTS & PEDI ATRI CS	558, 264	998, 396	229, 926			
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	87, 168 70, 087	308, 433	114, 725			
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	44, 399	221, 212 119, 480	40, 825 15, 050			32. 00 35. 00
41. 00	04100 SUBPROVI DER – I RF	15, 312	19, 807	2, 958			41. 00
42. 00	04200 SUBPROVI DER	13, 312	17,007	2, 730		0	1
43. 00	04300 NURSERY	12, 675	64, 939	5, 593	4, 169, 160		1
10.00	ANCILLARY SERVICE COST CENTERS	12,070	3.17.707	0,070	17 1077 100		10.00
50.00	05000 OPERATI NG ROOM	114, 155	9, 107, 650	120, 544	239, 328, 144	0	50.00
50. 01	05001 CV SURGERY	0	0	C	0	0	50. 01
51.00	05100 RECOVERY ROOM	86, 360	174, 222	86, 058	36, 670, 565	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	57, 062	186, 663	37, 787	38, 708, 351	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 785	627, 598	63, 862			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	8, 316	20, 436	6, 646	97, 256, 258	0	55. 00
56. 00	05600 RADI 01 SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	1	84, 596	19, 930			57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	25 202	3, 610 1, 375, 257	11, 041			58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	25, 282	1,3/5,25/	41, 481	126, 652, 432		59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	120, 032, 432	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	257	628, 751	84	21, 296, 753	1	1
	06600 PHYSI CAL THERAPY	0	12, 747	270			1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0		0	
68. 00	06800 SPEECH PATHOLOGY	0	O	C	0	0	1
69.00	06900 ELECTROCARDI OLOGY	264	17, 227	3, 218	28, 178, 028	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	5, 997	C	7, 685, 510	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 554, 509	C	88, 969, 814	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 318, 550	C	147, 655, 652		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	37, 375, 675			73. 00
73. 01	07302 OP PHARMACY	30	2, 534	0	1, 867, 246		73. 01
74.00	07400 RENAL DIALYSIS	0	5, 065	2, 849	4, 411, 873	0	
75. 00	07500 ASC (NON-DISTINCT PART) 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		75. 00
75. 01 76. 97	07697 CARDIAC REHABILITATION	5, 462	1, 045	0	2 024 227	0	
70. 97	OUTPATIENT SERVICE COST CENTERS	3, 402	1, 045		2, 836, 327	0	70.97
90.00	09000 CLINIC	15, 198	5, 845	2, 681	2, 592, 524	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	82, 584	122, 195	253, 457			1
90. 02	09002 WOUND CARE CENTER	12, 734	26, 739	225			1
90. 03	09003 PAIN CLINIC	4, 348	16, 093	540			1
90. 05	09005 OP PSYCH CLINIC	9, 092	547	C	4, 235, 570	0	90. 05
91.00	09100 EMERGENCY	147, 582	473, 247	352, 085	223, 980, 081	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09400 HOME PROGRAM DI ALYSI S	0	0	C	0	0	
	09500 AMBULANCE SERVI CES	1, 887	92, 676	17, 360	28, 757, 169		
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	101. 00
113 00	11300 INTEREST EXPENSE		J				113. 00
	11400 UTI LI ZATI ON REVI EW-SNF					1	114. 00
	1	1	<u> </u>		II.	1	

	_	U TILALTII BLOOMI				u or rorm cws-	
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2021	Worksheet B-1	
					Го 12/31/2021 	Date/Time Pre 5/26/2022 1:0	
						OTHER GENERAL	
						SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	
		ADMI NI STRATI ON		(COSTED	RECORDS &	SERVICES	
		(DI RECT NURS.	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	(TIME SPENT)	
		HRS.)	REQUISITIONS)		CHARGES)		
		13. 00	14. 00	15. 00	16. 00	18. 00	
115. 00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115. 00
116.00 11600		0	0		0	0	116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 375, 308	38, 779, 760	38, 804, 870	0 1, 979, 057, 736	0	118. 00
	IMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	844	0		0 0	0	190. 00
190. 01 19001	PROMPTCARE	11, 535	22, 625	3:	2 0	0	190. 01
	RENTAL PROPERTIES	0	0		0 0		190. 02
190. 03 19003	l control of the cont	6, 538	2, 623		0		190. 03
	PHYSI CI AN RECRUI TMENT	0	0		0		190. 04
190. 05 19005		0	0		0		190. 05
190. 06 19006		0	0	(0		190. 06
190. 07 19007		0	0	(0		190. 07
	UNUSED SPACE	0	0	(0		190. 08
	CLINICAL TRIALS	0	0		0		190. 09
	MORGAN OP BEHAVIORAL HEALTH CLINIC	10.7/5	11 211		0		190. 10
	COMMUNITY HEALTH SERVICES	19, 765	11, 311		0		190. 11
191. 00 19100 191. 01 19101		0	0		0 0		191. 00 191. 01
	OTHER SPONSORED ACTIVITIES	0	0		0 0		191. 01
	PHYSI CI ANS' PRI VATE OFFI CES	110	0				192.00
	NONPALD WORKERS	110	0		0		193. 00
	IU HEALTH PAOLI HOSPITAL	0	0		0		194. 00
	IU HEALTH BEDFORD HOSPITAL	0	0		0 0		194. 01
	IU HEALTH MORGAN HOSPITAL	0	0		0 0		194. 02
	IU HEALTH SIP	123	0		0		194. 03
194. 04 07954		0	0		0		194. 04
194. 05 07955	HOSPI CE	0	0		0 0	0	194. 05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	25, 496, 793	17, 535, 292	11, 899, 74	9 237, 255	0	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	18. 028835	0. 451751	0. 30665	0. 000120	0.000000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	707, 985	308, 980	242, 95	94, 274	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 500618	0. 007960	0. 00626	0. 000048	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 1:09 pm Provider CCN: 15-0051

CONTROL CONT					5/26/2022 1:0)9 pm
COST COUNTED POSITION CRITINAL STREET LEATER STREET LEATER STREET LEATER STREET LEATER STREET ST						
STRILLIZATION POIL-PARMACY CYTHE STRIPEY RESIDENCY CYTHE STRIPEY RESIDENCY CYTHE STRIPEY RESIDENCY RESIDENCY		Cook Cooker Doorsinties		DADAMED ED		
CTIME SPENTY TOTAL STRIPT COST CINITIES 1.00		Cost Center Description				
CTMS_SPENT COMPANDED 1.00 1.						
DEMPAIL SERVICE COST CENTERS 1.00			(TIME SIENT)			
1.00 00100 CAP REL COSTS-BUDG & FIXT			18. 01			
2.00						
4.00 0.0400 DMPLOYEE BENEFITS DEPARTMENT		1				1
0.000 0.000 DAMIN ISTRATIVE & CENERAL		1	_			1
7.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000			II			1
8.00 00000 LANDRY & LINEN SERVICE 9.00 00000 DETARY 10.00 10.0						1
9. 00 00000 MUSENEEPING 10. 00 11. 00						1
10.00 1000 DETARY 10.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 15		1				1
13.00 1300 MURSING ADMINISTRATION 14.00 1400 (CHTRIAL SERVICE S & SUPPLY 14.00 1400 (CHTRIAL SERVICE S & SUPPLY 15.00		1				10.00
14.00 10400 (ENTRAL SERVICES & SUPPLY 14.00 16.00 10600 MEDICAL RECORDS & LIBRARY 15.00 10500 MEDICAL RECORDS & LIBRARY 16.00 10851 (SOCIAL SERVICES 10.00	11. 00	01100 CAFETERI A				11. 00
15.00 10500 PHARMACY						1
16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 18.00 18.00 01850 SOCIAL SERVICES 0 100 18.00 18.00 18.00 01851 CENTRAL STERI LI ZATION 100 18.00 18		1				1
18. 00 01850 SOCIAL SERVICES 18. 01 01851 CENTRAL STETIL L'ATLION 10.0		1				1
18. 01 01851 CENTRAL STERI LIZATION 100 23. 00 200 100 100 23. 00 200 100 100 23. 00 2		1				1
23.00			100			1
INPATI ENT ROUTH NE SERVICE COST CENTERS 0 0 0 0 33.0 0 30.0 0 33.0 0 31.0 0 33.0 0 31.0 0 33.0 0 31.0 0 33		1				
31.00 03100 NTENSIVE CARE UNIT 0 0 0 32.00 320.00 32		INPATIENT ROUTINE SERVICE COST CE	ENTERS			
32.00 03200 CORONARY CARE UNIT 0 0 35.00 35.00 20500 NEONATAL INTENSIVE CARE UNIT 0 0 0 35.00 20500 NEONATAL INTENSIVE CARE UNIT 0 0 0 44.00 42.00 4		1	1	1	•	
35.00		1			•	1
41.00 04100 SUBPROVI DER 1F		1	_ (l .	1
42.00 04200 SUBROVI DER 0 0 0 42.00 0 43.00		1			l .	1
A3. 00 O-3000 NURSERPY 0 0 0 0 0 0 0 0 0		1			i e	1
ANCILLARY SERVICE COST CENTERS 50.00 50.		1		1	•	
SO. 01 OSDOT CV SURCERY SO. 0 ST. 0. 0 ST.			<u> </u>	,		
51.00 05100 RECOVERY ROOM 51.00 52.0	50.00	05000 OPERATING ROOM	100	1	1	
S2.00 05200 05200 05200 05200 05200 05200 0530		1		1	1	1
S3.00 05300 AISTHESI OLOGY S5.00 S5.		1			l .	1
S4. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0		1			l .	1
55.00 05500 RADI OLOGY-THERPEUTI C 0 0 0 0 0 0 0 0 0				l .	1	1
56. 00 05600 RADI OI SOTOPE 0 0 0 0 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 58		1		-		1
\$8. 00 05800 MACNETIC RESONANCE I IMAGING (MRI)	56.00	1		o		56.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0	57. 00	1		0		57. 00
60. 00 06400 LABORATORY 0 0 0 0 0 0 0 0 0			(MRI)		•	1
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0		1		-	l .	1
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0		1			•	1
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0		1			l .	1
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0		1			l .	1
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 07000 ELECTROCARDI OLOGY 0 0 0 0 07000 ELECTROCARDI OLOGY 0 0 0 0 0 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		0		1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1			l .	1
71. 00		1		1	1	1
72. 00			DATI ENTS	l .	•	1
73. 00				1	•	
73. 01 07302 OP PHARMACY 0 0 0 7400 RENAL DI ALYSIS 0 0 0 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76. 97 CARDI AC REHABI LI TATI ON 0 0 76. 97 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 76. 97 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					•	
75. 00				l .	l .	
75. 01	74.00	07400 RENAL DIALYSIS		0		
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0017PATI ENT SERVI CE COST CENTERS 0 0 0 90. 00 09000 CLI NI C 0 0 0 90. 01 09001 0P ONCOLOGY I NFUSI ON CENTER 0 0 0 90. 02 09002 WOUND CARE CENTER 0 0 0 90. 03 09003 PAI N CLI NI C 0 0 0 90. 05 09005 0P PSYCH CLI NI C 0 0 0 91. 00 09100 EMERGENCY 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 95. 00 0 0 0 96. 07 0 0 0 97. 07 0 0 0 98. 07 0 0 0 99. 08 0 0 0 99. 09 0 0 0 99. 09 0 0 0 99. 09 0 0 0 99. 09 0 0 99. 09 0 0 99. 09 0 0 99. 09 0 0 99. 09 0 0 99. 09 0 0 99. 09 0 0 99. 09 0 0 99. 09			(1	l .	
OUTPATIENT SERVICE COST CENTERS O		1	SERVI CES		•	
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0	76. 97)[76.97
90. 01	90 00		(90, 00
90. 02 09002 WOUND CARE CENTER 0 0 0 90. 02 90. 03 09003 PAI N CLINIC 0 0 0 90. 03 90. 05 09005 OP PSYCH CLINIC 0 0 0 90. 05 91. 00 09100 EMERGENCY 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 94. 00 0 0 94. 00					l .	1
90. 05	90. 02	09002 WOUND CARE CENTER		0		
91. 00				0		1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00 94. 00				1	l .	1
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94.00		1	NOT BAST)	0		1
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00	92.00		NCI PARI)			92.00
	94 00					94 00
95. 00 09500 AMBULANCE SERVICES 0 0 95. 00		09500 AMBULANCE SERVICES		ol o	•	95. 00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 100. 00			SM		l control of the cont	1
101. 00 10100 HOME HEALTH AGENCY 0 0 101. 00	101.00) 0		101. 00
SPECIAL PURPOSE COST CENTERS	440.0-				I	110 00
113. 00 11300 I NTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF		1				1
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00			(D. P.)	0		
10.000		<u> </u>	· · · · · · · · · · · · · · · · · · ·	•		

				To 12/31/2021	Date/Time Prepared: 5/26/2022 1:09 pm
		OTHER GENERAL			572672022 1.09 piii
		SERVI CE			
	Cost Center Description	CENTRAL	PARAMED ED		
		STERI LI ZATI ON	PRGM-PHARMACY		
		(TIME SPENT)	RESI DENCY		
			(TIME SPENT)		
		18. 01	23. 00		
1	11600 HOSPI CE	0	1	l .	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100	100		118. 00
	NONREI MBURSABLE COST CENTERS				
1	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	_	l .	190. 00
	19001 PROMPTCARE	0	0	l .	190. 01
	19002 RENTAL PROPERTIES	0	0		190. 02
	19003 OLCOTT	0	0		190. 03
190.04	19004 PHYSICIAN RECRUITMENT	0	0		190. 04
190. 05	19005 FOUNDATION	0	0		190. 05
190.06	19006 MARKETI NG	0	0		190. 06
190. 07	19007 HME STORE	0	0		190. 07
190.08	19008 UNUSED SPACE	0	0		190. 08
190.09	19009 CLINICAL TRIALS	0	0		190. 09
190. 10	19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0		190. 10
190. 11	19011 COMMUNITY HEALTH SERVICES	0	0		190. 11
191.00	19100 RESEARCH	0	0		191. 00
191.01	19101 RESEARCH	0	0		191. 01
191.02	19102 OTHER SPONSORED ACTIVITIES	0	o		191. 02
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
193.00	19300 NONPALD WORKERS	0	0		193. 00
194.000	07950 IU HEALTH PAOLI HOSPITAL	0	0		194. 00
194.01	07951 IU HEALTH BEDFORD HOSPITAL	0	0		194. 01
194. 02 (07952 IU HEALTH MORGAN HOSPITAL	0	0		194. 02
194. 03 (07953 IU HEALTH SIP	0	0		194. 03
194. 04 (07954 HOME CARE	0	0		194. 04
194. 05 (07955 HOSPI CE	0	0		194. 05
200.00	Cross Foot Adjustments				200. 00
201.00	Negative Cost Centers				201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 777, 990	638, 123		202. 00
	Part I)	, , ,			
203.00	Unit cost multiplier (Wkst. B, Part I)	17, 779, 900000	6, 381. 230000		203. 00
204.00	Cost to be allocated (per Wkst. B,	97, 670		l .	204. 00
	Part II)		·		
205.00	Unit cost multiplier (Wkst. B, Part	976. 700000	316. 050000		205. 00
	11)				
206.00	NAHE adjustment amount to be allocated		0		206. 00
	(per Wkst. B-2)				
207.00	NAHE unit cost multiplier (Wkst. D,		0. 000000		207. 00
	Parts III and IV)				

	ATION OF RATIO OF COSTS TO CHARGES	o nenem bessiii		CCN: 15-0051	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 1:0	
			Ti tl	e XVIII	Hospi tal	PPS	7 PIII
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	74, 326, 397	l .	74, 326, 39			
31. 00 32. 00	03100 I NTENSI VE CARE UNI T	10, 342, 050	l .	10, 342, 05			•
35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	8, 806, 573 4, 807, 999		8, 806, 57 4, 807, 99		8, 806, 573 4, 891, 510	
41. 00	04100 SUBPROVI DER - I RF	2, 206, 640		2, 206, 64			
42. 00	04200 SUBPROVI DER	0	l .		o o	0	42. 00
43.00	04300 NURSERY	1, 795, 605		1, 795, 60	5 0	1, 795, 605	43. 00
	ANCILLARY SERVICE COST CENTERS		T	T 00 000 (0	-1		
50. 00 50. 01	05000 OPERATI NG ROOM 05001 CV SURGERY	28, 230, 687	l .	28, 230, 68	7 0	28, 230, 687 0	50. 00 50. 01
51. 00	05100 RECOVERY ROOM	7, 973, 070		7, 973, 07		7, 973, 070	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	8, 722, 084	l .	8, 722, 08		8, 722, 084	•
53.00	05300 ANESTHESI OLOGY	0		1	0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 725, 924	l .	8, 725, 92		8, 725, 924	
55. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	5, 827, 060		5, 827, 06	0	5, 827, 060	
56. 00 57. 00	05700 CT SCAN	1, 386, 450		1, 386, 45	0 0	0 1, 386, 450	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 135, 461		1, 135, 46	-	1, 135, 461	
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 153, 960	l .	4, 153, 96		4, 153, 960	
60.00	06000 LABORATORY	21, 816, 849		21, 816, 84		21, 816, 849	
64. 00	06400 I NTRAVENOUS THERAPY	0			0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	5, 467, 227	l .	0 5, 467, 22		5, 467, 227	
66.00	06600 PHYSI CAL THERAPY	10, 968, 476	l .	0 10, 968, 47	6 0	10, 968, 476 0	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY			0			67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 265, 122		1, 265, 12	2 0	1, 265, 122	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 262, 665		1, 262, 66		1, 262, 665	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 062, 060		16, 062, 06	0 0	16, 062, 060	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	24, 072, 581		24, 072, 58		24, 072, 581	
73. 00	07300 DRUGS CHARGED TO PATIENTS	58, 045, 190		58, 045, 19		58, 045, 190	
73. 01 74. 00	07302 OP PHARMACY 07400 RENAL DIALYSIS	2, 150, 030 2, 050, 081	l .	2, 150, 03 2, 050, 08		2, 150, 030 2, 050, 081	
75. 00	07500 ASC (NON-DISTINCT PART)	2,030,001	l .	2, 030, 00	0 0	2,030,081	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 134, 787		1, 134, 78	7 0	1, 134, 787	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2.051.070	ı	2 051 07		2 051 070	00.00
90. 00 90. 01	09000 CLINIC 09001 OP ONCOLOGY INFUSION CENTER	3, 951, 068 9, 047, 894	l .	3, 951, 06 9, 047, 89		3, 951, 068 9, 047, 894	
90. 01	09002 WOUND CARE CENTER	1, 548, 025		1, 548, 02			•
90. 03	09003 PAIN CLINIC	1, 105, 720		1, 105, 72			
90. 05	09005 OP PSYCH CLINIC	2, 854, 503		2, 854, 50	3 0	2, 854, 503	90. 05
	09100 EMERGENCY	19, 362, 157		19, 362, 15		19, 362, 157	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 501, 212		5, 501, 21	2	5, 501, 212	92. 00
94 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSIS			T	0 0	0	94. 00
	09500 AMBULANCE SERVICES	5, 089, 399		5, 089, 39			
	10000 I &R SERVICES-NOT APPRVD PRGM	0	l .		0		100. 00
	10100 HOME HEALTH AGENCY	0			0	0	101. 00
110 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0	l e	115. 00
	11600 HOSPI CE				o	0	116. 00
200.00	,	361, 195, 006		361, 195, 00			
201.00		5, 501, 212	l .	5, 501, 21		5, 501, 212	
202.00	Total (see instructions)	355, 693, 794	1	0 355, 693, 79	4 175, 050	355, 868, 844	1202.00

Health Financial Systems

IU HEALTH BLOOMINGTON HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0051

From 01/01/2021
To 12/31/2021

Period:
From 01/01/2021
To 12/31/2021

Part I
Date/Time Prepared:
5/26/2022 1:09 pm

Charges

Cost Center Description

Inpatient
Outpatient
Total (col. 6
+ col. 7)
Ratio
Inpatient
Ratio
Ratio

The part				litle	XVIII	Hospi tal	PPS	
IMPRILIAN NOILIN SINVICE COST CINTERS				Charges				
IMPRILIAN NOILIN SINVICE COST CINTERS		Cost Center Description	Inpati ent	Outpatient	Total (col. o	Cost or Other	l TEFRA	
INPATIENT ROUTINE SERVICE COST CENTERS				,				
INPATLENT ROUTINE SERVICE COST CENTERS					' 001. //	Nati o		
IMPAIL TENT ROUTINE SERVICE COST CENTERS 169, 499, 211 169, 499, 211 30, 001 3100 3100 MITTENS UP CARE UNIT 30, 845, 931 30, 845, 931 31, 00 320, 001 32			/ 00	7.00	0.00	0.00		
30.00			6.00	7.00	8.00	9.00	10.00	
31.00 03100 INTERSIY VE CARE UNIT 30, B45, 931 30, 945, 931 31, 00 200, 0200 CRINGARY CARE UNIT 27, 647, 790 22, 647, 790 32, 00 35, 00 200, 0200 REDMATAL INTERSIY VE CARE UNIT 16, 879, 676 16, 879, 676 35, 00 42, 00 200, 0200 REDMATAL INTERSIY VE CARE UNIT 16, 879, 676 16, 879, 676 35, 00 42, 00								
32.00 03200 (CORDMARY CARE UNIT 16,879,676 16,879,676 35.00 03200 (DROMATE) INTENSIVE CARE UNIT 16,879,676 16,879,676 35.00 03200 (DROMATE) INTENSIVE CARE UNIT 16,879,676 16,879,676 35.00 04200	30.00 03000	ADULTS & PEDIATRICS	169, 499, 211		169, 499, 21	1		30.00
32.00 03200 (CORDMARY CARE UNIT 16,879,676 16,879,676 35.00 03200 (DROMATE) INTENSIVE CARE UNIT 16,879,676 16,879,676 35.00 03200 (DROMATE) INTENSIVE CARE UNIT 16,879,676 16,879,676 35.00 04200	31.00 03100	INTENSIVE CARE UNIT	30, 845, 931		30, 845, 93	1		31.00
35.00								1
1.00 04100 SUBPROVI DER - IFF 3.396, 448 3.396, 448 41.00 0420 04200								
42.00 04200 NURSERY 0.0000000 0.00								
43.00 04300 NURSERY 4.169, 160 4.169, 160 4.169, 160 4.169, 160 4.169, 160 4.169, 160 4.169, 160 4.169, 160 4.169, 160 4.169, 160 4.169, 160 4.169, 160 5.00 5.			3, 396, 448		3, 396, 44	8		
MAIL LLARY SERVICE COST CENTERS			0			0		
50.00 05000 OPERATI NG ROOM 83, 927, 572 155, 400, 572 299, 328, 144 0. 117958 0. 000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 000000 0. 000000 50.00 0. 000000 0. 000000 50.00 0. 0000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000	43.00 04300	NURSERY	4, 169, 160		4, 169, 16	0		43. 00
50.00 05000 OPERATI NG ROOM 83, 927, 572 155, 400, 572 299, 328, 144 0. 117958 0. 000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 0000000 50.00 0. 000000 0. 000000 50.00 0. 000000 0. 000000 50.00 0. 0000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000	ANCI L	LARY SERVICE COST CENTERS						
50.00 05000 CV SURGERY CO			83, 927, 572	155, 400, 572	239, 328, 14	4 0. 117958	0.000000	50.00
15.1 0.0			1		1			1
1.0 0.5200 0.5200 0.511 0.51 0.51 0.525 0.50 0.500 0.500 0.51				-	1			
53.00 05300 ARSTHESIOLOGY 0 0 0 0 0 0 0 0 0		•						
54.00 05400 RADIOLOGY-DIAGNOSTIC 21, 255, 792 30, 227, 440 51, 483, 232 0. 169491 0. 000000 56.00 56.00 05500 08500 RADIOLOGY-THERAPEUTIC 4, 468, 474 92, 787, 784 97, 256, 258 0. 059914 0. 000000 56.00 56.00 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000			36, 000, 338					
55.00 OSDO RADIO LOGY-THERAPEUTIC 4, 468, 474 92, 787, 784 97, 256, 258 0, 059914 0, 000000 55.00 056.00 OSDO RADIO STOTOPE 0 0 0 0, 000000 56.00 056.00 OSDO CARDIO STOTOPE 0 0 0 0, 000000 56.00 056.00 OSDO CARDIO STOTOPE 0 0 0, 000000 56.00 056.00 OSDO CARDIO LOGO			0	0		0. 000000	0. 000000	53. 00
6.0 0.5600 RADIO I SOTOPE 0 0 0 0 0 0.000000 0.000000 0.57.00 0.57.00 0.570.0 0.000.0	54.00 05400	RADI OLOGY-DI AGNOSTI C	21, 255, 792	30, 227, 440	51, 483, 23	0. 169491	0.000000	54.00
6.0 0.5600 RADIO I SOTOPE 0 0 0 0 0 0.000000 0.000000 0.57.00 0.57.00 0.570.0 0.000.0	55. 00 05500	RADI OLOGY-THERAPEUTI C	4, 468, 474	92, 787, 784	97, 256, 25	0. 059914	0.000000	55.00
1.2, 0.3, 0.65 0.5, 0.00 0.5, 0.00 0								
SB. 00 OSBOO MAGNETIC RESONANCE I MAGING (MRI) 2, 902, 537 6, 35.6, 505 9, 259, 042 0, 122633 0, 000000 59. 00 59. 00 05000 CARDIAC CATHETERIZATION 28, 634, 064 44, 012, 131 126, 652, 432 0, 172258 0, 000000 69. 00 0. 0000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 0000000 0			12 042 405	-				
SP								
60.00 06.0000 06.00000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.000000 06.00000 06.00000 06.00000 06.000000 06.000000 06.000000 06.000000 06.000000 06.000000 06.000000 06.000000 06.000000 06.0000000 06.000000 06.0000000000								
64.00 06400 INTRAVENDUS THERAPY 18,565,996 2,730,757 21,296,753 0,256716 0,000000 64,00 65,00 06500 RESPIRATORY THERAPY 14,360,204 17,035,924 31,396,128 0,349358 0,000000 66,00 067,00 067000 067000 067000 067000 06700 0670000 067000 067000 067000 067000 067000 067000 0670000 0670000 0670000 0670000 0670000 0670000 06700000 06700000 06700000 06700000 06700000 06700000 067000000 06700000 067000000 067000000 0670000000 06700000000 0670000000000								
65.00 06500 RESPIRATORY THERAPY 18,565,996 2,730,757 21,296,753 0.256716 0.00000 65.00 66.00 66.00 66.00 66.00 67.00 0.00000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0	60.00 06000	LABORATORY	50, 613, 434	76, 038, 998	126, 652, 43	2 0. 172258	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY 18,565,996 2,730,757 21,296,753 0.256716 0.00000 65.00 66.00 66.00 66.00 66.00 67.00 0.00000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0	64.00 06400	INTRAVENOUS THERAPY	l ol	0		0. 000000	0.000000	64.00
66.00 06600 06600 067.00 069.00			18 565 996	2 730 757	21 296 75			1
67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0.000000 0.000000 68.00 06800 SPECEL PATHOLOGY 15.345,172 12.832,856 28.178,028 0.044897 0.000000 68.00 0.00000000								
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0			14, 300, 204					
69.00 06900 ELECTROCARDI OLOGY 15, 345, 172 12, 832, 856 28, 178, 028 0. 044897 0. 000000 69, 00 070.0			ا					
70. 00 07000 ELECTROENCEPHALLOGRAPHY 1, 314, 999 6, 370, 511 7, 685, 510 0, 164292 0, 000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 33, 703, 250 55, 266, 564 88, 969, 814 0. 180534 0. 000000 71. 00 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 71, 406, 857 76, 248, 795 147, 655, 652 0. 163032 0. 0000000 72. 00 73. 00 73. 01 70302 DP PHRMACY 0 101, 428, 664 231, 445, 994 332, 874, 658 0. 174376 0. 000000 73. 01 70302 DP PHRMACY 0 1, 867, 246 1. 151444 0. 0000000 73. 01 74. 00 75.			0	0				68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 33, 703, 250 55, 266, 564 88, 969, 814 0. 180534 0. 000000 71. 00 72. 00 73. 01 73. 01 73. 01 73. 02 07.			15, 345, 172	12, 832, 856	28, 178, 02	0. 044897	0.000000	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 33, 703, 250 55, 266, 564 88, 969, 814 0. 180534 0. 000000 71. 00 72. 00 73. 01 73. 01 73. 01 73. 02 07.	70.00 07000	ELECTROENCEPHALOGRAPHY	1, 314, 999	6, 370, 511	7, 685, 51	0. 164292	0.000000	70.00
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 71, 406,857 76, 248,795 147,655,652 0.163032 0.000000 72. 00 73. 00								
73. 01 07300 DRUGS CHARGED TO PATIENTS								
73.01 07302 OP PHARMACY 0 1, 867, 246 1, 867, 246 1. 151444 0. 000000 73. 01 74. 00 07400 RENAL DIALYSIS 3, 787, 638 624, 235 4, 411, 873 0. 464674 0. 000000 74. 00 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 75. 00 0. 000000 0. 000000 0. 000000 75. 00 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000			1					
74. 00 07400 RENAL DI ALYSI S 3, 787, 638 624, 235 4, 411, 873 0, 464674 0, 000000 74. 00 75. 00 75. 00 0 0 0 0 0 0 0 0 0			101, 428, 664					
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			0	1, 867, 246	1, 867, 24			
75. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0	74.00 07400	RENAL DIALYSIS	3, 787, 638	624, 235	4, 411, 87	0. 464674	0.000000	74. 00
75. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0	75.00 07500	ASC (NON-DISTINCT PART)	0	0		0. 000000	0.000000	75. 00
76. 97 07697 CARDI AC REHABILITATION 266, 395 2, 569, 932 2, 836, 327 0. 400090 0. 000000 76. 97			ام	0				
OUTPATIENT SERVICE COST CENTERS		ł .	266 395	2 569 932	2 836 32			1
90. 00			200,070	2,007,702	2,000,02	7 0. 100070	0.00000	70.77
90. 01			4 (04	2 507 020	2 502 52	1 524024	0.00000	- 00 00
90. 02		•	1					
90. 03			1					
90. 05			28, 604				0.000000	90. 02
90. 05 09005 0P PSYCH CLINIC 17, 274 4, 218, 296 4, 235, 570 0. 673936 0. 000000 90. 05 91. 00 09100 EMERGENCY 52, 832, 289 171, 147, 792 223, 980, 081 0. 086446 0. 000000 91. 00 92. 00 O9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 733, 047 36, 844, 590 37, 577, 637 0. 146396 0. 000000 94. 00 O9400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0. 000000 94. 00 95. 00 09500 AMBULANCE SERVI CES 138, 803 28, 618, 366 28, 757, 169 0. 176978 0. 000000 95. 00 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0. 176978 0. 000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATI ON REVI EW-SNF 114. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 0 101. 00 10500 HOSPI CE 0 0 0 0 0 0 0 0 Subtotal (see instructions) 816, 991, 653 1, 162, 066, 083 1, 979, 057, 736 200. 00 201. 00 Less Observation Beds 201. 00 0 0 0 102. 00 201. 00 0 0 0 0 0 103. 00 0 0 0 0 0 0 0 0 104. 00 0 0 0 0 0 0 0 105. 00 0 0 0 0 0 0 0 0 106. 00 0 0 0 0 0 0 0 0 0 107. 00 0 0 0 0 0 0 0 0 0 0 0 108. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	90. 03 09003	PAIN CLINIC	0	1, 747, 486	1, 747, 48	6 0. 632749	0.000000	90. 03
91. 00 09100 EMERGENCY 52, 832, 289 171, 147, 792 223, 980, 081 0. 086446 0. 000000 91. 00 0 0 0. 000000 92. 00 0 0 0 0 0 0 0 0 0	90. 05 09005	OP PSYCH CLINIC	17, 274			0. 673936	0.000000	90. 05
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 733, 047 36, 844, 590 37, 577, 637 0. 146396 0. 000000 92. 00								
94. 00								1
94. 00			733,047	30, 044, 370	37, 377, 03	7 0. 140370	0.00000	72.00
95. 00 09500 AMBULANCE SERVI CES 138, 803 28, 618, 366 28, 757, 169 0. 176978 0. 000000 95. 00 100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 100. 00 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00			1		1			
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM								
101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00	95. 00 09500	AMBULANCE SERVICES	138, 803	28, 618, 366	28, 757, 16	9 0. 176978	0.000000	95. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 115.00 116.00	100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 115.00 116.00	101. 00 10100	HOME HEALTH AGENCY	l ol	0		o		101.00
113. 00			9			<u> </u>	·	1
114.00			I					113 00
115. 00								1
116. 00 11600 HOSPI CE		l .				_		1
200.00 Subtotal (see instructions) 816,991,653 1,162,066,083 1,979,057,736 200.00 201.00 Less Observation Beds			0	0	1	O		
201.00 Less Observation Beds 201.00	116. 00 11600	HOSPI CE	0	0		0		116. 00
201.00 Less Observation Beds 201.00	200. 00	Subtotal (see instructions)	816, 991, 653	1, 162, 066, 083	1, 979, 057, 73	6		200.00
					1			
202.00			816 991 653	1 162 066 083	1 979 057 73	6		
	202.00	1.513. (555 111511 4511 6115)	010, 771, 000	., 102, 000, 000	1 ., ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	~	I	1-02.00

In Lieu of Form CMS-2552-10
Worksheet C
01/2021 Part I
01/2021 Date/Time Prepared: 5/26/2022 1:09 pm Peri od: From 01/01/2021 To 12/31/2021

			Title XVIII	Hospi tal	PPS	Ja pili
	Cost Center Description	PPS Inpatient	THE ATTE	1103pi tui	113	
	5551 551151 25551 Pt. 511	Ratio				
		11.00				
LNF	PATIENT ROUTINE SERVICE COST CENTERS					
	000 ADULTS & PEDIATRICS					30.00
	100 INTENSIVE CARE UNIT					31.00
	200 CORONARY CARE UNIT					32. 00
35. 00 020	060 NEONATAL INTENSIVE CARE UNIT					35. 00
	100 SUBPROVIDER - IRF					41.00
	200 SUBPROVI DER					42.00
43.00 043	300 NURSERY					43.00
ANC	CILLARY SERVICE COST CENTERS	<u> </u>				
50.00 050	000 OPERATING ROOM	0. 117958				50.00
50. 01 050	001 CV SURGERY	0. 000000				50. 01
51.00 051	100 RECOVERY ROOM	0. 217424				51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM	0. 225328				52. 00
53. 00 053	300 ANESTHESI OLOGY	0. 000000				53. 00
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	0. 169491				54.00
55. 00 055	500 RADI OLOGY-THERAPEUTI C	0. 059914				55. 00
56.00 056	600 RADI OI SOTOPE	0. 000000				56. 00
	700 CT SCAN	0. 037366				57. 00
58. 00 058	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 122633				58. 00
59. 00 059	900 CARDI AC CATHETERI ZATI ON	0. 057181				59. 00
60.00 060	000 LABORATORY	0. 172258				60.00
	400 INTRAVENOUS THERAPY	0. 000000				64. 00
1	500 RESPI RATORY THERAPY	0. 256716				65. 00
	600 PHYSI CAL THERAPY	0. 349358				66. 00
	700 OCCUPATIONAL THERAPY	0. 000000				67. 00
	800 SPEECH PATHOLOGY	0. 000000				68. 00
	900 ELECTROCARDI OLOGY	0. 044897				69. 00
	000 ELECTROENCEPHALOGRAPHY	0. 164292				70. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 180534				71. 00
	200 I MPL. DEV. CHARGED TO PATIENTS	0. 163032				72. 00
	300 DRUGS CHARGED TO PATIENTS	0. 174376				73. 00
	302 OP PHARMACY	1. 151444				73. 01
	400 RENAL DIALYSIS	0. 464674				74. 00
	500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				75. 01
	697 CARDI AC REHABI LI TATI ON	0. 400090				76. 97
	TPATIENT SERVICE COST CENTERS	4 504004				
	000 CLINIC	1. 524024				90.00
	001 OP ONCOLOGY INFUSION CENTER	0. 209370				90. 01
	002 WOUND CARE CENTER	0. 188024				90. 02
	003 PAIN CLINIC 005 OP PSYCH CLINIC	0. 632749				90. 03
	100 EMERGENCY	0. 673936 0. 086446				90. 05 91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 146396				91.00
	HER REIMBURSABLE COST CENTERS	0. 140370				92.00
	400 HOME PROGRAM DIALYSIS	0. 000000				94. 00
	500 AMBULANCE SERVICES	0. 176978				95. 00
	000 I&R SERVICES-NOT APPRVD PRGM	0. 170770				100.00
	100 HOME HEALTH AGENCY					100.00
	ECIAL PURPOSE COST CENTERS					101.00
	300 INTEREST EXPENSE					113. 00
	400 UTI LI ZATI ON REVI EW-SNF					114. 00
	500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
	600 HOSPI CE					116. 00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00
'						•

COMPUT	COMPUTATION OF RATIO OF COSTS TO CHARGES				Peri od:	Worksheet C Part I	
				From 01/01/2021 To 12/31/2021			nared:
					10 12/31/2021	Date/Time Pre 5/26/2022 1:0	9 pm
			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)					
	I NOATI ENT POUTI NE CEDVI CE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	74, 326, 397		74, 326, 39	7 91, 539	74, 417, 936	30.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	10, 342, 050		10, 342, 05	· ·	10, 342, 050	1
32.00	03200 CORONARY CARE UNIT	8, 806, 573		8, 806, 57		8, 806, 573	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 807, 999		4, 807, 99		4, 891, 510	
41. 00	04100 SUBPROVI DER - I RF	2, 206, 640		2, 206, 64		2, 206, 640	
42. 00	04200 SUBPROVI DER	2, 200, 010		2, 200, 01	0 0	2, 200, 010	42. 00
43. 00	04300 NURSERY	1, 795, 605		1, 795, 60		1, 795, 605	
	ANCILLARY SERVICE COST CENTERS	, , , , , , , , ,				, , , , , , , , , , , , , , , , , , , ,	
50.00	05000 OPERATI NG ROOM	28, 230, 687		28, 230, 68	7 0	28, 230, 687	50.00
50. 01	05001 CV SURGERY	0			0	0	50. 01
51.00	05100 RECOVERY ROOM	7, 973, 070		7, 973, 07	0	7, 973, 070	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 722, 084		8, 722, 08	4 0	8, 722, 084	52. 00
53.00	05300 ANESTHESI OLOGY	0			0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 725, 924		8, 725, 92		8, 725, 924	
55. 00	05500 RADI OLOGY-THERAPEUTI C	5, 827, 060		5, 827, 06		5, 827, 060	
56. 00	05600 RADI OI SOTOPE	0			0	0	56. 00
57. 00	05700 CT SCAN	1, 386, 450		1, 386, 45		1, 386, 450	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 135, 461		1, 135, 46		1, 135, 461	
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	4, 153, 960		4, 153, 96		4, 153, 960	
60. 00 64. 00	06400 I NTRAVENOUS THERAPY	21, 816, 849		21, 816, 84	0 0	21, 816, 849 0	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	5, 467, 227	0	5, 467, 22	7 0	5, 467, 227	1
66. 00	06600 PHYSI CAL THERAPY	10, 968, 476	0			10, 968, 476	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	10, 700, 17	0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0	,	o o	Ö	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 265, 122		1, 265, 12	2 0	1, 265, 122	1
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 262, 665		1, 262, 66		1, 262, 665	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 062, 060		16, 062, 06	0	16, 062, 060	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	24, 072, 581		24, 072, 58	1 0	24, 072, 581	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	58, 045, 190		58, 045, 19	0	58, 045, 190	73. 00
73. 01	07302 OP PHARMACY	2, 150, 030		2, 150, 03		2, 150, 030	
74. 00	07400 RENAL DI ALYSI S	2, 050, 081		2, 050, 08	1 0	2, 050, 081	
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	0	75. 00
75. 01	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	1 124 707		1 104 70	0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	1, 134, 787		1, 134, 78	7 0	1, 134, 787	76. 97
00 00	09000 CLINIC	3, 951, 068		3, 951, 06	0 0	3, 951, 068	90.00
90. 00	09001 OP ONCOLOGY INFUSION CENTER	9, 047, 894		9, 047, 89		9, 047, 894	
	09002 WOUND CARE CENTER	1, 548, 025		1, 548, 02		1, 548, 025	
	09003 PAIN CLINIC	1, 105, 720		1, 105, 72			
	09005 OP PSYCH CLINIC	2, 854, 503		2, 854, 50			
	09100 EMERGENCY	19, 362, 157		19, 362, 15			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 501, 212		5, 501, 21		5, 501, 212	
	OTHER REIMBURSABLE COST CENTERS				•		
	09400 HOME PROGRAM DIALYSIS	0			0	0	94. 00
	09500 AMBULANCE SERVI CES	5, 089, 399		5, 089, 39	9 0		
	10000 I&R SERVICES-NOT APPRVD PRGM	0			0		100. 00
101.00	10100 HOME HEALTH AGENCY	0			0	0	101. 00
440.00	SPECIAL PURPOSE COST CENTERS	1		1		1	
	11300 I NTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)					_	114. 00 115. 00
	111600 HOSPICE				0		116.00
200.00		361, 195, 006	0	361, 195, 00	6 175, 050	l e	
201.00	,	5, 501, 212	0	5, 501, 21	· ·	5, 501, 212	201. 00
202.00		355, 693, 794	0				
50	1 ()		· ·		1, 300	,,,	

		OF RATIO OF COSTS TO CHARGES	TILALIII BLOOMII	Provi der Co	CN: 15-0051 F	Period: Prom 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 1:0	pared:
			_	Ti tl	e XIX	Hospi tal	PPS	
		Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
			6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30.00	03000	ADULTS & PEDIATRICS	169, 499, 211		169, 499, 211			30. 00
31.00	03100	INTENSIVE CARE UNIT	30, 845, 931		30, 845, 931			31.00
32.00	03200	CORONARY CARE UNIT	27, 647, 790		27, 647, 790)		32. 00
35.00		NEONATAL INTENSIVE CARE UNIT	16, 879, 676		16, 879, 676	1		35. 00
41. 00		SUBPROVI DER - I RF	3, 396, 448		3, 396, 448	l e		41. 00
42. 00		SUBPROVI DER	0		(C)		42. 00
43. 00		NURSERY	4, 169, 160		4, 169, 160			43. 00
		LARY SERVICE COST CENTERS	00 007 570	455 400 570		0.447050		
50.00	1	OPERATING ROOM	83, 927, 572	155, 400, 572	1		l e	
50. 01		CV SURGERY	0	0 522 0/5	_		0.000000	
51.00	1	RECOVERY ROOM	6, 147, 700	30, 522, 865			0.000000	
52.00		DELIVERY ROOM & LABOR ROOM	36, 000, 338	2, 708, 013			0.000000	
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	21 255 702	20 227 440	1	0.00000	0. 000000 0. 000000	
55. 00		RADI OLOGY-DI AGNOSTI C	21, 255, 792 4, 468, 474	30, 227, 440 92, 787, 784			0.000000	
56. 00		RADI OI SOTOPE	4,400,474	92, 707, 704	97, 230, 230		0.000000	
57. 00		CT SCAN	12, 943, 685	24, 161, 207	1		0.000000	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	2, 902, 537	6, 356, 505			0. 000000	
59. 00	1	CARDI AC CATHETERI ZATI ON	28, 634, 064	44, 012, 131			0.00000	
60. 00		LABORATORY	50, 613, 434	76, 038, 998			0. 000000	
64. 00		INTRAVENOUS THERAPY	00,010,101	70,000,770			0. 000000	
65. 00		RESPI RATORY THERAPY	18, 565, 996	2, 730, 757	· ·		0. 000000	
66. 00		PHYSI CAL THERAPY	14, 360, 204	17, 035, 924			0.000000	
67. 00		OCCUPATI ONAL THERAPY	0	0	1		0.000000	
68. 00		SPEECH PATHOLOGY	0	0			0.000000	
69. 00		ELECTROCARDI OLOGY	15, 345, 172	12, 832, 856	28, 178, 028		0.000000	
70.00	07000	ELECTROENCEPHALOGRAPHY	1, 314, 999	6, 370, 511	7, 685, 510	0. 164292	0. 000000	70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 703, 250	55, 266, 564			0.000000	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	71, 406, 857	76, 248, 795	147, 655, 652	0. 163032	0.000000	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	101, 428, 664	231, 445, 994	332, 874, 658	0. 174376	0.000000	73. 00
73. 01	07302	OP PHARMACY	0	1, 867, 246	1, 867, 246	1. 151444	0.000000	73. 01
74.00		RENAL DIALYSIS	3, 787, 638	624, 235	4, 411, 873		0. 000000	
75. 00		ASC (NON-DISTINCT PART)	0	0) C		0. 000000	
75. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0. 000000	0. 000000	
76. 97		CARDI AC REHABI LI TATI ON	266, 395	2, 569, 932	2, 836, 327	0. 400090	0.000000	76. 97
00.00		TIENT SERVICE COST CENTERS	4 (04	0 507 000	0 500 504	4 504004	0.00000	00.00
90.00		CLINIC	4, 694	2, 587, 830				
90. 01 90. 02		OP ONCOLOGY INFUSION CENTER	3, 725, 955	39, 488, 891			0.000000	
90. 02		WOUND CARE CENTER PAIN CLINIC	28, 604	8, 204, 503 1, 747, 486	1		0. 000000 0. 000000	
90. 03		OP PSYCH CLINIC	17, 274	4, 218, 296			•	
	1	EMERGENCY	52, 832, 289	171, 147, 792			l .	1
	1	OBSERVATION BEDS (NON-DISTINCT PART)	733, 047	36, 844, 590			•	
72.00		REI MBURSABLE COST CENTERS	733,047	30, 044, 370	37,377,037	0. 140370	0.000000	72.00
94. 00		HOME PROGRAM DIALYSIS	0	0	C	0.000000	0.000000	94. 00
		AMBULANCE SERVICES	138, 803	28, 618, 366	1		0. 000000	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0)		100.00
101.00	10100	HOME HEALTH AGENCY	0	0) c)		101. 00
	SPECIA	AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113. 00
		UTILIZATION REVIEW-SNF						114. 00
	1	AMBULATORY SURGICAL CENTER (D.P.)	0	0	(C			115. 00
		HOSPI CE	0	0	C			116. 00
200.00	1	Subtotal (see instructions)	816, 991, 653	1, 162, 066, 083	1, 979, 057, 736			200.00
201.00		Less Observation Beds	01/ 001 /50	1 1/2 0// 000	1 070 057 70			201. 00
202.00	기	Total (see instructions)	816, 991, 653	1, 162, 066, 083	1, 979, 057, 736	1	I	202. 00

| N Lieu of Form CMS-2552-10 | Worksheet C | Part | | B1/2021 | Date/Time Prepared: | 5/26/2022 | 1:09 pm | tal | DDS Peri od: From 01/01/2021 To 12/31/2021

			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11.00			
1	NPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.00
31.00 0	03100 INTENSIVE CARE UNIT				31.00
32.00 0	03200 CORONARY CARE UNIT				32.00
35. 00 0	02060 NEONATAL INTENSIVE CARE UNIT				35.00
41.00 0	04100 SUBPROVI DER - I RF				41. 00
42.00 0	04200 SUBPROVI DER				42. 00
43.00 0	04300 NURSERY				43. 00
A	NCILLARY SERVICE COST CENTERS				
50.00 0	05000 OPERATING ROOM	0. 117958			50. 00
50. 01 0	05001 CV SURGERY	0. 000000			50. 01
51.00 0	05100 RECOVERY ROOM	0. 217424			51. 00
52.00 0	D5200 DELIVERY ROOM & LABOR ROOM	0. 225328			52. 00
53.00 0	05300 ANESTHESI OLOGY	0. 000000			53.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	0. 169491			54. 00
55. 00 0	05500 RADI OLOGY-THERAPEUTI C	0. 059914			55. 00
56.00 0	05600 RADI OI SOTOPE	0. 000000			56. 00
57.00 0	05700 CT SCAN	0. 037366			57. 00
58. 00 0	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 122633			58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 057181			59. 00
60.00 0	06000 LABORATORY	0. 172258			60.00
64.00 0	06400 INTRAVENOUS THERAPY	0. 000000			64. 00
	06500 RESPI RATORY THERAPY	0. 256716			65. 00
	06600 PHYSI CAL THERAPY	0. 349358			66. 00
	06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
	06800 SPEECH PATHOLOGY	0. 000000			68. 00
	06900 ELECTROCARDI OLOGY	0. 044897			69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 164292			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 180534			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 163032			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 174376			73. 00
	07302 OP PHARMACY	1. 151444			73. 01
	07400 RENAL DIALYSIS	0. 464674			74. 00
	07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			75. 01
	07697 CARDIAC REHABILITATION	0. 400090			76. 97
	OUTPATIENT SERVICE COST CENTERS	0			
	09000 CLI NI C	1. 524024			90.00
	09001 OP ONCOLOGY INFUSION CENTER	0. 209370			90. 01
	09002 WOUND CARE CENTER	0. 188024			90. 02
1	09003 PAIN CLINIC	0. 632749			90. 03
	09005 OP PSYCH CLINIC	0. 673936			90. 05
1	99100 EMERGENCY	0. 086446			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 146396			92. 00
	THER REIMBURSABLE COST CENTERS	01110070			72.00
	09400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
1	09500 AMBULANCE SERVI CES	0. 176978			95. 00
	0000 I &R SERVICES-NOT APPRVD PRGM	0.170770			100.00
	0100 HOME HEALTH AGENCY				101.00
	SPECIAL PURPOSE COST CENTERS				101:00
	11300 INTEREST EXPENSE				113. 00
	11400 UTILIZATION REVIEW-SNF				114. 00
	1500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
	11600 HOSPI CE				116. 00
200.00	Subtotal (see instructions)				200. 00
200.00	Less Observation Beds				200.00
202.00	Total (see instructions)				201.00
202.00	1.3441 (355 111341 4641 6113)	ı l			1202.00

Health Financial Systems I U HEALTH BLOG CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0051

				'	0 12/31/2021	5/26/2022 1:0	
-			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	,					
50. 00	05000 OPERATING ROOM	28, 230, 687	1, 763, 550	1			50.00
50. 01	05001 CV SURGERY	0	C	1	_		50. 01
51. 00	05100 RECOVERY ROOM	7, 973, 070					51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	8, 722, 084	1, 003, 338			_	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	7 ₁ ~		0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	8, 725, 924	1	1			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	5, 827, 060		1			55. 00
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	1 204 450	(2.5/3	1	_	_	56. 00 57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 386, 450 1, 135, 461					57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION		65, 658 263, 965		_	_	59. 00
60.00	06000 LABORATORY	4, 153, 960 21, 816, 849		1		_	60.00
64. 00	06400 I NTRAVENOUS THERAPY	21,010,049	073, 332	1	_	_	64. 00
65. 00	06500 RESPIRATORY THERAPY	5, 467, 227	96, 064	7 ₁			65. 00
66. 00	06600 PHYSI CAL THERAPY	10, 968, 476			_	_	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	10, 700, 470	303, 32	1			67. 00
68. 00	06800 SPEECH PATHOLOGY	0		ή	_	_	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 265, 122	1	1	-	_	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 262, 665		1		_	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 062, 060					71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	24, 072, 581	291, 684			Ō	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	58, 045, 190					73. 00
73. 01	07302 OP PHARMACY	2, 150, 030					73. 01
74.00	07400 RENAL DIALYSIS	2, 050, 081	40, 178			0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0			0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	l c	0	0	0	75. 01
76. 97	07697 CARDIAC REHABILITATION	1, 134, 787	109, 292	1, 025, 495	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	3, 951, 068					90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	9, 047, 894					90. 01
90. 02	09002 WOUND CARE CENTER	1, 548, 025				_	90. 02
90. 03	09003 PAIN CLINIC	1, 105, 720				_	90. 03
90. 05	09005 OP PSYCH CLINIC	2, 854, 503					90. 05
91. 00	09100 EMERGENCY	19, 362, 157					91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 501, 212	326, 299	5, 174, 913	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	1	1 -		1	1	
	09400 HOME PROGRAM DI ALYSI S	5 000 000	0.7.57				94. 00
	09500 AMBULANCE SERVICES	5, 089, 399		1			95. 00
	10000 I &R SERVICES-NOT APPRVD PRGM	0		1			100.00
101.00	10100 HOME HEALTH AGENCY	0) 0	0	0	101. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		I			I	113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	_			0	0	114. 00
	11600 HOSPICE						116. 00
200.00		258, 909, 742	10, 878, 052	248, 031, 690	0		200. 00
201.00	· · · · · · · · · · · · · · · · · · ·	5, 501, 212					200.00
202.00		253, 408, 530			_		201.00
_000	1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	200, 100, 000	, , , , , ,	2.2,000,777			00

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

I U HEALTH BLOOMINGTON HOSPITAL RATIOS NET OF Provider CO | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 1:09 pm Provi der CCN: 15-0051

							5/26/2022 1:0	9 pm
				Ti tl	e XIX	Hospi tal	PPS	
	Cos	st Center Description	Cost Net of	Total Charges	Outpati ent			
		'	Capital and		Cost to Charge			
					Ratio (col. 6			
			Reduction	8)	/ col . 7)			
			6. 00	7.00	8.00			
	ANCLILAR	Y SERVICE COST CENTERS	0.00	7.00	0.00			
50.00		ERATING ROOM	28, 230, 687	239, 328, 144	0. 117958			50.00
50. 00	05000 CV		28, 230, 087	1				50. 00
			_	1				1
51.00		COVERY ROOM	7, 973, 070					51.00
52.00		LIVERY ROOM & LABOR ROOM	8, 722, 084	1				52. 00
53. 00		ESTHESI OLOGY	0	1				53. 00
54.00		DI OLOGY-DI AGNOSTI C	8, 725, 924					54. 00
55.00	05500 RAI	DI OLOGY-THERAPEUTI C	5, 827, 060	97, 256, 258	0. 059914			55.00
56.00	05600 RAI	DI OI SOTOPE	0	0	0.000000			56. 00
57.00	05700 CT		1, 386, 450	37, 104, 892	0. 037366			57. 00
58.00	05800 MAG	GNETIC RESONANCE IMAGING (MRI)	1, 135, 461	9, 259, 042	0. 122633			58. 00
59.00	05900 CAF	RDI AC CATHETERI ZATI ON	4, 153, 960	72, 646, 195	0. 057181			59.00
60.00	06000 LAE	BORATORY	21, 816, 849		0. 172258			60.00
64.00		TRAVENOUS THERAPY	0	0				64.00
65. 00		SPI RATORY THERAPY	5, 467, 227					65. 00
66. 00	1 1	YSI CAL THERAPY	10, 968, 476					66. 00
67. 00		CUPATI ONAL THERAPY	10, 700, 470	01, 370, 120				67. 00
68. 00		EECH PATHOLOGY	0					68. 00
69. 00		ECTROCARDI OLOGY	1 2/5 122					69. 00
			1, 265, 122					
70.00		ECTROENCEPHALOGRAPHY	1, 262, 665					70. 00
71. 00		DICAL SUPPLIES CHARGED TO PATIENTS	16, 062, 060					71. 00
72. 00	1 1	PL. DEV. CHARGED TO PATIENTS	24, 072, 581					72. 00
73. 00		UGS CHARGED TO PATIENTS	58, 045, 190					73. 00
73. 01		PHARMACY	2, 150, 030					73. 01
74.00	07400 REN	NAL DIALYSIS	2, 050, 081	4, 411, 873	0. 464674			74. 00
75.00	07500 ASC	C (NON-DISTINCT PART)	0	0	0.000000			75. 00
75. 01	03550 PS\	YCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.000000			75. 01
76. 97	07697 CAF	RDIAC REHABILITATION	1, 134, 787	2, 836, 327	0. 400090			76. 97
		NT SERVICE COST CENTERS			•			
90.00	09000 CLI	INIC	3, 951, 068	2, 592, 524	1.524024			90.00
90. 01	09001 OP	ONCOLOGY INFUSION CENTER	9, 047, 894					90. 01
90. 02		UND CARE CENTER	1, 548, 025					90. 02
90. 03		IN CLINIC	1, 105, 720					90. 03
90. 05		PSYCH CLINIC	2, 854, 503					90. 05
91. 00	09100 EME		19, 362, 157	1				91.00
92. 00		SERVATION BEDS (NON-DISTINCT PART)	5, 501, 212					92. 00
92.00			3, 301, 212	37, 377, 037	0. 140390			92.00
04.00		I MBURSABLE COST CENTERS	0		0.000000			04.00
94.00		ME PROGRAM DI ALYSI S	0	1				94. 00
95.00		BULANCE SERVICES	5, 089, 399	1				95. 00
		R SERVICES-NOT APPRVD PRGM	0					100. 00
101.00	0 <u> 10100 H0N</u>	ME HEALTH AGENCY	0	0	0.000000			101. 00
		PURPOSE COST CENTERS						
		TEREST EXPENSE						113. 00
		ILIZATION REVIEW-SNF						114. 00
115.00	0 11500 AME	BULATORY SURGICAL CENTER (D. P.)	0	0	0.000000			115. 00
116.00	11600 HOS	SPI CE	0	0	0.000000			116. 00
200.00	1 1	btotal (sum of lines 50 thru 199)	258, 909, 742	1, 726, 619, 520				200. 00
201.00		ss Observation Beds	5, 501, 212					201. 00
202.00	1 1	tal (line 200 minus line 201)		1, 726, 619, 520				202. 00
00	1.0		,,,	, , , 0 . , , 020	1	II .		,

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT.	IU HEALTH BLOOMI			In_Lie Period:	u of Form CMS-	2552-10
APPORTIONMENT OF INPATTENT ROUTINE SERVICE CAPITA	AL CUSIS	Provi der C		erioa: From 01/01/2021	Worksheet D Part I	
				To 12/31/2021	Date/Time Pre	pared:
					5/26/2022 1:0	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 414, 043	0	4, 414, 043			
31.00 INTENSIVE CARE UNIT	433, 057		433, 057	4, 293	100.88	31. 00
32. 00 CORONARY CARE UNIT	540, 245		540, 245			
35.00 NEONATAL INTENSIVE CARE UNIT	241, 177		241, 177	3, 527	68. 38	35.00
41. 00 SUBPROVI DER - I RF	229, 899	0	229, 899	1, 357	169. 42	41.00
42. 00 SUBPROVI DER	0	0	(0	0.00	42.00
43. 00 NURSERY	137, 762		137, 762	2, 816	48. 92	43.00
200.00 Total (lines 30 through 199)	5, 996, 183		5, 996, 183	67, 748		200.00
Cost Center Description	I npati ent	I npati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	15, 688	1, 342, 893				30.00
31.00 INTENSIVE CARE UNIT	1, 512	152, 531				31.00
32. 00 CORONARY CARE UNIT	1, 589	204, 981				32. 00
35. OO NEONATAL INTENSIVE CARE UNIT	0	0)			35. 00
41. 00 SUBPROVI DER - I RF	596	100, 974				41.00
42 OO SUBPROVI DER		1	d .			12 00

19, 385

1, 801, 379

42.00 43. 00 200. 00

42.00 SUBPROVI DER 43.00 NURSERY 200.00 Total (lines 30 through 199)

Heal th Financial	Systems	IU HEALTH BLOOMINGTON	I HOSPI	TAL	 In Lie	u of Form	CMS-2552-10

Health Financial Systems IU	U HEALTH BLOOMINGTON HOSPITAL			In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	L COSTS	Provi der Co	CN: 15-0051	Peri od:	Worksheet D	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre	pared:
		Ti +Lo	XVIII	Hospi tal	5/26/2022 1: 0 PPS	9 pm
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescriptron		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	. Charges	COT UIIIT 4)	
	26)	0)	2)			
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1. 00	2.00	0.00	1. 00	0.00	
50. 00 05000 OPERATING ROOM	1, 763, 550	239, 328, 144	0. 00736	9 32, 165, 879	237, 030	50. 00
50. 01 05001 CV SURGERY	0	1			0	50. 01
51. 00 05100 RECOVERY ROOM	239, 472	36, 670, 565			15, 491	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 003, 338					
53. 00 05300 ANESTHESI OLOGY	0	0	i		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	603, 369	-				
55. 00 05500 RADI OLOGY-THERAPEUTI C	684, 324					55. 00
56. 00 05600 RADI OI SOTOPE	001,021				1	56. 00
57. 00 05700 CT SCAN	63, 567				8, 801	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	65, 658	1				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	263, 965					
60. 00 06000 LABORATORY	673, 352					60.00
64. 00 06400 NTRAVENOUS THERAPY	073, 332				05, 107	64. 00
65. 00 06500 RESPI RATORY THERAPY	96, 064	-				65. 00
66. 00 06600 PHYSI CAL THERAPY	385, 329					
67. 00 06700 OCCUPATI ONAL THERAPY	300, 329	l			1	67. 00
68. 00 06800 SPEECH PATHOLOGY	0				0	68. 00
69. 00 06900 SPEECH PATHOLOGY	81, 527	ľ				
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	121, 655				9, 157	70.00
1 1	194, 177				l	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	291, 684					•
	694, 636				l	
1 1	21, 833				14 154	73. 01
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	40, 178	l ' '	1		16, 154	74.00
	0	0			0	75. 00 75. 01
	100 202	0 007 207	0.00000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	109, 292	2, 836, 327	0. 03853	3 93, 330	3, 596	76. 97
90. 00 09000 CLINIC	625, 820	2, 592, 524	0. 24139	4, 613	1, 114	90.00
90. 01 09001 OP ONCOLOGY NFUSION CENTER	639, 249			•		90.00
90. 02 09002 WOUND CARE CENTER						
	148, 606				l e	90. 02
90. 03 09003 PALN CLINIC	94, 656				0	90. 03
90. 05 09005 0P PSYCH CLINIC	363, 020					90.05
91. 00 09100 EMERGENCY	1, 015, 858				l	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	326, 299	37, 577, 637	0. 00868	3 171, 149	1, 486	92. 00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	^	0	0.00000	0	0	04.00
95. 00 09500 AMBULANCE SERVICES	0		0.00000			94. 00 95. 00
	10 (10 470	1 (07 0(2 251		10/ 071 014	011 010	
200.00 Total (lines 50 through 199)	10, 610, 478	1, 697, 862, 351	l	196, 071, 014	911, 018	J∠UU. UU

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

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider Co	CN: 15-0051 F	Peri od:	Worksheet D	
				rom 01/01/2021	Part III	
			1	o 12/31/2021	Date/Time Pre	pared:
-		Ti +Lo	xVIII	Hospi tal	5/26/2022 1:0 PPS	9 pm
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
Cost Center Description	Program	Program	Post-Stepdown		Medical	
	Post-Stepdown	1 Togram	Adjustments		Education Cost	
	Adjustments		Auj us tillerits		Luucati on cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	17	1.00	211	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0			0	31.00
32. 00 03200 CORONARY CARE UNIT		0			0	32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0		o o	ő	35.00
41. 00 04100 SUBPROVI DER - RF				o o	ő	41. 00
42. 00 04200 SUBPROVI DER					0	42.00
43. 00 04200 3001 KOVY DEK 43. 00 04300 NURSERY					0	43. 00
200.00 Total (lines 30 through 199)					_	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dationt	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Days	3 . coi . o)	l 11 Ogi alli bays	
	instructions)					
	4.00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			2.22	1		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	51, 567	0.00	15, 688	30.00
31. 00 03100 INTENSIVE CARE UNIT		0	4, 293	0.00	1, 512	31.00
32. 00 03200 CORONARY CARE UNIT		0	4, 188	0.00	1, 589	32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	3, 527	0.00	0	35. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	1, 357	0.00	596	41.00
42. 00 04200 SUBPROVI DER	0	0	. (0.00	0	42.00
43. 00 04300 NURSERY		0	2, 816			43.00
200.00 Total (lines 30 through 199)		0			19, 385	
Cost Center Description	I npati ent					
· ·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
41. 00 04100 SUBPROVI DER - I RF	0					41. 00
42. 00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200. 00
	•	•				-

| Peri od: | Worksheet D | Part IV | To | 12/31/2021 | Date/Time Prepared: | To | To | To | Part IV | Part
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

					10 12/31/2021	5/26/2022 1:09	
			Title	e XVIII	Hospi tal	PPS	<i>y</i> piii
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	'	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	1	0	0	50.00
50. 01	05001 CV SURGERY	0	0	1	0	0	50. 01
51.00	05100 RECOVERY ROOM	0	0	1	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	1	0	0	56. 00
57.00	05700 CT SCAN	0	0	1	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0)	0 0	0	59. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0)	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0)	0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0)	0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0)	0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0)	0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0)	0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0 0	638, 123	73.00
73. 01	07302 OP PHARMACY	0	0)	0 0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	0)	0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0)	0 0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0)	0 0	0	75. 01
76. 97	07697 CARDI AC REHABI LITATION	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0		0 0	0	90. 01
90. 02	09002 WOUND CARE CENTER	0	0		0 0	0	90. 02
90. 03	09003 PAIN CLINIC	0	0		0 0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	0	0)	0 0	0	90. 05
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						
94.00	09400 HOME PROGRAM DIALYSIS	0	C		0 0	0	94. 00
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 0	638, 123	200. 00

	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	OVICE OTHER DASS		N: 15 0051 E	Peri od:	Worksheet D	2332-10
	SH COSTS	WICE UINER PAS	5 Provider C		rom 01/01/2021		
TTIKOOC	00010				o 12/31/2021	Date/Time Pre	pared:
						5/26/2022 1:0	9 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	/ 00	7.00	instructions)	
	ANOLLI ADV. CEDVI OF COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	1 0			220 220 144	0.000000	FO 00
50.00	05000 OPERATI NG ROOM	0	0	(0.000000	
50. 01	05001 CV SURGERY	0	0			0.000000	
51.00	05100 RECOVERY ROOM	0	0	(,,		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		38, 708, 351	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0		ή	0.000000	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	0		,,	0.000000	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		97, 256, 258	0.000000	
56.00	05600 RADI OI SOTOPE	0	0		0	0.000000	
57. 00	05700 CT SCAN	0	0		37, 104, 892	0.000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		7,207,012	0.000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		, ,		
60.00	06000 LABORATORY	0	0		120,002,102		
64.00	06400 NTRAVENOUS THERAPY	0	0			0.000000	
65. 00	06500 RESPI RATORY THERAPY	0	0				
66.00	06600 PHYSI CAL THERAPY	0	0		31, 396, 128		
67. 00	06700 OCCUPATIONAL THERAPY	0	0			0.000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 170 020	0.000000	1
69. 00	06900 ELECTROCARDI OLOGY	0	0				
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		7, 685, 510		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		, ,	0.000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	(20 122	(20.12)	, ,		
73. 00 73. 01		0	638, 123	638, 123			73.00
74. 00	07302 OP PHARMACY 07400 RENAL DIALYSIS	0	0		1, 867, 246		1
75. 00	1 1	0	0		4, 411, 873		
75. 00 75. 01	07500 ASC (NON-DISTINCT PART) 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0		ή	0. 000000 0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0			1	0. 000000	
70. 97	OUTPATIENT SERVICE COST CENTERS	0	0		2, 030, 327	0.000000	70.97
90. 00	09000 CLINIC	0	0		2, 592, 524	0. 000000	90.00
90. 00	09001 OP ONCOLOGY INFUSION CENTER	0	1 0		43, 214, 846	0.000000	
90. 01					8, 233, 107	0.000000	
							1
90. 03 90. 05	O9003 PAIN CLINIC O9005 OP PSYCH CLINIC				1, 747, 486 4, 235, 570		
90.05	09100 EMERGENCY	0					1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						
92.00	OTHER REIMBURSABLE COST CENTERS	0	<u> </u>		J 31, 311, 031	0.000000	72.00
04 00	09400 HOME PROGRAM DIALYSIS	1 0	0		0	0. 000000	94. 00
	09500 AMBULANCE SERVICES		١		,	0.00000	95.00
200.00		0	638, 123	63 <u>8</u> 123	1, 697, 862, 351		200.00
200.00	7 Total (Tilles 30 till ough 177)	1	1 030, 123	1 030, 123	1,071,002,331	I	₁ 200.00

Health Financial Systems	IU HEALTH BLOOMINGT	IU HEALTH BLOOMINGTON HOSPITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT (OUTDATIENT	MICH LARY CERVILOE OTHER DACC	D CON 15 0051	D!!	Wasaliala a de D

Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS From 01/01/2021 To 12/31/2021 THROUGH COSTS Date/Time Prepared: 5/26/2022 1:09 pm Title XVIII Hospi tal **PPS** Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges $(col. 6 \div col$ Costs (col. Costs (col. x col. 10) x col. 12) 7) 13. 00 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 32, 165, 879 32, 176, 225 0 0 50.01 05001 CV SURGERY 0.000000 0 50.01 05100 RECOVERY ROOM 0.000000 2, 372, 338 0 6, 813, 995 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 12, 939 52.00 52.00 162, 454 0 05300 ANESTHESI OLOGY 0.000000 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 8, 412, 884 0 6, 380, 550 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 2, 059, 324 36, 480, 436 0 55.00 05600 RADI OI SOTOPE 0.000000 0 56 00 0 56 00 0 57.00 05700 CT SCAN 0.000000 5, 137, 761 5, 661, 649 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 1, 089, 005 1, 238, 763 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 11, 015, 922 0 5, 515, 963 0 59.00 06000 LABORATORY 60 00 0.000000 16, 017, 869 6, 832, 860 60 00 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 5, 745, 333 65.00 0.000000 596, 543 0 65.00 06600 PHYSI CAL THERAPY 124, 847 66 00 0.000000 4, 592, 634 0 66 00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 6, 354, 248 3, 637, 354 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0.000000 578, 471 70 00 1, 266, 184 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 12, 241, 702 0 15, 987, 407 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 32, 539, 431 20, 520, 886 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.001917 33, 207, 583 63, 659 91, 264, 023 174, 953 73.00 07302 OP PHARMACY 0.000000 73.01 73 01 0 0 07400 RENAL DIALYSIS 74.00 0.000000 1, 773, 831 0 45, 623 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 75.00 0.000000 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75. 01 0.000000 0 75.01 07697 CARDIAC REHABILITATION 0 894, 872 76.97 0.000000 93, 330 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0.000000 4,613 1, 187, 232 1, 373, 662 09001 OP ONCOLOGY INFUSION CENTER 0.000000 0 90.01 90.01 14, 762, 645 0 09002 WOUND CARE CENTER 0 90 02 0.000000 26, 245 1, 618, 928 Λ 90 02 09003 PAIN CLINIC 0.000000 338, 077 90.03 90.03 09005 OP PSYCH CLINIC 0 90.05 0.000000 4, 265 305, 629 0 90.05 09100 EMERGENCY 0 26, 636, 449 91.00 0.000000 18, 931, 081 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 171, 149 20, 795, 663 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95. 00 09500 AMBULANCE SERVICES 95 00 63, 659 200.00 Total (lines 50 through 199) 196, 071, 014 301, 095, 742 174, 953 200. 00

Heal th	Financial Systems I	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0051	Peri od:	Worksheet D	
					From 01/01/2021	Part V	
					To 12/31/2021	Date/Time Pre 5/26/2022 1:0	parea:
			Ti +Lo	xVIII	Hospi tal	PPS	9 рііі
			11110	Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge	DDC Doimburged		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9	11131.)	Subject To	Subject To		
		1 al t 1, col. 7		Ded. & Coins	,		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50.00	05000 OPERATI NG ROOM	0. 117958	32, 176, 225		0 0	3, 795, 443	50.00
50. 01	05001 CV SURGERY	0. 000000	02, 170, 220		0 0	0, 7,0, 1.10	50. 01
51. 00	05100 RECOVERY ROOM	0. 217424	6, 813, 995		0 0	1, 481, 526	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 225328	12, 939		0 0	2, 916	
53. 00	05300 ANESTHESI OLOGY	0. 000000	12, 707		0 0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 169491	6, 380, 550		0 0	1, 081, 446	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 059914	36, 480, 436		0 0	2, 185, 689	
56. 00	05600 RADI OI SOTOPE	0. 000000	30, 400, 430	1	0 0	2, 103, 007	1
57. 00	05700 CT SCAN	0. 037366	5, 661, 649		0 0	211, 553	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 037300	1, 238, 763		0 0	151, 913	
59. 00	05900 CARDIAC CATHETERIZATION	0. 122033	5, 515, 963		0 0	315, 408	
60.00	06000 LABORATORY	0. 037181	6, 832, 860	l .	0 0	1, 177, 015	
	1	1	0, 832, 800				1
64.00	06400 I NTRAVENOUS THERAPY	0.000000	E04 E43			152 142	
65. 00	06500 RESPI RATORY THERAPY	0. 256716	596, 543	1		153, 142	1
66. 00	06600 PHYSI CAL THERAPY	0. 349358	124, 847		٥	43, 616	
67. 00	06700 OCCUPATIONAL THERAPY	0. 000000	0		-	0	
68. 00	06800 SPEECH PATHOLOGY	0.000000	0 (07 054		0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 044897	3, 637, 354	•	0	163, 306	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 164292	1, 266, 184		0	208, 024	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 180534	15, 987, 407		0	2, 886, 271	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 163032	20, 520, 886		0 0	3, 345, 561	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 174376	91, 264, 023		0 58, 204	15, 914, 255	
73. 01	07302 OP PHARMACY	1. 151444	0		0	0	73. 01
74. 00	07400 RENAL DIALYSIS	0. 464674	45, 623		0	21, 200	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 400090	894, 872		0 0	358, 029	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	4 504004	4 407 000	1		4 000 070	
90.00	09000 CLINIC	1. 524024	1, 187, 232		0	1, 809, 370	
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 209370	14, 762, 645		0	3, 090, 855	
90. 02	09002 WOUND CARE CENTER	0. 188024	1, 618, 928		0	304, 397	1
90. 03	09003 PAIN CLINIC	0. 632749	338, 077		0	213, 918	1
90. 05	09005 OP PSYCH CLINIC	0. 673936	305, 629		0	205, 974	
91. 00	09100 EMERGENCY	0. 086446	26, 636, 449		0	2, 302, 614	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 146396	20, 795, 663		0 0	3, 044, 402	92.00
	OTHER REIMBURSABLE COST CENTERS			1	_ _		
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000			0		94.00
95. 00	09500 AMBULANCE SERVI CES	0. 176978			0		95. 00
200.00	, ,		301, 095, 742		0 58, 204	44, 467, 843	
201.00					0		201. 00
202.00	Only Charges (Line 200 Line 201)		201 005 740		50.004	44 447 040	202 00
202.00	Net Charges (line 200 - line 201)		301, 095, 742	l	0 58, 204	44, 467, 843	1202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/26/2022 1:09 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 50.01 05001 CV SURGERY 0000000000000000000000000000 0 50.01 51. 00 05100 RECOVERY ROOM 0 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 10, 149 73.00 73. 01 07302 OP PHARMACY 0 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75.01 0 75.01 07697 CARDIAC REHABILITATION 76.97 76.97 0 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 0 90.00 90.00 0 09001 OP ONCOLOGY INFUSION CENTER 90. 01 0 90.01 09002 WOUND CARE CENTER 0 90. 02 0 0 90.02 09003 PAIN CLINIC 90.03 0 90.03 09005 OP PSYCH CLINIC 90.05 0 90.05 0 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95. 00 09500 AMBULANCE SERVICES 0 0 95.00 Subtotal (see instructions) Less PBP Clinic Lab. Services-Program 200.00 200.00 10, 149

0

10, 149

201. 00

202.00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

		U HEALTH BLOOMI				u of Form CMS-	2552-10
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0051	Peri od:	Worksheet D	
			Component	CCN: 15-T051	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/26/2022 1:0	pared:
			Ti tl e	e XVIII	Subprovider - IRF	PPS	, p
	Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATI NG ROOM	1, 763, 550	239, 328, 144			24	1
50. 01	05001 CV SURGERY	0		0.0000		0	50. 01
51. 00	05100 RECOVERY ROOM	239, 472		•		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 003, 338	38, 708, 351			0	52. 00
53.00	05300 ANESTHESI OLOGY	0	1			0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	603, 369	51, 483, 232	0. 01172	5, 596	66	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	684, 324	97, 256, 258	0. 00703	66 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0) C	0.00000	0 0	0	56. 00
57.00	05700 CT SCAN	63, 567	37, 104, 892	0. 00171	3 4, 944	8	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	65, 658	9, 259, 042	0.00709	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	263, 965	72, 646, 195	0.00363	0	0	59. 00
60.00	06000 LABORATORY	673, 352	126, 652, 432	0. 00531	7 103, 820	552	60.00
64.00	06400 I NTRAVENOUS THERAPY	0) C	0.00000	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	96, 064	21, 296, 753	0. 00451	1 19, 351	87	65.00
66.00	06600 PHYSI CAL THERAPY	385, 329	31, 396, 128	0. 01227	1, 373, 296	16, 854	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0) c	0. 00000	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0) c	0. 00000	0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	81, 527	28, 178, 028	0. 00289	5, 007	14	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	121, 655	7, 685, 510	0. 01582	.9 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	194, 177	88, 969, 814	0. 00218	15, 634	34	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	291, 684	147, 655, 652	0. 00197	'5 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	694, 636	332, 874, 658	0. 00208	248, 960	520	73. 00
73. 01	07302 OP PHARMACY	21, 833	1, 867, 246	0. 01169	0	0	73. 01
74.00	07400 RENAL DIALYSIS	40, 178	4, 411, 873	0. 00910	07	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0) c	0. 00000	0 0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0) c	0. 00000	0 0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	109, 292	2, 836, 327	0. 03853	3, 100	119	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	625, 820	2, 592, 524	0. 24139	04 0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	639, 249		•		0	90. 01
90. 02	09002 WOUND CARE CENTER	148, 606				0	90. 02
90. 03	09003 PAIN CLINIC	94, 656		•		0	90. 03
90. 05	09005 OP PSYCH CLINIC	363, 020				0	90. 05
91. 00	09100 EMERGENCY	1, 015, 858				4	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
	OTHER REIMBURSABLE COST CENTERS	· -					1
94.00	09400 HOME PROGRAM DIALYSIS	0) C	0.00000	0 0	0	94. 00

10, 284, 179 1, 697, 862, 351

0 94.00 95.00 18,282 200.00

0

1, 783, 891

Heal th	Financial Systems II	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-:	2552_10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od:	Worksheet D	2332-10
	H COSTS	WICE OTHER TAS			From 01/01/2021	Part IV	
			Component	CCN: 15-T051	To 12/31/2021		
			Ti +Lo	XVIII	Subprovi der -	5/26/2022 1:0 PPS	19 pm
			11116	: AVIII	I RF	FF3	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	ANOLI ADV. OFDINOS OCCUPANDO	1.00	2A	2. 00	3A	3. 00	
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			ı			FO 00
50. 00 50. 01	05000 OPERATING ROOM	0	1		0 0	1	
50.01	05100 RECOVERY ROOM	0		1			50.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	
53. 00	05300 ANESTHESI OLOGY	0				0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0					
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	ر آ	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0 0	ر ا	56. 00
57. 00	05700 CT SCAN	0	0		0	o o	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	O		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	O		0 0	o o	59. 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	1 07.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	1 , 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0			638, 123	
	07302 OP PHARMACY	0				0	
	07400 RENAL DIALYSIS	0	0			0	
75. 00 75. 01	07500 ASC (NON-DISTINCT PART) 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0			0	75.00
75. 01 76. 97	07697 CARDIAC REHABILITATION	0				0	
10.71	OUTDATIENT CEDALCE COCT CENTERS		<u> </u>	1	<u> </u>		10.71

0

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638, 123 200. 00

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94.00

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90.01

90.02

90.03

90.05

91.00

92.00

94.00

200.00

09002 WOUND CARE CENTER

09005 OP PSYCH CLINIC

09003 PAIN CLINIC

95. 00 09500 AMBULANCE SERVICES

09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09400 HOME PROGRAM DIALYSIS

09001 OP ONCOLOGY INFUSION CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

09000 CLI NI C

<i>J</i>	U HEALTH BLOOMI			In Lie	u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider C	CN: 15-0051 F	Period: From 01/01/2021	Worksheet D Part IV	
THROUGH COSTS		Component		To 12/31/2021	Date/Time Pre 5/26/2022 1:0	pared: 9 pm
		Title	: XVIII	Subprovi der - I RF	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		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	5. 00	6.00	7. 00	instructions) 8.00	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
50. 00 05000 OPERATI NG ROOM	0	0		239, 328, 144	0. 000000	50.00
50. 01 05001 CV SURGERY					0. 000000	
51. 00 05100 RECOVERY ROOM	Ö				0. 000000	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0			0. 000000	1
53. 00 05300 ANESTHESI OLOGY	0	0			0. 000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	Ö			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	Ö			0. 000000	1
56. 00 05600 RADI OI SOTOPE	0	0			0. 000000	
57. 00 05700 CT SCAN	0	Ö			0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	Ö				0. 000000	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	Ö			0. 000000	
60. 00 06000 LABORATORY	0	Ō			0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	Ō			0. 000000	1
65. 00 06500 RESPIRATORY THERAPY	0	0		21, 296, 753	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		31, 396, 128	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(28, 178, 028	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(7, 685, 510	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(88, 969, 814	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(147, 655, 652	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	638, 123	638, 123	332, 874, 658	0. 001917	73. 00
73. 01 07302 OP PHARMACY	0	0	(1, 867, 246	0. 000000	73. 01
74. 00 07400 RENAL DI ALYSI S	0	0	(4, 411, 873	0. 000000	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(0	0. 000000	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0	0. 000000	75. 01
76. 97 O7697 CARDIAC REHABILITATION	0	0	(2, 836, 327	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS				+		
90. 00 09000 CLI NI C	0				0. 000000	
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0				0. 000000	
90. 02 09002 WOUND CARE CENTER	0	0			0. 000000	
90. 03 09003 PAIN CLINIC	0	0	(0. 000000	
90. 05 09005 0P PSYCH CLINIC	0	0	(0.000000	
91. 00 09100 EMERGENCY	0				0.000000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	(37, 577, 637	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	1 ^	1 ^	1 /		0.000000	04.00
94. 00 09400 HOME PROGRAM DI ALYSIS	0	0	(0	0. 000000	1
95.00 09500 AMBULANCE SERVICES 200.00 Total (Lines 50 through 199)	0	420 122	420 12	1 407 042 251		95.00
200.00 Total (lines 50 through 199)	1	638, 123	038, 12	3 1, 697, 862, 351	I	200. 00

	J HEALTH BLOOMIN				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CO		eriod: rom 01/01/2021	Worksheet D Part IV	
THROUGH COSTS		Component (CCN: 15-T051		Date/Time Pre 5/26/2022 1:0	pared: 9 pm
		Title	XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)	40.00	x col . 10)	10.00	x col . 12)	
ANOLLI ADV. CEDVI OF COCT. CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS		2 221		al		
50. 00 05000 OPERATING ROOM	0. 000000	3, 231	0	0	0	
50. 01 05001 CV SURGERY	0. 000000	0	0	0	0	
51. 00 05100 RECOVERY ROOM	0. 000000	0	0	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 596	0	0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	0	0	0	0	
57. 00 05700 CT SCAN	0. 000000	4, 944	0	0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	103, 820	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0	0	0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	19, 351	0	0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 373, 296	0	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	5, 007	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	15, 634	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 001917	248, 960	477	0	0	73. 00
73. 01 07302 OP PHARMACY	0. 000000	0	0	0	0	73. 01
74. 00 07400 RENAL DI ALYSI S	0. 000000	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	0	0	0	75. 01
76. 97 07697 CARDIAC REHABILITATION	0. 000000	3, 100	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	0	95	0	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0. 000000	0	0	0	0	90. 01
90. 02 09002 WOUND CARE CENTER	0. 000000	0	0	0	0	90. 02
90. 03 09003 PAIN CLINIC	0. 000000	0	0	0	0	90. 03
90. 05 09005 OP PSYCH CLINIC	0. 000000	0	0	o	0	90. 05
91. 00 09100 EMERGENCY	0. 000000	952	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	o	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
a t aa laa taa taar ppaantu ni ti vala	0. 000000	0	0	0	0	94. 00
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000	O	-	-1		
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0.000000	0		[· ·	95. 00

Component CCN: 15-T051 То Date/Time Prepared: 12/31/2021 5/26/2022 1:09 pm Title XVIII Subprovi der -PPS **IRF** Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost PPS Services Cost Rei mbursed Ratio From Services (see Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Subject To Part I, col. Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst. 5. 00 1.00 2.00 4.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 117958 0 50.00 50. 01 05001 CV SURGERY 0.000000 0 0 50.01 0 0 05100 RECOVERY ROOM 0.217424 0 51 00 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 225328 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0. 169491 0 54.00 0 54.00 0 ol 0.059914 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55 00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 0 56.00 57.00 05700 CT SCAN 0.037366 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 0.122633 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 0.057181 0 0 59.00 06000 LABORATORY 0.172258 60.00 60.00 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0.256716 0 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0. 349358 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 0 0 67.00 0 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 0 06900 ELECTROCARDI OLOGY 0.044897 0 0 69.00 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0.164292 0 70.00 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.180534 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 0.163032 0 0 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.174376 0 14 0 73.00 07302 OP PHARMACY 1. 151444 73.01 0 0 0 0 0 73.01 0 0 74.00 07400 RENAL DIALYSIS 0.464674 0 74.00 0 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 0 75.00 75.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 75.01 07697 CARDIAC REHABILITATION 0 76.97 0.400090 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 1.524024 95 0 0 145 90.01 09001 OP ONCOLOGY INFUSION CENTER 0.209370 0 0 0 0 90.01 0 90. 02 09002 WOUND CARE CENTER 0.188024 0 0 90.02 0 09003 PAIN CLINIC 0 0 90.03 0 632749 90 03 0 09005 OP PSYCH CLINIC 0 0 90.05 0.673936 0 0 90.05 91.00 09100 EMERGENCY 0.086446 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.146396 0 0 0 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0.176978 0 95.00 Subtotal (see instructions) 95 0 145 200.00 200.00 14 0 Less PBP Clinic Lab. Services-Program

95

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14

0

201.00

145 202. 00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems	IU HEALTH BLOOMING	In Lieu of Form CMS-2552-10		
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0051	Peri od: From 01/01/2021	Worksheet D Part V
		Component CCN: 15-T051	To 12/31/2021	Date/Time Prepared: 5/26/2022 1:09 pm
		Title XVIII	Subprovi der -	PPS
			IRF	

			Titl€	e XVIII	Subprovi der - I RF	PPS	
		Cos	sts		TIXI		
	Cost Center Description	Cost	Cost				
	, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	NCILLARY SERVICE COST CENTERS			,			
4	5000 OPERATING ROOM	0		1			50.00
4	5001 CV SURGERY	0		1			50. 01
1	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM	0	-	1			51. 00 52. 00
	5300 ANESTHESI OLOGY	0	1	1			53.00
4	5400 RADI OLOGY-DI AGNOSTI C	0	-	1			54.00
	5500 RADI OLOGY-THERAPEUTI C	0	1	1			55.00
4	5600 RADI OLOGI - MEKAI EUTT C	0	-	1			56.00
	5700 CT SCAN	0	1	1			57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	-	1			58.00
	5900 CARDI AC CATHETERI ZATI ON	0	l e	1			59. 00
	6000 LABORATORY	0		1			60.00
1	6400 I NTRAVENOUS THERAPY	0		1			64. 00
	6500 RESPI RATORY THERAPY	0					65. 00
	6600 PHYSI CAL THERAPY	0	l c				66. 00
67. 00 0	6700 OCCUPATIONAL THERAPY	0	C				67. 00
68. 00 0	6800 SPEECH PATHOLOGY	0	C				68. 00
69. 00 0	6900 ELECTROCARDI OLOGY	0	C				69. 00
70. 00 0	7000 ELECTROENCEPHALOGRAPHY	0	C				70. 00
71. 00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)			71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0		1			72. 00
	7300 DRUGS CHARGED TO PATIENTS	0					73. 00
	7302 OP PHARMACY	0	C	•			73. 01
4	7400 RENAL DI ALYSI S	0	C	1			74. 00
1	7500 ASC (NON-DISTINCT PART)	0		1			75. 00
4	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		1			75. 01
	7697 CARDIAC REHABILITATION UTPATIENT SERVICE COST CENTERS	0	C	η			76. 97
	9000 CLINIC	0					90.00
4	9001 OP ONCOLOGY INFUSION CENTER	0		1			90.00
	9002 WOUND CARE CENTER	0		1			90.02
4	9003 PAIN CLINIC	0	1	1			90. 03
4	9005 OP PSYCH CLINIC	0	-	1			90. 05
	9100 EMERGENCY	0		1			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1			92. 00
	THER REIMBURSABLE COST CENTERS						1
	9400 HOME PROGRAM DIALYSIS	0	C				94. 00
95. 00 0	9500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)	0	2	2			200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	0	2	2			202. 00

	Financial Systems TONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	IU HEALTH BLOOMI	Provider C	ON. 15 0051	In Lieu of Form CMS Period: Worksheet D		2552-10
APPURI	TONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provider Co		Period: From 01/01/2021	Worksheet D Part I	
					To 12/31/2021	Date/Time Pre	pared:
						5/26/2022 1:0	9 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col . 1 - col			
		26)		2)			
	1	1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		,		1		
30. 00	ADULTS & PEDIATRICS	4, 414, 043	1	4, 414, 04			
31. 00	INTENSIVE CARE UNIT	433, 057		433, 05			
32. 00	CORONARY CARE UNIT	540, 245		540, 24			
35.00	NEONATAL INTENSIVE CARE UNIT	241, 177		241, 17	· ·		
41. 00	SUBPROVI DER - I RF	229, 899	0	229, 89	9 1, 357		
42.00	SUBPROVI DER	0	0		0	0.00	
	NURSERY	137, 762		137, 76			
200.00	Total (lines 30 through 199)	5, 996, 183		5, 996, 18	3 67, 748		200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6. 00	7. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	ADULTS & PEDIATRICS	834					30. 00
31. 00	INTENSIVE CARE UNIT	1, 294	1				31. 00
32. 00	CORONARY CARE UNIT	0	1				32. 00
35. 00	NEONATAL INTENSIVE CARE UNIT	313					35. 00
41. 00	SUBPROVI DER - I RF	24	4, 066				41. 00
	SUBPROVI DER	0	0				42. 00
42 00	NUDCEDY	1 210	4 4 4 7 7	1			1 12 00

1, 318 3, 783

64, 477 291, 875

42. 00 43. 00 200. 00

42.00 SUBPROVI DER 43.00 NURSERY 200.00 Total (lines 30 through 199)

Heal th Financial	Systems	IU HEALTH BLOOMINGTON HOS	SPITAL	In Lieu	u of Form CMS-2552-10

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0051	Peri od: From 01/01/2021	Worksheet D Part II	
				To 12/31/2021	Date/Time Pre	pared:
		Ti †I	e XIX	Hospi tal	5/26/2022 1:0 PPS	9 pm
Cost Center Description	Capi tal	Total Charges			Capital Costs	
555t 5511t61 55551 pt. 611	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col . 1 ÷ col		column 4)	
	Part II, col.	8)	2)		.,	
	26)		'			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	<u>'</u>					
50. 00 05000 OPERATING ROOM	1, 763, 550	239, 328, 144	0.00736	9 1, 119, 607	8, 250	50.00
50. 01 05001 CV SURGERY	0	0	0. 00000	00	0	50. 01
51.00 05100 RECOVERY ROOM	239, 472	36, 670, 565	0.00653	94, 794	619	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 003, 338	38, 708, 351	0. 02592	20 579, 979	15, 033	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	603, 369	51, 483, 232	0. 01172	20 446, 528	5, 233	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	684, 324	97, 256, 258	0. 00703	59, 176	416	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000	0 0	0	56. 00
57.00 05700 CT SCAN	63, 567	37, 104, 892	0. 00171	3 207, 223	355	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	65, 658	9, 259, 042	0.00709	42, 686	303	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	263, 965	72, 646, 195	0.00363	189, 766	690	59. 00
60. 00 06000 LABORATORY	673, 352		0.00531	7 1, 075, 693	5, 719	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0.00000	00	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	96, 064	21, 296, 753	0. 00451	1 438, 097	1, 976	65. 00
66. 00 06600 PHYSI CAL THERAPY	385, 329				2, 976	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		1	0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0.00000	00	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	81, 527	28, 178, 028	1		624	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	121, 655	7, 685, 510	0. 01582	13, 985	221	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	194, 177	88, 969, 814	0. 00218	588, 119	1, 284	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	291, 684		0.00197	75 814, 135	1, 608	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	694, 636	332, 874, 658	0. 00208	1, 768, 557	3, 691	73. 00
73. 01 07302 OP PHARMACY	21, 833	1, 867, 246	0. 01169	0	0	73. 01
74.00 07400 RENAL DIALYSIS	40, 178			07 69, 153	630	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	O	0.00000	00	0	75. 00
75. 01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	l c	0.00000	00	0	75. 01
76. 97 07697 CARDIAC REHABILITATION	109, 292	2, 836, 327	0. 03853	2, 828	109	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	625, 820	2, 592, 524	0. 24139	0	0	90.00
90.01 09001 OP ONCOLOGY INFUSION CENTER	639, 249	43, 214, 846	0. 01479	96, 741	1, 431	90. 01
90. 02 09002 WOUND CARE CENTER	148, 606	8, 233, 107	0. 01805	0 0	0	90. 02
90. 03 09003 PAIN CLINIC	94, 656	1, 747, 486	0. 05416	0	0	90. 03
90. 05 09005 OP PSYCH CLINIC	363, 020	4, 235, 570	0. 08570	557	48	90. 05
91. 00 09100 EMERGENCY	1, 015, 858			1, 049, 525	4, 760	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	326, 299	37, 577, 637	0. 00868	5, 720	50	92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	10, 610, 478	1, 697, 862, 351		9, 120, 909	56, 026	200. 00

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

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL	-	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS		1	Period: From 01/01/2021 To 12/31/2021	5/26/2022 1:0	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	0000	_	1	0 0 0	0	31. 00 32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVI DER - IRF 42. 00 04200 SUBPROVI DER				0 0	0 0	41. 00 42. 00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)				0	0	43. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.00
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	C	51, 56	7 0.00	834	30.00
31.00 03100 INTENSIVE CARE UNIT		C	4, 29	0.00	1, 294	31. 00
32. 00 03200 CORONARY CARE UNIT		C	.,			
35.00 02060 NEONATAL INTENSIVE CARE UNIT		C	0,02			1
41. 00 04100 SUBPROVI DER - RF	C	_	1 ., 00			
42. 00 04200 SUBPROVI DER	C	_	1	0.00		
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)		C				
200.00 Total (lines 30 through 199) Cost Center Description	Inpatient		67, 74	5	3, 783	200. 00
	Program Pass-Through Cost (col. 7 x col. 8) 9.00	-				
INPATIENT ROUTINE SERVICE COST CENTERS						20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT						30. 00 31. 00 32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	C					35. 00
41. 00 04100 SUBPROVI DER - RF	C					41.00
42. 00 04200 SUBPROVI DER	C					42.00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	C					43. 00 200. 00

| Peri od: | Worksheet D | Part IV | To | 12/31/2021 | Date/Time Prepared: | To | To | To | Part IV | Part
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

					10 12/31/202	5/26/2022 1:0	
			Ti tl	e XIX	Hospi tal	PPS	7 PIII
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	, and the second	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments		_		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C)	0	0 0	
50. 01	05001 CV SURGERY	0	C)	0	0 0	50. 01
51.00	05100 RECOVERY ROOM	0	C)	0	0 0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C)	0	0 0	52. 00
53.00	05300 ANESTHESI OLOGY	0	C)	0	0 0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	0	0 0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C)	0	0 0	55. 00
56.00	05600 RADI OI SOTOPE	0	C)	0	0 0	56. 00
57.00	05700 CT SCAN	0	C)	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0	0	59. 00
60.00	06000 LABORATORY	0	C		0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	C		0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	0	C		0	0 0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	l c		0	0 0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	l		0	0 (67. 00
68.00	06800 SPEECH PATHOLOGY	0	C		0	0 0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	l c		0	0 0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	l c		0	0 0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l c		0	0 0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0	o l	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0	638, 123	73. 00
73. 01	07302 OP PHARMACY	0	l c		0	ol o	1
74. 00	07400 RENAL DIALYSIS	0	l c		0	ol o	1
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	ol o	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	l c		0		75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	l c		0		76. 97
	OUTPATIENT SERVICE COST CENTERS			•	-		
90.00	09000 CLI NI C	0	C		0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	l c			ol o	
90. 02	09002 WOUND CARE CENTER	0	l c		0	ol o	90. 02
90. 03	09003 PAIN CLINIC	0	l c		0	ol o	90. 03
90. 05	09005 OP PSYCH CLINIC	0			0		90. 05
91. 00	09100 EMERGENCY	0	l d		0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_		0	0	
,	OTHER REIMBURSABLE COST CENTERS					<u> </u>	1
94. 00	09400 HOME PROGRAM DIALYSIS	0	С	ol	0 (0 0	94. 00
95. 00	09500 AMBULANCE SERVICES				,		95.00
200.00		0	c		0	638, 123	
200.00	1.2.2. (1	1	1	-1	-1 333, 120	1=30.00

Heal th	Financial Systems I	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2021	Part IV	
					To 12/31/2021	Date/Time Pre	pared:
						5/26/2022 1:0	9 pm
			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.	Outpatient	(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)	
			ŕ	and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0	0		0 239, 328, 144	0.000000	50.00
50. 00	05001 CV SURGERY		0		0 237, 320, 144		1
		1					ł
51.00	05100 RECOVERY ROOM	0	0		0 36, 670, 565		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 38, 708, 351	0. 000000	1
53.00	05300 ANESTHESI OLOGY	0	0		0	0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 51, 483, 232		•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 97, 256, 258	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0.000000	56. 00
57.00	05700 CT SCAN	0	0		0 37, 104, 892	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 9, 259, 042	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 72, 646, 195		
60.00	06000 LABORATORY	0	0	•	0 126, 652, 432		ı
64. 00	06400 I NTRAVENOUS THERAPY	Ö	0	1	0 120, 002, 102	0. 000000	•
65. 00	06500 RESPI RATORY THERAPY	0	0		0 21, 296, 753		
66. 00	06600 PHYSI CAL THERAPY		0	1	0 31, 396, 128		ł
		0	0		0 31, 390, 120		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0.000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0. 000000	•
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0 28, 178, 028		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 7, 685, 510		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 88, 969, 814	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 147, 655, 652	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	638, 123	638, 12	3 332, 874, 658	0. 001917	73. 00
73. 01	07302 OP PHARMACY	o	0		0 1, 867, 246	0.000000	73. 01
74.00	07400 RENAL DI ALYSI S	0	0		0 4, 411, 873		1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0		1
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0	•	o o	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	ő	0		0 2, 836, 327		1
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>			2,030,327	0.000000	70.77
90. 00	09000 CLINIC	0	0		0 2, 592, 524	0.000000	90.00
90. 00	09001 OP ONCOLOGY INFUSION CENTER		0				l
		1	0				
90. 02	09002 WOUND CARE CENTER	0	0		0 8, 233, 107		•
90. 03	09003 PAIN CLINIC	0	0	•	0 1, 747, 486		
90. 05	09005 OP PSYCH CLINIC	0	0	•	0 4, 235, 570		1
91.00	09100 EMERGENCY	0	0		0 223, 980, 081	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 37, 577, 637	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0.000000	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
200.00		0	638, 123	638, 12	3 1, 697, 862, 351		200.00
	, , , , , , , , , , , , , , , , , , , ,			•			

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2021 THROUGH COSTS Part IV 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm Title XIX Hospi tal PPS Outpati ent Outpati ent Cost Center Description Inpatient I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. $(col. 6 \div col$ Costs (col. x col . 12) 13.00 7) x col. 10) 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0.000000 1, 119, 607 0 0 50.00 0 50.01 05001 CV SURGERY 0.000000 0 50.01 05100 RECOVERY ROOM 0.000000 94, 794 0 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 579, 979 0 52.00 52.00 0 0 0.000000 53.00 05300 ANESTHESI OLOGY 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 446, 528 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 59, 176 0 0 55.00 0 05600 RADI OI SOTOPE 0.000000 56 00 0 56 00 207, 223 0 05700 CT SCAN 57.00 0.000000 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 42, 686 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 189, 766 0 59.00 0 06000 LABORATORY 0.000000 60 00 60 00 1,075,693 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0.000000 438, 097 0 65.00 0 65.00 0 06600 PHYSI CAL THERAPY 66 00 0.000000 242, 462 0 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 215, 578 0 69.00 07000 ELECTROENCEPHALOGRAPHY 13, 985 0 70 00 0.000000 70 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 588, 119 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 814, 135 0 72.00 1, 768, 557 73.00 07300 DRUGS CHARGED TO PATIENTS 0.001917 3, 390 0 73.00 07302 OP PHARMACY 0.000000 73.01 73.01 0 0 07400 RENAL DIALYSIS 0 74.00 0.000000 69, 153 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75. 01 75. 01 0.000000 0 07697 CARDIAC REHABILITATION 0 0.000000 2,828 0 76.97 76.97 OUTPATIENT SERVICE COST CENTERS

0.000000

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09000 CLI NI C

09001 OP ONCOLOGY INFUSION CENTER

OTHER REIMBURSABLE COST CENTERS

09400 HOME PROGRAM DIALYSIS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

09002 WOUND CARE CENTER

09005 OP PSYCH CLINIC

09003 PAIN CLINIC

95. 00 09500 AMBULANCE SERVICES

09100 EMERGENCY

90 00

90.01

90 02

90.03

90.05

91.00

92.00

94.00

200.00

Health Financial Systems 10 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	U HEALTH BLOOMI IL COSTS	Provi der C	F	Period: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet D Part II Date/Time Pre 5/26/2022 1:0	pared:
		Ti tl	e XIX	Subprovi der -	PPS	9 рііі
Cost Center Description	Capi tal		Ratio of Cost	Inpati ent	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col .	Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
50. 00 05000 OPERATI NG ROOM	1, 763, 550	239, 328, 144	0. 007369	0	0	50.00
50. 01 05001 CV SURGERY	0	0	0. 000000	o	0	50. 01
51. 00 05100 RECOVERY ROOM	239, 472	36, 670, 565	0. 006530	o	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 003, 338	38, 708, 351	0. 025920	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.000000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	603, 369		0. 011720		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	684, 324	97, 256, 258	•		0	
56. 00 05600 RADI OI SOTOPE	0	0	0.000000		0	56. 00
57. 00 05700 CT SCAN	63, 567	37, 104, 892	0. 001713		0	01.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	65, 658		0. 007091		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	263, 965				0	59.00
64. 00 06400 I NTRAVENOUS THERAPY	673, 352	126, 652, 432	0. 005317 0. 000000		0	60.00
65. 00 06500 RESPI RATORY THERAPY	96, 064	21, 296, 753	•		0	65.00
66. 00 06600 PHYSI CAL THERAPY	385, 329				0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0 0 0		0. 000000		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	1	0. 000000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	81, 527	28, 178, 028			0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	121, 655				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	194, 177	88, 969, 814		o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	291, 684	147, 655, 652	0. 001975	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	694, 636	332, 874, 658	0. 002087	0	0	73. 00
73. 01 07302 OP PHARMACY	21, 833				0	
74. 00 07400 RENAL DI ALYSI S	40, 178				0	,
75. 00 07500 ASC (NON-DISTINCT PART)	0	0			0	
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0. 000000		0	
76. 97 O7697 CARDI AC REHABILITATION	109, 292	2, 836, 327	0. 038533	8 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC	625, 820	2, 592, 524	0. 241394	l 0	0	90.00
90. 01 09000 CLINIC 90. 01 09001 OP ONCOLOGY INFUSION CENTER	639, 249				0	
90. 02 09002 WOUND CARE CENTER	148, 606		0.014792		0	1
90. 03 09003 PAI N CLI NI C	94, 656				0	1
90. 05 09005 OP PSYCH CLINIC	363, 020				0	
91. 00 09100 EMERGENCY	1, 015, 858		0.003707		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
OTHER REIMBURSABLE COST CENTERS				-		1
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94. 00
OF OO LOOFOO AMBULLANOE CERVILOEC	1	I	I .	1		1 05 00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)		1, 697, 862, 351		0		95. 00 200. 00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR THROUGH COSTS	RY SERVICE OTHER PASS			Peri od: From 01/01/2021	Worksheet D Part IV	
		·	CCN: 15-T051	To 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		Ti tl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
50. 01 05001 CV SURGERY	0	0		0 0	0	50. 01
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53. 00
E4 OO OE4OO DADLOLOCY DIACNOSTIC		0	I		0	I = 1 00

		II JIEAL TU DI COMI	NOTON HOODITAL			C.F. ONC	0550 40
APPOR1	Financial Systems I TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS	U HEALTH BLOOMI RVICE OTHER PASS	S Provider C		In Lie Period: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet D Part IV Date/Time Pre 5/26/2022 1:0	epared:
			Ti tl	e XIX	Subprovider - IRF	PPS	
	Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C,	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see	
		4.00	5.00	6. 00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00	05000 OPERATING ROOM	0	0		0 239, 328, 144	0. 000000	50.00
50. 00	05001 CV SURGERY	0			0 234, 328, 144	0. 000000	
51. 00	05100 RECOVERY ROOM		l .		0 36, 670, 565	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 38, 708, 351	0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0	1	0 30, 700, 331	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 51, 483, 232	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 97, 256, 258	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0		0 77, 230, 230	0. 000000	
57. 00	05700 CT SCAN	0			0 37, 104, 892	0. 000000	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	•	0 9, 259, 042	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 72, 646, 195	0. 000000	
60. 00	06000 LABORATORY	0	0		0 126, 652, 432	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0			0 120, 032, 432	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	0	0		0 21, 296, 753	0. 000000	
66. 00	06600 PHYSI CAL THERAPY		0		0 31, 396, 128	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY		Ö		0 31, 370, 120	0. 000000	
68. 00	06800 SPEECH PATHOLOGY				0 0	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY				0 28, 178, 028	0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY				0 7, 685, 510	0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 88, 969, 814	0. 000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 147, 655, 652	0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	_			0. 001917	1
73. 00	07302 OP PHARMACY		030, 123		0 1, 867, 246	0. 000000	1
74. 00	07400 RENAL DI ALYSI S		0		0 4, 411, 873	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	_		0 4, 411, 679	0. 000000	1
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	Ö		o o	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0			0 2, 836, 327	0. 000000	1
, 0. , ,	OUTPATIENT SERVICE COST CENTERS				2/000/02/	0,00000	1
90.00	09000 CLI NI C	0	0		0 2, 592, 524	0. 000000	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0			0 43, 214, 846	0. 000000	
90. 02	09002 WOUND CARE CENTER	0	0		0 8, 233, 107	0. 000000	
90. 03	09003 PAIN CLINIC	0	l o		0 1, 747, 486	0. 000000	1
90. 05	09005 OP PSYCH CLINIC	0	Ō		0 4, 235, 570	0. 000000	
91. 00	09100 EMERGENCY	0	0		0 223, 980, 081	0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 37, 577, 637	0. 000000	
	OTHER REIMBURSABLE COST CENTERS	<u> </u>		•	, , , , , , , , , , , , , , , , , , , ,		1
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0.000000	94. 00
95.00	09500 AMBULANCE SERVICES	1					95.00
200.00	Total (lines 50 through 199)	0	638, 123	638, 12	3 1, 697, 862, 351		200. 00

Health Financial Systems II APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	U HEALTH BLOOMIN RVICE OTHER PASS	Provi der C	CN: 15-0051 P	eriod: rom 01/01/2021	u of Form CMS-2 Worksheet D Part IV Date/Time Pre	pared:
		Ti tl	e XIX	Subprovider -	5/26/2022 1: 0 PPS	9 pm
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
ANCI LLARY SERVI CE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATI NG ROOM 50. 01 05001 CV SURGERY 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 73. 01 07302 OP PHARMACY 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000 0. 000000			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 73. 01 74. 00 75. 01
0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 90. 01 09001 OP ONCOLOGY INFUSION CENTER 90. 02 09002 WOUND CARE CENTER 90. 03 09003 PAIN CLINIC	0. 000000 0. 000000 0. 000000 0. 000000	000000000000000000000000000000000000000	0	0 0	0 0 0	
90. 05	0. 000000 0. 000000 0. 000000	000000000000000000000000000000000000000	0 0	0 0	0 0	90. 05 91. 00
94. 00	0. 000000	C			0	94. 00 95. 00 200. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2021	Worksheet D-1	
			Date/Time Pre	pared:
			5/26/2022 1:0	9 pm
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	5/26/2022 1: 0 PPS	9 pm
	Cost Center Description	I tie will	1103pi tai	113	
1.0					
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,				1. 00 2. 00 3. 00
4. 00 5. 00	.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost				4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6. 00
7. 00				0	7. 00
8. 00				0	8. 00
9. 00				15, 688	9. 00
10. 00	through December 31 of the cost reporting period (see instructions)				10. 00
11. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12. 00 13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)			0	12. 00 13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this lin	e)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	am (exciduling swring-bed	uays)	0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medical d rate for swing-bed NF services applicable to services reporting period	J		0.00	19. 00
20. 00	Medical drate for swing-bed NF services applicable to services reporting period		he cost	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to SNF type services through $December 5 ext{ x line } 17$)		ing period (line	74, 417, 936 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x,y) line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		74, 417, 936	26. 00 27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation hed ch	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	a and observation bed on	ui ges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 74, 417, 936	36. 00 37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		1	1 442 12	20 00
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 443. 13	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		22, 639, 823 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		22, 639, 823	
11.00	22, 007, 025				

MPUT	Financial Systems II ATION OF INPATIENT OPERATING COST	U HEALTH BLOOMIN	Provider CC		Peri od:	w of Form CMS-2 Worksheet D-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:0	
			Title	XVIII	Hospi tal	PPS	7 Pili
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	10, 342, 050	4, 293	2, 409. 0	1, 512	3, 642, 484	43.
. 00		8, 806, 573	4, 293 4, 188	2, 102. 8			
5. 00	BURN INTENSIVE CARE UNIT	0,000,373	4, 100	2, 102. 0	1, 307	3, 341, 303	45.
	SURGICAL INTENSIVE CARE UNIT						46.
. 00	NEONATAL INTENSIVE CARE UNIT	4, 891, 510	3, 527	1, 386. 8	8 0	0	47.
	Cost Center Description					1 00	
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 29, 201, 496	48.
0.00	Total Program inpatient costs (sum of lines			ns)		58, 825, 168	
	PASS THROUGH COST ADJUSTMENTS	V , ,		•			
0. 00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, sum	of Parts I and	1, 700, 405	50.
. 00	Describerant costs applicable to Drogram in	ationt anaillam	u comulaca (fr	om Wko+ D o	um of Dosto II	074 (77	F1
. 00	Pass through costs applicable to Program inpland IV)	attent anditially	y services (iii	UIII WKSt. D, S	uii 01 Pai 15 11	974, 677	51.
2. 00	Total Program excludable cost (sum of lines	50 and 51)				2, 675, 082	52
3. 00	Total Program inpatient operating cost exclu	9 1	lated, non-phy	sician anesth	etist, and	56, 150, 086	53.
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00						0.00	
. 00	Target amount (line 54 x line 55)					0	1
. 00	Difference between adjusted inpatient operat	ing cost and tar	rget amount (I	ine 56 minus	line 53)	0	
. 00	, , ,		1. 4007			0	
. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period (enaing 1996, u	paatea ana co	mpounded by the	0.00	59
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the ma	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 e	enter the Less	er of 50% of	the amount by	0	61
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			_	63
	PROGRAM INPATIENT ROUTINE SWING BED COST	(1000)					
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	cost reporti	ng period (See	0	64
. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	to after Decembe	or 21 of the e	oct roporting	pariod (Saa	0	65
. 00	instructions)(title XVIII only)	ts arter beceiling	er 31 or the co	ust reporting	perrou (see	0	05
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVII	I only). For	0	66
	CAH (see instructions)						
. 00	9 1	e costs through	December 31 o	f the cost re	porting period	0	67
3 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	rting period	0	68
00	(line 13 x line 20)	0 00010 0.10. 0.		0001 . 000	g por . ou		
00 .	Total title V or XIX swing-bed NF inpatient					0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						7.0
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70 71
2. 00	Program routine service cost (line 9 x line		THE 70 . TIME .	2)			72
. 00	Medically necessary private room cost applic	abĺe to Program	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv						74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	orksheet B, P	art II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line	,					77
. 00	,	,					78
00	Aggregate charges to beneficiaries for exces	, ,		•	uo lin- 70)		79
00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		UST IIMITATION	(iine /8 min	us iinė 79)		80
. 00	Inpatient routine service cost per drem from)				82
. 00	Reasonable inpatient routine service costs (83
. 00	Program inpatient ancillary services (see in	structions)					84
	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					3, 812	87
	,	•					۱ ' '
3. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 443. 13	88

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Prep 5/26/2022 1:09	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	4, 414, 043	74, 417, 936	0. 05931	4 5, 501, 212	326, 299	90.00
91.00 Nursing Program cost	0	74, 417, 936	0.00000	5, 501, 212	0	91.00
92.00 Allied health cost	0	74, 417, 936	0.00000	5, 501, 212	0	92.00
93.00 All other Medical Education	0	74, 417, 936	0.00000	5, 501, 212	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0051	Peri od: From 01/01/2021	Worksheet D-1
		Component CCN: 15-T051	To 12/31/2021	Date/Time Prepared: 5/26/2022 1:09 pm
		Title XVIII	Subprovi der -	PPS

		In the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			1, 357	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 357	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 357	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
4 00	reporting period	om daya) after December (21 of the cost	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	oni days) arter becember .	of the cost	١	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 3	l of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	596	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-	nly (including private ro	oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar ye			j	10.00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
	reporting period	-			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		2, 206, 640	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
00.00	5 x line 17)	04 6 11			00.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December (x,y)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 206, 640	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and about the had about	2000)		20.00
28.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	ous line 33)(see instruct	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin			0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 206, 640	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 626. 12	
39. 00	Program general inpatient routine service cost (line 9 x line			969, 168	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 969, 168	40.00
- 1. 00	Total Trogram general Impatrent routine service cost (IIIIe 37	11110 40)	'	707, 100	71.00

Heal th	Financial Systems	J HEALTH BLOOMING	TON HOSPITAL		In Li€	eu of Form CMS-2	<u> 2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Peri od: From 01/01/2021	Worksheet D-1	
			Component C		To 12/31/2021	Date/Time Pre 5/26/2022 1:0	
				XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient CostIn	Total Ipati ent Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42, 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		0. 0	0		42.00
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0. 0 0. 0			
45. 00	BURN INTENSIVE CARE UNIT		Ĭ	0. 0		Ĭ	45. 00
46.00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	o	0	0. 0	00	_	46. 00 47. 00
47.00	Cost Center Description	<u> </u>	<u> </u>	0. 0	0	U	47.00
48. 00	Program inpatient ancillary service cost (Wk	s+ D 2 col 2	Line 200)			1. 00 551, 920	49.00
49. 00	Total Program inpatient costs (sum of lines			ns)		1, 521, 088	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine se	ervices (from	Wkst. D. sum	of Parts I and	100, 974	50.00
			·				
51. 00	Pass through costs applicable to Program inpand IV)	attent ancillary	services (Tro	OM WKST. D, S	um or Parts II	18, 759	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	,	atod non nhw	sician anosth	otist and	119, 733 1, 401, 355	
33.00	medical education costs (line 49 minus line		rteu, non-pny.		etist, and	1, 401, 333	33.00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					Ι ο	54.00
55. 00							55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tare	not amount (Li	ino E4 minus	lino E2)	0	
58. 00	Bonus payment (see instructions)	ing cost and targ	jet alliourit (Fi	THE 36 IIITHUS	111le 55)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	oorting period er	ndi ng 1996, uլ	pdated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the ma	arket basket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61. 00
	amount (line 56), otherwise enter zero (see		(TITIES 54 X)	50), 01 1% 01	the target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST				1 1 (0	1	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	per 31 or the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 of the co	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	l plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through D	December 31 o	f the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of	the cost repo	rting period	0	68. 00
60.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			·	3 1		69. 00
09.00	PART III - SKILLED NURSING FACILITY, OTHER N						09.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		,			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line		ie 70 ÷ Title .	2)			72.00
73.00	Medically necessary private room cost applic		•	ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	orksheet B, F	art II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider records	s)			78. 00 79. 00
80. 00	Total Program routine service costs for comp	arison to the cos			us line 79)		80. 00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (,	1				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	/				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			0.00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	2)				89. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		Title	XVIII	Subprovi der -	PPS	
				<u>I RF</u>		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	229, 899	2, 206, 640	0. 10418	5 0	0	90.00
91.00 Nursing Program cost	0	2, 206, 640	0.00000	0	0	91. 00
92.00 Allied health cost	0	2, 206, 640	0.00000	0	0	92. 00
93.00 All other Medical Education	0	2, 206, 640	0. 00000	0	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Pre 5/26/2022 1:0	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	

DATE OF THE POST PRICE OF THE CONCENTRATE PART OF THE POST PRICE OF THE CONCENTRATE 1.00 PART OF THE POST PRICE OF THE CONCENTRATE 1.00 PART OF THE POST PRICE OF THE CONCENTRATE 1.00 PRICE OF THE POST PRICE OF THE CONCENTRATE OF THE POST PRICE OF THE POST P			Title XIX	Hospi tal	5/26/2022 1: 0 PPS	9 pm
INSERT LET. ALL PROVIDER COMPONENTS		Cost Center Description	THE WAY	1.0001 (4.		
IMPARTIAND PAYS 1.00 Impatient days (including private room days and swing-bed days, excluding nextorn) 51.567 1.00 Impatient days (including private room days, axcluding swing-bed and newborn days) 1.567 2.00 1.00		DART I ALL PROVIDED COMPONENTS			1. 00	
Impatient days (including private room days, excluding swing-bed and neberon days)						
Private room days (excluding swing-bed and observation bed days) If you have only private room days 0 3.00						
do not complete this line. 4. OS Semi-provider from days (excluding saring-bed and observation bed days) through Becember 31 of the cost 7. OS 7. OD 17 of 17 of 18 of						
5.00 Total swing-hed SRF type inpatient days (net uding private room days) strough December 31 of the cost paper in a period period in the cost into cost into cost in the cost into cost into cost into cost in the cost into cos	3.00		/s). If you have only pri	vate room days,	0	3.00
reporting period ("Cale didary sear, enter 0 on this line) 7.00 Total swing-hed SNF type inpatient days (including private room days) after December 31 of the cost reporting period ("Cale didary sear, enter 0 on this line) 8.00 Total swing-hed NF type inpatient days (including private room days) through December 31 of the cost reporting period ("Cale alendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period ("Cale alendar year, enter 0 on this line) 10.00 Swing-hed SNF type inpatient days applicable to the Program (excluding swing-hed and newborn days) (see instructions) 11.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 14.00 Swing-hed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-hed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Newborn days (see instructions) 17.00 Swing-hed NF type inpatient days applicable to titles V or XIX only (including private room days) 18.00 Newborn days (see instructions) 18.00 Newborn days (see inst	4.00		ed days)		47, 755	4. 00
Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) Total inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) Total inpatient days (including private room days) and the program (excluding swing-bed and neathorn days) (see instructions) Total inpatient days (see instructions) Total inpatient (see instructions) Total in	5.00		om days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, either 0 on this line) 7. 00 Total sain-jebed NF type inpatient days (including private room days) shrough December 31 of the cost reporting period to the sain-jebed NF type inpatient days (including private room days) after December 31 of the cost on the sain sain days and period NF type inpatient days (including private room days) after December 31 of the cost on the sain sain sain sain sain sain sain sain	4 00		om days) after December (21 of the cost	0	4 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0.00		oni days) arter becember .	of the cost	0	6.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 0.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0.10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through becember 31 of the cost reporting period (see instructions) 0.10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after some probable of the cost reporting period (see instructions) 0.12 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0.12 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0.13 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 0.13 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 0.13 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 0.14 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 0.14 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 0.14 Swing-bed SNF type services applicable to services through December 31 of the cost 0.00 1.00	7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) after support of the cost reporting period (see instructions) 12.00 Swing-bed SRF type inpatient days applicable to title XVIII only of on this line) 13.00 Swing-bed SRF type inpatient days applicable to title XVIII only of on this line) 13.00 Swing-bed SRF type inpatient days applicable to title XVIII only of on this line) 13.00 Swing-bed SRF type inpatient days applicable to title XVIII only of on this line) 14.00 Swing-bed SRF type inpatient days applicable to title XVIII only of on this line) 15.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) 16.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) 17.00 Swing-bed SRF type inpatient days applicable to the Program (excluding swing-bed days) 18.00 Swing-bed SRF type inpatient days applicable to the Program (excluding swing-bed days) 18.00 Swing-bed SRF type SRF vices applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Swing-Bed SRF type SRF vices applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Swing-Bed SRF services applicable to services through December 31 of the cost reporting period (line SRF type services applicable to services after December 31 of the cost reporting period (line SRF type services through December 31 of the cost reporting period (line SRF type services through December 31 of the cost reporting period (line SRF type services through December 31 of the cost reporting period (line SRF type services through December 31 of the cost reporting peri	0.00			1 -6 +1+		0.00
10.00 Swing-bed SNF type inpati ent days applicable to the Program (excluding swing-bed and sys) 0.00 10.00	8.00		n days) after December 3	or the cost	0	8.00
10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 12. 00 Swing-bed NF type inpatient days applicable to titles VI or XIX only (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Nursery days (title V or XIX only) 17. 00 Nursery days (title V or XIX only) 18. 00 Nursery days (title V or XIX only) 18. 00 Nursery days (title V or XIX only) 19. 00 Nursery days (title V or XIX only	9.00		the Program (excluding	swing-bed and	834	9. 00
through December 31 of the cost reporting period (see Instructions) 1.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.10 SWINDS (including private room days) 1.11 Only after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.12 Only after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.13 Only after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.14 Only after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.15 Only after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.16 Only after December 31 of the cost reporting period (in the cost of calendar year) 1.17 Only after Swing-bed SNF services applicable to services after December 31 of the cost reporting period (in the cost in the cost period year) 1.18 Only after SWINDS after Swing-bed NF services after December 31 of the cost reporting period (line of year) 1.19 Only after Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of year) 1.10 Only after Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of year) 1.10 Only after Swing-bed cost (see instructions) 1.10 Only after Swing-bed cost (see instructions) 1.10 Only after Swing-b					_	
11. 00 Swing-bed SNF type inpatrient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12. 00 Swing-bed NF type inpatrient days applicable to titles V or XIX only (including private room days) 13. 00 Swing-bed NF type inpatrient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16. 00 Nursery days (title V or XIX only) 17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18. 00 Nursery days (title V or XIX only) 18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 20. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 21. 00 Swing-bed cost applicable to SNF type services after December 31	10. 00			oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 12.00 13.00 13.00 14.00 14.00 15.00	11. 00			oom davs) after	0	11. 00
through December 31 of the cost reporting period 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Nursery days (title V or XIX only) 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Micare rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 20. 00 Medical drate for swing-bed services after December 31 of the cost reporting period (line 6 x line 18) 21. 00 Total general inpatient routine service services after December 31 of the cost reporting period (line 6 x line 19) 22. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 24. 00 Swing-bed cost applicable to NF type services after December 31 of t		December 31 of the cost reporting period (if calendar year, en	nter O on this line)	3 ,		
3. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 13. 00	12. 00		only (including private	e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 14,00 15.00 Total nursery days (title V or XIX only) 2,816 15.00 16.00 Nursery days (title V or XIX only) 2,816 15.00 17.00 Nursery days (title V or XIX only) 2,816 15.00 Nursery days (title V or XIX only) 3,318 1,31	13 00		Conty (including private	e room days)	0	13 00
15.00 Total nursery days (title V or XIX only) 1,318 16.00 1.00 1.318 16.00 1.318 16.00 1.318 16.00 1.318 16.00 1.318 16.00 1.318 16.00 1.318 16.00 17.00 18	10.00					10.00
1, 318 16.00 Nursery days (title V or XIX only) 1, 318 16.00 SINING BED ADJUSTMENT 1, 318 16.00 SINING BED ADJUSTMENT 1, 318 16.00 17.00 Modi care rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 19.00 19.00 Modi care rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.0			am (excluding swing-bed o	days)		
SWING BED ADJUSTMENT 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period period rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 period medicare rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 period rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 period period 0.00 medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 period 0.00 period 0.00 medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 period 0.00 peri						
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18. 00 reporting period 19. 00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. 00 1	10.00				1,310	10.00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 19.	17. 00		es through December 31 o	f the cost	0.00	17. 00
reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29.00 Private room charges (excluding swing-bed charges) 20.00 Semi-private room charges (excluding swing-bed charges) 20.00 Overage perivate room per diem charge (line 29 + line 3) 20.00 Average private room per diem charge (line 29 + line 3) 20.00 Average perivate room per diem charge (line 30 + line 4) 20.00 Average perivate room cost differential (line 32 minus line 33) (see instructions) 20.00 Average perivate room cost differential (line 3 x line 31) 20.00 Average perivate room cost differential (line 3 x line 31) 20.00 Average perivate room cost differential (line 3 x line 35) 20.00 Average perivate room cost differential (line 3 x line 35) 20.00 Average perivate room cost differential (line 3 x line 35) 20.00 Average perivate room cost differential (line 3 x line 35) 20.00 Average perivate room cost differential (line 3 x line 35) 20.00 Average perivate room cost diff	40.00		61 5 1 24 6		0.00	40.00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 20	18.00		es after December 31 of	the cost	0.00	18.00
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	Financial Systems I	U HEALTH BLOOMII	NGTON HOSPITAL Provider CO	N: 15_0051	In Lie	worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Co		From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/26/2022 1:0	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient Cost				Program Cost (col. 3 x col.	
				col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1. 00 1, 795, 605	2. 00 2, 816	3. 00 637. 6	4. 00 1, 318	5. 00 840, 410	42 00
12.00	Intensive Care Type Inpatient Hospital Units		2,010	007.0	1,010	010,110	12.00
43.00	INTENSIVE CARE UNIT	10, 342, 050	4, 293				1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	8, 806, 573	4, 188	2, 102. 8	0	0	44. 00 45. 00
46. 00	4						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	4, 891, 510	3, 527	1, 386. 8	313	434, 093	47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk					1, 473, 624	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		7, 069, 008	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	287, 809	50.00
F1 00		-+:+:!!		WI+ D -	£ Dt- 11	FO 41/	F1 00
51. 00	Pass through costs applicable to Program inpland IV)	attent anciliar	y services (Tr	OM WKST. D, S	um or Parts II	59, 416	51.00
52.00	Total Program excludable cost (sum of lines					347, 225	ł
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anesth	etist, and	6, 721, 783	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57. 00	, ,	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)		l' 4007			0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	enaing 1996, u	paatea ana co	mpounaea by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year						60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		s (Titles 54 X	00), 01 1% 01	the target		
	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	<u>ient (see Enstru</u>	CTIONS)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Necemb	ar 31 of the c	ost reporting	narind (See	0	65. 00
	instructions) (title XVIII only)						05.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost re	porting period	0	67. 00
	(line 12 x line 19)						,,,,,,,
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ie costs after D	ecember 31 or	tne cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil					T	70.00
71. 00	Adjusted general inpatient routine service of						71.00
72.00	,		/II: 44 II:	05)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv			ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	,		orksheet B, P	art II, column		75. 00
74 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76. 00
76. 00 77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00	,	,		_			78. 00
79.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*	us line 70)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi		ost iimi tati Oli	(1116 70 11111	MG 11110 17)		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		S)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					3, 812	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 443. 13	88. 00
	Observation bed cost (line 87 x line 88) (se					5, 501, 212	

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2021	Worksheet D-1	
				Γο 12/31/2021	Date/Time Prep 5/26/2022 1:00	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	4, 414, 043	74, 417, 936	0. 05931	5, 501, 212	326, 299	90.00
91.00 Nursing Program cost	0	74, 417, 936	0.00000	5, 501, 212	0	91.00
92.00 Allied health cost	0	74, 417, 936	0.00000	5, 501, 212	0	92.00
93.00 All other Medical Education	0	74, 417, 936	0. 000000	5, 501, 212	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTO	ON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0051	Period: From 01/01/2021	Worksheet D-1
		Component CCN: 15-T051	To 12/31/2021	Date/Time Prepared: 5/26/2022 1:09 pm
		Title XIX	Subprovi der -	PPS
			IDE	

		litie XIX	I RF	PPS	
	Cost Center Description			1	
	DADT I ALL DROW DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		1, 357	1. 00
2.00	Inpatient days (including private room days, excluding swing-k			1, 357	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		1, 357	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	1, 337	5. 00
	reporting period			_	
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n daya) through Dagamban	21 of the cost	0	7. 00
7.00	reporting period	ii days) tiii ougii beceiibei	31 Of the Cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	24	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private r	nom days)	0	10. 00
	through December 31 of the cost reporting period (see instruct	tions)	com dayo)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frictualing privat	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13.00
44.00	after December 31 of the cost reporting period (if calendar ye				
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	2 916	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)				16. 00
	SWING BED ADJUSTMENT			, , ,	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period	30 4. (6. 200020. 0. 0.		0.00	
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	=)		2, 206, 640	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 206, 640	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		, ,	_	
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x line		tions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 206, 640	
	27 minus line 36)		· .		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 626. 12	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			39, 027	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	l	39, 027	41. 00

Heal th	Financial Systems	J HEALTH BLOOMING	STON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN		Period: From 01/01/2021	Worksheet D-1	
			Component CO		To 12/31/2021 Subprovi der -	Date/Time Pre 5/26/2022 1:0 PPS	
					I RF		
	Cost Center Description	Total Inpatient CostIr	Total npatient DaysD	Average Per iem (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	J 0	ΟĮ	0.00	<u>J</u>	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0. 00 0. 00		0	
45. 00	BURN INTENSIVE CARE UNIT		o _l	0.00			45. 00
46.00	SURGICAL INTENSIVE CARE UNIT			0.00			46. 00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	0	0	0.00	0	0	47. 00
10.00	·					1.00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS			s)		0 39, 027	
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	4, 066	50. 00
51. 00		atient ancillary	services (fro	m Wkst D si	ım of Parts II	0	51.00
	and IV)	,	30. 7. 000 (1. 0		01 . 41 . 63 . 1		
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclu		ated non-nhvs	ician anesthe	tist and	4, 066 34, 961	•
00.00	medical education costs (line 49 minus line		area, non phys	rerun unestric	errot, una	31, 701	00.00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and targ	ret amount (li	ne 56 minus l	ine 53)	0 0	
58. 00	Bonus payment (see instructions)	ring cost and targ	get amount (11	ne so ilirius i	THE 33)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	oorting period er	nding 1996, up	dated and cor	npounded by the	0. 00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the ma	rket basket		0.00	60. 00
61. 00							61. 00
	amount (line 56), otherwise enter zero (see			,	3	_	
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	tions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decemb	per 31 of the	cost reportir	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after December	31 of the co	st reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 64	4 plus line 65)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through [December 31 of	the cost rep	oorting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of t	he cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil	<u> </u>					70. 00
71. 00	Adjusted general inpatient routine service co	ost per diem (lir		,			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	,	(line 14 v lin	e 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	•	•	c 55)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service o	costs (from Wo	rksheet B, Pa	art II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79.00	Aggregate charges to beneficiaries for excess				1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		st limitation	(iine /8 minu	ıs iine /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ne 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:	· · · · · · · · · · · · · · · · · · ·)				83. 00 84. 00
85. 00			s)				85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00
87. 00	Total observation bed days (see instructions					0	
88.00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	ine 2)				88. 00 89. 00
U7. UU	Topservation bed cost (Time of X Time of) (Set	o manuchons)				0	1 07.00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		Titl	e XIX	Subprovi der -	PPS	
	-			IRF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	229, 899	2, 206, 640	0. 10418	5 0	0	90. 00
91.00 Nursing Program cost	0	2, 206, 640	0.00000	0	0	91.00
92.00 Allied health cost	0	2, 206, 640	0.00000	0	0	92. 00
93.00 All other Medical Education	0	2, 206, 640	0. 00000	0	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Li	eu of Form CMS-2552-10
INDATI ENT ANGLE LADV CEDVICE COCT ADDODTI ONMENT		D ' 1 OON 45 OOE4	D!I	W I I I D O

Heal th	Financial Systems IU HEALTH BLOOMING	ON HOSPITAL		In Li€	eu of Form CMS-	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 15-0051	Peri od:	Worksheet D-3	}
				From 01/01/2021		
				To 12/31/2021		
					5/26/2022 1:0	19 pm
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				, and the second	2)	
			1.00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			53, 827, 353		30.00
31. 00	03100 NTENSI VE CARE UNI T			9, 770, 587		31. 00
32. 00	03200 CORONARY CARE UNIT			10, 324, 720		32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
41. 00	04100 SUBPROVI DER - I RF			65, 213	l .	41. 00
42.00	04200 SUBPROVI DER			0		42. 00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 1179	58 32, 165, 879	3, 794, 223	50.00
50. 01	05001 CV SURGERY		0.0000	00	0	50. 01
51.00	05100 RECOVERY ROOM		0. 2174		515, 803	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 2253			
53. 00	05300 ANESTHESI OLOGY		0. 0000		0	1
						1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1694			
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 0599			
56.00	05600 RADI 0I SOTOPE		0.0000		1	
57.00	05700 CT SCAN		0. 0373	5, 137, 761	191, 978	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 1226	1, 089, 005	133, 548	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 0571	31 11, 015, 922	629, 901	59. 00
60.00	06000 LABORATORY		0. 1722	58 16, 017, 869	2, 759, 206	60.00
64.00	06400 I NTRAVENOUS THERAPY		0.0000		0	1
65. 00	06500 RESPI RATORY THERAPY		0. 2567			
66. 00	06600 PHYSI CAL THERAPY		0. 3493			
			1			1
67. 00	06700 OCCUPATI ONAL THERAPY		0.0000			
68. 00	06800 SPEECH PATHOLOGY		0.0000		0	
69. 00	06900 ELECTROCARDI OLOGY		0. 0448			
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1642		95, 038	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1805	34 12, 241, 702	2, 210, 043	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1630	32, 539, 431	5, 304, 969	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1743	76 33, 207, 583	5, 790, 605	73. 00
73. 01	07302 OP PHARMACY		1. 1514	44 0	0	73. 01
74.00	07400 RENAL DIALYSIS		0. 4646		824, 253	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0.0000			1
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000			1
	07697 CARDI AC REHABI LI TATI ON		0.4000			
70. 77			0.4000	70 73, 330	37, 340	70.97
00 00	OUTPATIENT SERVICE COST CENTERS		1 5240	24 (12	7 000	00.00
90.00	09000 CLI NI C		1. 5240			1
90. 01	09001 OP ONCOLOGY INFUSION CENTER		0. 2093			
90. 02	09002 WOUND CARE CENTER		0. 1880	24 26, 245	4, 935	90. 02
90. 03	09003 PAIN CLINIC		0. 6327	49 0	0	90. 03
90. 05	09005 OP PSYCH CLINIC		0. 6739	36 4, 265	2, 874	90. 05
91.00	09100 EMERGENCY		0. 0864	46 18, 931, 081	1, 636, 516	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1463	96 171, 149	25, 056	92. 00
	OTHER REIMBURSABLE COST CENTERS			,		1
94. 00	09400 HOME PROGRAM DI ALYSI S		0.0000	00 00	0	94. 00
95. 00	09500 AMBULANCE SERVICES		0.0000	30		95. 00
			[10/ 071 044	20 201 407	
200.00		(1)	1	196, 071, 014	29, 201, 496	
201.00		(IIne 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)		1	196, 071, 014		202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0051 CCN: 15-T051	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Pre 5/26/2022 1:0	pared:
	Ti tl e	e XVIII	Subprovider -	PPS	19 pili
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NEONATAL INTENSIVE CARE UNIT ADV. CERTIFICATION ADV. CERTIFICATIO			1, 493, 173		30. 0 31. 0 32. 0 35. 0 41. 0 42. 0 43. 0
ANCILLARY SERVICE COST CENTERS 50.00 OFERATING ROOM		0 11705	0 2 221	381	50.0
50.00 05000 0PERATING ROOM 50.01 05001 CV SURGERY		0. 11795 0. 00000		381	
51. 00 05100 RECOVERY ROOM		0. 21742		0	1
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 21742		0	
53. 00 05300 ANESTHESI OLOGY		0. 00000		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16949		948	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 05991		0	1
56. 00 05600 RADI 0I SOTOPE		0.00000		0	1
57. 00 05700 CT SCAN		0. 03736		185	
88.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 12263		0	1
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 05718		0	
0. 00 06000 LABORATORY		0. 17225		17, 884	
4. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	1
5. 00 06500 RESPIRATORY THERAPY		0. 25671	6 19, 351	4, 968	65.
6. 00 06600 PHYSI CAL THERAPY		0. 34935	1, 373, 296	479, 772	66.
7. 00 06700 OCCUPATI ONAL THERAPY		0.00000	00	0	67.
8. 00 06800 SPEECH PATHOLOGY		0.00000	00	0	68.
9. 00 06900 ELECTROCARDI OLOGY		0. 04489		225	1
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 16429		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18053		2, 822	1
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 16303		0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17437		43, 413	
3. 01 07302 OP PHARMACY		1. 15144		0	
4. 00 07400 RENAL DI ALYSI S		0. 46467		0	1 ' ''
5. 00 07500 ASC (NON-DI STI NCT PART)		0.00000		0	
5. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 6. 97 07697 CARDI AC REHABI LI TATI ON		0.00000		0	
6. 97 O7697 CARDI AC REHABI LITATION OUTPATIENT SERVICE COST CENTERS		0. 40009	90 3, 100	1, 240	76.
0. 00 09000 CLINIC		1. 52402	24 0	0	90.
0.01 09001 OP ONCOLOGY INFUSION CENTER		0. 20937		0	
20. 02 09002 WOUND CARE CENTER		0. 18802		Ö	
PO. 03 09003 PAIN CLINIC		0. 63274		ő	1
DO DE DODOE DE DEVOU CLINIC		0.6027		0	1

0. 673936

0. 086446

0. 146396

0.000000

1, 783, 891

1, 783, 891

0 90.05

82

0 92.00

0

551, 920 200. 00

91.00

94. 00

95. 00

201.00

202. 00

90. 05 09005 OP PSYCH CLINIC

09100 EMERGENCY

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

OTHER REIMBURSABLE COST CENTERS

91.00

92.00

200.00

201.00

202.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
LABORT FAIT ANGLE AND CORNEL OF COOK ADDODES OF THE	D 11 000 15 0051 D 1 1	

Hear th Frhanciai				In Lie	u or Form CMS	2552-10
INPATIENT ANCILL	LARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre	
					5/26/2022 1:0	9 pm
		litl	e XIX	Hospi tal	PPS	
Cost	t Center Description		Ratio of Cost		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
I NPATI ENT	ROUTINE SERVICE COST CENTERS		•			
	LTS & PEDIATRICS			5, 259, 431		30.00
	ENSI VE CARE UNIT			393, 628		31.00
	ONARY CARE UNIT			424, 522		32.00
	NATAL INTENSIVE CARE UNIT					35.00
				1, 465, 840		
	PROVIDER - IRF			0		41.00
42. 00 04200 SUBF				0		42. 00
43. 00 04300 NURS				189, 440		43. 00
	SERVI CE COST CENTERS					
50. 00 05000 OPER	RATING ROOM		0. 11795	8 1, 119, 607	132, 067	50.00
50. 01 05001 CV S	SURGERY		0.00000	0	0	50. 01
51. 00 05100 RECO	OVERY ROOM		0. 21742	4 94, 794	20, 610	51.00
	IVERY ROOM & LABOR ROOM		0. 22532		130, 686	52.00
	STHESI OLOGY		0. 00000		0	53. 00
	I OLOGY-DI AGNOSTI C		0. 16949			
	I OLOGY-THERAPEUTI C		0. 05991		3, 545	
56. 00 05600 RADI			0.00000		0	56.00
57. 00 05700 CT S			0. 03736		7, 743	
	NETIC RESONANCE IMAGING (MRI)		0. 12263		5, 235	
	DI AC CATHETERI ZATI ON		0. 05718		10, 851	
60. 00 06000 LAB	ORATORY		0. 17225	8 1, 075, 693	185, 297	60.00
64. 00 06400 I NTF	RAVENOUS THERAPY		0.00000	0	0	64.00
65. 00 06500 RESF	PI RATORY THERAPY		0. 25671	6 438, 097	112, 467	65.00
	SI CAL THERAPY		0. 34935	8 242, 462	84, 706	66. 00
	UPATI ONAL THERAPY		0.00000		0	67.00
	ECH PATHOLOGY		0. 00000		Ö	68.00
	CTROCARDI OLOGY		0. 04489		9, 679	69.00
	CTROENCEPHALOGRAPHY		0. 16429		2, 298	
					· ·	
	I CAL SUPPLIES CHARGED TO PATIENTS		0. 18053		106, 175	
	L. DEV. CHARGED TO PATIENTS		0. 16303		132, 730	72. 00
	GS CHARGED TO PATIENTS		0. 17437		308, 394	
73. 01 07302 OP F			1. 15144		0	73. 01
	AL DIALYSIS		0. 46467		32, 134	
75. 00 07500 ASC	(NON-DISTINCT PART)		0.00000	0	0	75. 00
75. 01 03550 PSY	CHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000	0	0	75. 01
76. 97 07697 CARI	DIAC REHABILITATION		0.40009	0 2, 828	1, 131	76. 97
OUTPATI EN	T SERVICE COST CENTERS					1
90. 00 09000 CLI N			1. 52402	4 0	0	90.00
	ONCOLOGY INFUSION CENTER		0. 20937		20, 255	
	ND CARE CENTER		0. 18802		0	90. 02
90. 03 09003 PAIN			0. 63274		0	90. 02
	PSYCH CLINIC		0. 67393		375	90. 05
91. 00 09100 EMEF			0. 08644		90, 727	91.00
	ERVATION BEDS (NON-DISTINCT PART)		0. 14639	6 5, 720	837	92. 00
	MBURSABLE COST CENTERS					
94.00 09400 HOME	E PROGRAM DIALYSIS		0.00000	0	0	94. 00
95. 00 09500 AMBU	ULANCE SERVICES					95. 00
200. 00 Tota	al (sum of lines 50 through 94 and 96 through 98)			9, 120, 909	1, 473, 624	200.00
	s PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
	charges (line 200 minus line 201)			9, 120, 909		202. 00
1.100	<u> </u>		1		•	

		TH BLOOMINGTON HOSPITAL			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0051	Peri od: From 01/01/2021	Worksheet D-3	
		Component	CCN: 15-T051	To 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		Ti tl	e XIX	Subprovi der – I RF	PPS	•
	Cost Center Description	·	Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY ANCILLARY SERVICE COST CENTERS			0		30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
50. 00	05000 OPERATING ROOM		0. 11795	58 0	0	50.00
50. 01	05001 CV SURGERY		0.00000		0	
51.00	05100 RECOVERY ROOM		0. 21742		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 22532	28 0	0	52. 00
53.00	05300 ANESTHESI OLOGY		0.00000	00	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 16949	91 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C		0.05991	14 0	0	55. 00
56.00	05600 RADI OI SOTOPE		0.00000	00	0	
57.00	05700 CT SCAN		0. 03736		0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 12263		0	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 05718		0	1
60.00	06000 LABORATORY		0. 17225		0	
64. 00	06400 I NTRAVENOUS THERAPY		0.00000		0	
65. 00	06500 RESPI RATORY THERAPY		0. 2567		0	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0. 34935		0	
68. 00	06800 SPEECH PATHOLOGY		0.00000		0	
69. 00	06900 ELECTROCARDI OLOGY		0. 04489		0	
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 16429		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18053		0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 16303		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 17437		0	
73. 01	07302 OP PHARMACY		1. 15144		0	
74.00	07400 RENAL DIALYSIS		0. 46467		0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0.00000	00	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000	00	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON		0.40009	90 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS					4
90.00	09000 CLI NI C		1. 52402		0	
90. 01	09001 OP ONCOLOGY INFUSION CENTER		0. 20937		0	
90. 02	09002 WOUND CARE CENTER		0. 18802		0	
90. 03	09003 PAIN CLINIC		0. 63274		0	
90.05	09005 OP PSYCH CLINIC		0. 67393		0	
91. 00 92. 00	09100 EMERGENCY		0. 08644		0	
72. UU	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 14639	96 0	0	J 7∠. UU

0.000000

94.00

95. 00

0 200. 00

201.00

202. 00

0

0 0

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

OTHER REIMBURSABLE COST CENTERS

200.00

201.00

202.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 1:09 pm

PART A INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00				10 12/31/2021	5/26/2022 1:0	
Name			Title XVIII	Hospi tal	PPS	
Name					1 00	
1.00 RSS Amounts other than outlier payments for discharges occurring prior to October 1 (see 0.213, 756 1.00 1.01 1		PART A - INPATIENT HOSPITAL SERVICES LINDER LPPS			1.00	
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 10,13,988 1.01 Instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on a rather October 1 (see 10,13,988 1.01 1.02 DRG for Toedoral specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for Toedoral specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.03 1.04 DRG for Toedoral specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 1.02 1	1.00				0	1.00
DBC amounts other than outlier payments for discharges occurring on or after October 1 (see Instructions) DBC for federal specific operating payment for Wodel 4 BPCI for discharges occurring prior to October 1 (see Instructions) 1.03		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see				
Instructions 1.03 Ref For Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0 1.03		1				
1.03 16 (see instructions) 1.04 18 16 16 16 10 16 16 16 16	1. 02	, ,	on or after October 1	(see	10, 135, 006	1. 02
1 (see instructions)	1 03		discharges occurring r	orior to October	0	1 03
1.04 Oktober Lise Instructions 2.00 0.1.04	1.03		discharges occurring p	or to october	O	1.03
2.00 Outlier payments for discharges (see Instructions) 0.10 0.1	1.04		discharges occurring o	on or after	0	1. 04
Outlier reconciliation anount 0 2.01						
2.02 Outlier payment for discharges cocurring prior to October 1 (see Instructions) 8,25,400 2.0 2.03 Outlier payments for discharges occurring on or after October 1 (see Instructions) 42,30 3,20 3.00 Managed Care Similar that Payments 3,00		, ,				
2.03 Outlier payments for discharges occurring prior to October 1 (see Instructions) 825, 460 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 461,930 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 2.03 3.00 3.00 Outlier payments for discharges occurring on or after October 1 (see Instructions) 2.56.30 3.00 3.00 Outlier payments for discharges of the Most recent cost reporting period ending on or before 12/37/1996 (see Instructions) 5.00 FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/37/1996 (see Instructions) 7.00 Outlier of Period (see Instructions) 7.00 Outlier of Instructions 0.00 Outlier of Instruc			-)		-	
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions)		, , ,	*		- 1	
Managed Care Simulated Payments 0 3.00		, , ,				
Bed days available divided by number of days in the cost reporting period (see instructions) 256.30 4.00 Indirect Medical Education Adjustment 5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 6.00 7.00 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.01 FTE out of a second received in the like cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(1) 6.00 7.00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for a sefficial end of 7 R 50009 (August 1, 2002). FTE out of a first interpretation of the first count for all opathic and osteopathic programs for a sefficial end of 7 R 50009 (August 1, 2002). FTE out of a first interpretation of a first interpretation of 7 R 50009 (August 1, 2002). FTE out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out of 7 R 50009 (August 1, 2002). FTE out out for 7 R 50009 (August 1, 2002). FTE out out for 7 R 50009 (August 1, 2002). FTE out out for 7 R 50009 (August 1, 2002). FTE out out for 7 R 50009 (August 1, 2002). FTE out out for 7 R 50009 (August 1, 2002). FTE out out for 7 R 50009 (August 1, 2002). FTE out for 7 R 50009 (August 1, 2002). FTE out for 7 R 50009 (August 1, 2002). FTE out for 7 R 50009 (August 1, 2002). FTE out for 7 R		, , ,	(See Thisti detrons)			
Indirect Medical Education Adjustment			ng period (see instru	ctions)		
or before 12/31/19%. (See Instructions) 6. 00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7. 00 MM. Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions) 8. 00 Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(c), 413.79(c)(2)(iv), 64 FR 26340 (Mey 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 9. 03 Line films in the special structions of the special structions				,		
TEC count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddies July 1, 2011 then see instructions.	5.00		ecent cost reporting p	period ending on	0.00	5. 00
new programs in accordance with 42 CFR 413.79(e) 0.00 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions 0.00 7.01 0.00 7.01 0.00 3.01 0.00 3.01 0.00 0.		1				,
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(v)(Ø)(B)(2) if the cost report straddles July 1, 2011 then see instructions. 0.00 7.00 8.00 Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1999), and 67 FR 50009 (Mayust 1, 2002). 0.00 8.00 8.01 The amount of increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions. 0.00 8.01 8.02 The amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 0.00 8.02 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FIE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 Current year allowable FIE (see instructions) 0.00 10.00 11.00 Current year allowable FIE count for the prior year. 0.00 10.00 15.00 Sum of lines 12 through 14 divided by 3. 0.00 10.00 16.00 Aljustment for residents in initial years of the program or hospital c	6.00		criteria for an add-or	n to the cap for	0.00	6.00
ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see instructions.	7 00	1 9	er 42 CER 8412 105(f)	(1) (i v) (B) (1)	0.00	7 00
cost report straddles July 1, 2011 then see instructions. 8.00 Ajusthent (increase or decrease) to the FTE count for all opathic and osteopathic programs for affil lated programs in accordance with 42 CFR 413, 75(b), 413, 79(c)(2)(iv), 64 FR 26340 (May 12, 1999), and 67 FR 50099 (Mugust 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital ounder § 5506 of ACA. (see instructions). 8.02 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 instructions). 8.02 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 instructions). 8.03 Current year allowable FTE (see instructions). 8.04 Current year allowable FTE (see instructions). 8.05 Sum of lines 12 through 14 divided by 3. 8.06 Sum of lines 12 through 14 divided by 3. 8.07 Sum of lines 12 through 14 divided by 3. 8.08 Sum of lines 12 through 14 divided by 3. 8.09 Current year residents in initial years of the program on the program of lines 12 through 14 divided by 16 Sum of lines 12 through 14 divided by 16 Sum of lines 12 through 14 divided by 16 Sum of lines 12 through 14 divided by 16 Sum of lines 12 through 14 divided by 16 Sum of lines 12 through 14 divided by 16 Sum of lines 19 on 0.00 12 Sum of lines 19 Sum of lines 19 or 20 (see instructions) 0.00 Sum of lines 19 Sum of lines 19 or 20 (see instructions) 0.00 Sum of lines 19 Sum of lines 19 or 20 (see instructions) 0.00 Sum of lines 19 Summer 14 Summer 14 Summer 14 Summer 15 Summer 1						
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	,, , ,		5. K 3.1.21 165 (1) (1)	,,(5)(2)	0.00	,
1998), and 67 FR 50069 (August 1, 2002).	8.00		and osteopathic pro	grams for	0.00	8. 00
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) The count for residents in dental and podiatric programs in the current year from your records 0.00 10,00 1			c)(2)(iv), 64 FR 26340	May 12,		
report straddles July 1, 2011, see instructions.						
1.00 1.00	8. 01		under § 5503 of the A	NCA. If the cost	0. 00	8. 01
under § 5506 of ACA. (see instructions) under § 5506 of ACA. (see instructions) 0.00 9.00 10. 00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 11. 00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12. 00 Current year allowable FTE (see instructions) 0.00 11.00 13. 00 Total allowable FTE count for the prior year. 0.00 13.00 14. 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 13.00 15. 00 Sum of Lines 12 through 14 divided by 3. 0.00 15.00 16. 00 Adjustment for residents in initial years of the program 0.00 17.00 18. 00 Adjustent for residents in initial years of the program 0.00 17.00 18. 00 Adjusted rolling average FTE count 0.00 0.00 0.00 0.00 19. 00 Current year resident to bed ratio (see instructions) 0.000000 0.00 0.000000 0.00 0.000000 0.000000 2.00 10. 00 Earth the lessers of Lines 19 or 20 (see instructions) 0.000000 0.00 0.000000 0.00 0.000000	0 02		from a closed teachin	na hosni tol	0.00	0 02
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 9.00 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 12.00 13.00 10	6. 02		Troil a crosed teachir	ig nospi tai	0.00	0.02
instructions) 1.0 00 FTE count for allopathic and osteopathic programs in the current year from your records 1.0 00 FTE count for residents in dental and podiatric programs. 1.0 00 Current year allowable FTE (see Instructions) 1.0 00 Current year allowable FTE count for the prior year. 1.0 12 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, one of the third in the time of the prior year. 1.0 10 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, one of the third in the time of time o	9 00		(8 8 01 and 8 02) (see	0.00	9 00
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 10.00 1	7.00		(0, 0,0. a.a. 0,02)	,,,,	0.00	7.00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00	10.00	FTE count for allopathic and osteopathic programs in the current	year from your record	ls		
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 15.00 15.00 16.00 18.00						
14.00						
Otherwise enter zero. Othe				20 1007		
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 18.00 18.00 18.00 18.00 19	14.00		ended on or after Sep	.ember 30, 1997,	0.00	14.00
16.00 Adjustment for residents in initial years of the program 16.00 17.00 Adjustment for residents displaced by program or hospital closure 17.00 Adjustment for residents displaced by program or hospital closure 17.00 18.00 17.00 18.00 18.00 Adjustment for resident to bed ratio (line 18 divided by line 4). 17.00 18.00 18.00 18.00 19.00	15 00				0.00	15 00
17. 00						
18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 22. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment (see instructions) 0.000000 22. 00 1 IME payment adjustment - Managed Care (see instructions) 0.000000 22. 01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000000 23. 00 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 0.00 23. 00 (f)(1)(iv)(C). 0.1 0.000000 24. 00 25. 00 15 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment amount (see instructions) 0.000000 27. 00 28. 01 IME add-on adjustment amount (see instructions) 0.0000000 28. 01 29. 00			Э			
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.0000000 21.00 0.0000000 21.00 0.0000000 21.00 0.0000000 21.00 0.0000000 22.00 0.0000000 22.00 0.0000000 22.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	18.00				0.00	18. 00
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 22.01 IME payment adjustment - Managed Care (see instructions) 0.22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 24.00 IME FTE Resident Count Over Cap (see instructions) 0.000 23.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 25.00 IME payments adjustment factor. (see instructions) 0.000000 26.00 27.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 29.01 Total IME payment (sum of lines 22 and 28) 0.00 29.00 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 0.00000 31.00 Sum of lines 30 and 31 35.15 3.2.00 33.00 Allowable disproportionate share percentage (see instructions) 18.2 33.00 33.00 Allowable disproportionate share percentage (see instructions) 18.2 33.00 33.00 Allowable disproportionate share percentage (see instructions) 18.2 33.00 34.00 Allowable disproportionate share percentage (see instructions) 18.2 33.00 35.00 Allowable disproportionate share percentage (see instructions) 22.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 38.00 38.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00	19. 00	Current year resident to bed ratio (line 18 divided by line 4).				
22.00 IME payment adjustment (see instructions)		, ,				
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 (f) (1) (iv) (C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 29. 01 IME add-on adjustment amount (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 10 22. 01 10 22. 01 22. 01 22. 02 23. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 01 29. 00						
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23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). (f)(22.01		f the MMA		U	22.01
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27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Sum of lines 30 and 31 30. 00 Allowable disproportionate share percentage (see instructions) 31. 00 Allowable disproportionate share percentage (see instructions) 32. 00 IME payment adjustment amount (see instructions) 0. 000000 28. 01 29. 00 29. 00 29. 01 30. 00 30. 00 31. 00 32. 00 33. 00 34. Iowable disproportionate share percentage (see instructions) 33. 00						
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31.00 Percentage of Medicaid patient days (see instructions) 29.06 31.00 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 18.21 33.00		Di sproporti onate Share Adjustment				
32.00 Sum of lines 30 and 31 35.15 32.00 33.00 Allowable disproportionate share percentage (see instructions) 18.21 33.00	30. 00	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruct	i ons)	6. 09	30.00
33.00 Allowable disproportionate share percentage (see instructions) 18.21 33.00		, , , , , , , , , , , , , , , , , , , ,				
						•
34. 00 pri spropor tronate share augustillent (see fristructions)						
	34.00	The sproportionate share and astiment (see this tructions)			1, 830, 887	34.00

	Financial Systems IU HEALTH BLOOMING ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet E Part A Date/Time Pre	pared:
		T: 11 20/11		5/26/2022 1:0	9 pm
		Title XVIII	Hospital Prior to 10/1	PPS On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8, 290, 014, 521		
35. 01	Factor 3 (see instructions)		0. 000299564	0. 000280434	•
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente instructions)	er zero on this line) (se	e 2, 483, 392	2, 016, 882	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	1, 857, 441	508, 365	35. 03
	Total uncompensated care (sum of columns 1 and 2 on line 35.0		2, 365, 806	000, 000	36.00
	Additional payment for high percentage of ESRD beneficiary di				
40.00	Total Medicare discharges (see instructions)		0		40. 00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct		0.00		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days (see instructions)	ry for adjustment)	0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 00
	days)	2,			
45.00	Average weekly cost for dialysis treatments (see instructions		0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41	1. 01)	0		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	mall rural baaritala	45, 839, 047		47. 00
48.00	only. (see instructions)	silari rurai nospitars	0		48. 00
	join y. (see Tristi de trons)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions	,		45, 839, 047	1
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			3, 351, 552	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment	ne 49 see instructions).		0 37, 518	52. 00 53. 00
54. 00	Special add-on payments for new technologies			630, 613	ł
54. 01	Islet isolation add-on payment			0	ı
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	55. 00
56.00	Cost of physicians' services in a teaching hospital (see intr			0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		63, 659	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			49, 922, 389 483	
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		49, 921, 906	ı
62. 00	Deductibles billed to program beneficiaries			4, 099, 612	
63.00	Coinsurance billed to program beneficiaries			117, 655	63.00
64.00	Allowable bad debts (see instructions)			518, 718	1
65.00	Adjusted reimbursable bad debts (see instructions)			337, 167	65. 00
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		86, 994	1
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS DDCs (s	oo instructions)	46, 041, 806 0	1
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69.00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(. 5. 55 555		0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70.89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90 70. 91
70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 91
70. 72	HVBP payment adjustment amount (see instructions)			-37, 869	ł
	HRR adjustment amount (see instructions)			0	ı
70. 94	Tikk aujustillerit alliourit (see rristructions)			O I	, 0. , .

	LIL LIEALTH DI COMUNICTON LICCOLTAL			6.5 046	0550 40
Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	-	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0051		Worksheet E Part A Date/Time Pre 5/26/2022 1:0	
	Ti tl e	e XVIII	Hospi tal	PPS	
		FFY	['] (уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal			0	0	70. 96

			1	o 12/31/2021	Date/Time Pre 5/26/2022 1:0	
		Title	e XVIII	Hospi tal	PPS	, biii
				уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 97
	the corresponding federal year for the period ending on or aft	ter 10/1)				
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			46, 003, 937	71.00
71. 01	Sequestration adjustment (see instructions)				0	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				45, 194, 866	72.00
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73.00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			809, 071	74.00
	[73]					
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			1, 162, 156	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	1
92. 00	Operating outlier reconciliation adjustment amount (see instru				0	
93. 00	Capital outlier reconciliation adjustment amount (see instruct				0	
	The rate used to calculate the time value of money (see instru	uctions)			0. 00	
95. 00	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruct	tions)			0	96. 00
				Prior to 10/1		
	h			1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)	`		0.0000000000	0.0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	5)		0	0	102.00
400.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100 00
	HRR adjustment factor (see instructions)			0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstr					
200.00	Is this the first year of the current 5-year demonstration per	riod under t	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					-
201 00	Cost Reimbursement	- 40)				201 00
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	9 49)				201. 00
	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)	£: t	-6 +1	F	4!	203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	TITST year	or the current	5-year demonst	ration	
204.00	peri od)					1004 00
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
207.00	Adjustment to Medicare Part A Inpatient Reimbursement			T T		207 00
	Program reimbursement under the §410A Demonstration (see instruments and see instruments are seen as a second of the second of t					207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	1111e 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00
	Reserved for future use					210.00
Z11.00	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
010 00	Comparision of PPS versus Cost Reimbursement	244)				1010 0
	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions)					213. 00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS ar	na cost reim	noursement)			218. 00
	(line 212 minus line 213) (see instructions)			1		I

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2021 | Part A Exhibit 4 | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 1:09 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0051

						0 12/31/2021	5/26/2022 1:0	
		W/C E D+ A	A		XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	C	0	0	1. 00
4 04	payments	4.04	00 040 050		00 040 050		20 040 050	4 04
1. 01	DRG amounts other than outlier payments for discharges	1. 01	30, 213, 958	0	30, 213, 958		30, 213, 958	1. 01
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	10, 135, 006	0		10, 135, 006	10, 135, 006	1. 02
	payments for discharges							
	occurring on or after October							
1.03	DRG for Federal specific	1. 03	О	0	C		0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.01	operating payment for Model 4	1.01	J	ŭ		J	· ·	1.01
	BPCI occurring on or after							
2. 00	October 1 Outlier payments for	2. 00						2. 00
2.00	discharges (see instructions)	2.00						2.00
2.01	Outlier payments for	2. 02	0	0	C	0	0	2. 01
2 02	discharges for Model 4 BPCI	2.02	025 4/0		025 4/0		005 4/0	2 02
2. 02	Outlier payments for discharges occurring prior to	2. 03	825, 460	U	825, 460		825, 460	2. 02
	October 1 (see instructions)							
2.03	Outlier payments for	2. 04	461, 930	0		461, 930	461, 930	2. 03
	discharges occurring on or after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	0	0	C	0	0	3. 00
4 00	reconciliation	2.00		0			0	4 00
4. 00	Managed care simulated payments	3. 00	U	U	C	U	0	4. 00
	Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
0.00	instructions)	22.00		J			0	0.00
6. 01	IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adju	ustment for the	Add-on for Sec	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27.00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
0.00	(see instructions)	20.00		0			0	0.00
8. 00	IME adjustment (see instructions)	28. 00	0	U	C	U	0	8. 00
8. 01	IME payment adjustment add on	28. 01	0	0	C	0	0	8. 01
	for managed care (see							
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	c	0	0	9. 00
7.00	lines 6 and 8)	27.00		O			0	9.00
9. 01	Total IME payment for managed	29. 01	0	0	C	0	0	9. 01
	care (sum of lines 6.01 and 8.01)							
	Disproportionate Share Adjustme	ent						
10.00	Allowable disproportionate	33.00	0. 1821	0. 1821	0. 1821	0. 1821		10. 00
	share percentage (see							
11. 00	instructions) Disproportionate share	34. 00	1, 836, 887	0	1, 375, 491	461, 396	1, 836, 887	11 00
00	adjustment (see instructions)	01.00	., 555, 557		., 0, 0, 1, 1	1017070	1,000,007	
11. 01	Uncompensated care payments	36. 00	2, 365, 806	0	1, 857, 441	508, 365	2, 365, 806	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESR 46.00	RD beneficiary o	di scharges 0	0	0	0	12. 00
12.00	(see instructions)	40.00		U			0	12.00
13. 00	Subtotal (see instructions)	47. 00	45, 839, 047	0	34, 272, 350	11, 566, 697	45, 839, 047	
14. 00	Hospital specific payments	48. 00	0	0	C	0	0	14. 00
	(completed by SCH and MDH, small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	45, 839, 047	0	34, 272, 350	11, 566, 697	45, 839, 047	15. 00
	operating costs (see							
16. 00	instructions) Payment for inpatient program	50. 00	3, 351, 552	0	2, 518, 140	833, 412	3, 351, 552	16 00
10.00	capital (from Wkst. L, Pt. I,	00.00	3, 331, 332		2, 510, 140	033, 412	5, 551, 552	10.00
	if applicable)							

LOW VO	ILUME CALCULATION EXHIBIT 4			Provi der CC		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/26/2022 1:0	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 00	Special add-on payments for	54.00	630, 613	0	450, 05	3 180, 560	630, 613	17. 00
	new technologies							
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	ol	0		0 0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	o	0		0 0	0	18. 00
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0	37, 240, 54	3 12, 580, 669	49, 821, 212	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	3, 083, 140	0	2, 318, 98	0 764, 160	3, 083, 140	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	40, 876	0	28, 01	9 12, 857	40, 876	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0		0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0.0000	0.000	0.0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0		0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10. 00	0. 0738	0. 0738	0. 073	0. 0738		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	227, 536	0	171, 14	1 56, 395	227, 536	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	3, 351, 552	0	2, 518, 14	0 833, 412	3, 351, 552	26. 00
	payments (see instructions)							
		W/S E, Part A						
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 00000	0. 000000		27. 00
28. 00	Low volume adjustment	70. 96				0	0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)					_	_	
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
400	Pt. A, line)							
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.						I	I

Provider CCN: 15-0051

Peri od:

From 01/01/2021 Part A Exhibit 5 Date/Time Prepared: 5/26/2022 1:09 pm 12/31/2021 Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 30, 213, 958 30, 213, 958 30, 213, 958 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 10, 135, 006 10, 135, 006 1.02 10, 135, 006 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 825, 460 825 460 825 460 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 461, 930 461, 930 461, 930 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1821 0.1821 0.1821 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1, 836, 887 1, 375, 491 461, 396 1, 836, 887 11.00 instructions) 11.01 1, 857, 441 Uncompensated care payments 36, 00 2, 365, 806 508, 365 2, 365, 806 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 45, 839, 047 34, 272, 350 11, 566, 697 45, 839, 047 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 45, 839, 047 34, 272, 350 45, 839, 047 15.00 15.00 11, 566, 697 (see instructions) 16.00 50 00 3, 351, 552 2, 518, 140 833 412 3, 351, 552 16,00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 630, 613 450, 053 180, 560 630, 613 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions) 19.00 SUBTOTAL 37, 240, 543 12, 580, 669 49, 821, 212

Heal th	Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
HOSPI TA	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:0	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	3, 083, 140	2, 318, 98	0 764, 160	3, 083, 140	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	40, 876	28, 01	9 12, 857	40, 876	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		o o	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0738	0. 073	0. 0738		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	227, 536	171, 14	1 56, 395	227, 536	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	3, 351, 552	2, 518, 14	0 833, 412	3, 351, 552	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4.00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		o	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-37, 869	-37, 86	9 0	-37, 869	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	0		0	0	31.00
	HRR adjustment for HSP bonus payment (see	70. 91	o		0 0	0	31. 01
	instructions)						
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 1:00 pm

			12/01/2021	5/26/2022 1:0	
		Title XVIII	Hospi tal	PPS	
				4.00	
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			10, 149	1.00
2.00	Medical and other services (see Instructions) Medical and other services reimbursed under OPPS (see instruct	ions)		44, 292, 890	2.00
3. 00	OPPS payments	1 0113)		38, 434, 187	3.00
4.00	Outlier payment (see instructions)			113, 672	4. 00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		174, 953	9.00
10.00	Organ acquisitions			10 140	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			10, 149	11. 00
	Reasonable charges				
12. 00	Ancillary service charges			58, 204	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			58, 204	14.00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p	ayment for services on a	charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18.00	Total customary charges (see instructions)	v if limo 10 overede lim	2 11) (222	58, 204	18.00
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y II IIIne 18 exceeds IIII	le II) (See	48, 055	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	v if line 11 exceeds lin	e 18) (see	0	20. 00
20.00	instructions)	y II IIIle II execeds IIII	(300	Ĭ	20.00
21.00	Lesser of cost or charges (see instructions)			10, 149	21. 00
22.00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			38, 722, 812	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•		6, 323, 775	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	rus the sum of fines 22	and 23] (See	32, 409, 186	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			Ö	29. 00
30.00	Subtotal (sum of lines 27 through 29)			32, 409, 186	ł
31.00	Primary payer payments			10, 404	31.00
32.00	Subtotal (line 30 minus line 31)			32, 398, 782	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34. 00	Allowable bad debts (see instructions)			848, 544	
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions)	ustions)		551, 554 419, 736	
37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	uctions)		32, 950, 336	
38. 00	MSP-LCC reconciliation amount from PS&R			-579	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration	•		0	39. 97
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruct	i ons)	245	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			32, 950, 915	40. 00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			32, 982, 572	40. 03
41. 00 41. 01	Interim payments Interim payments-PARHM			32, 902, 372	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00	Balance due provi der/program (see instructions)			-31, 657	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2, c	hapter 1,	20, 293	44. 00
	§115. 2				ļ
a -	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	92. 00 93. 00
	Total (sum of lines 91 and 93)			0	
00	1 (25 2		!		

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0051	Peri od: From 01/01/2021	Worksheet E
		Component CCN: 15-T051		Date/Time Prepared: 5/26/2022 1:09 pm
		Title XVIII	Subprovi der -	PPS

March			Title XVIII	Subprovi der - I RF	PPS	
Bedical and other services (see instructions)					1.00	
	1 00				2	1 00
3.00 OPPS payments 3.00 3.00 4.00 OUT 1.00		,	tions)			
0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.00		· ·	11 0113)			
Internation						
Line 2 times time 5 0 6.70	4.01				0	4. 01
		, , , , , , , , , , , , , , , , , , , ,	ctions)			
Transit tional corridor payment (see instructions) 0 8.00 0 0 0 0 0 0 0 0 0						
Ancillary service other pass through costs from Wist, D, Pt. IV, col. 13, line 200						
10.100 Total cost (sum of lines 1 and 10) (see instructions) 2 11.00			V col 13 line 200			
1.00			V, COI. 13, 1111C 200			
COMPUTATION OF LESSER OF COST OR CHARGES 12.00						
12.00 Ancillary service charges 14 12.00 13.00 Organ acquist it on charges (from West. D-4, Pt. III, col. 4, line 69) 14 14 00 13.00 15 15 15 15 15 15 15		COMPUTATION OF LESSER OF COST OR CHARGES				
13.00 Organ acquist fine charges (from Wist. D-4, Pt. III. col. 4, line 69)	40.00	9				40.00
14.00			72 (0)			
Customary_charges			ne 69)			
15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0 15.00	11.00					11.00
had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 17.00	15.00	Aggregate amount actually collected from patients liable for			0	15. 00
17.00	16. 00			n a chargebasis	0	16. 00
18.00 Total customary charges (see instructions) 14 18.00 12 19.00 15.00	47.00	, ,	e)		0 000000	47.00
19,00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 12 9,00 Instructions) 20,00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0,00 20,00 1 1 1 1 1 1 1 1 1					l .	
instructions		, , ,	v if line 18 exceeds lin	ne 11) (see	1	
Instructions 2 21.00	17.00	, , ,	y IT TITLE TO EXCEEDED ITT	10 11) (300	'-	17.00
2	20.00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds lin	ne 18) (see	0	20. 00
22.00 Interns and residents (see instructions) 0.22.00		1				
23.00 Cost of physicians' services in a teaching hospital (see instructions) 39 24.00		,				
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 39 24. 00			cuctions)			
COMPUTATION OF RELIMBURSEMENT SETTLEMENT		, ,	uctions)			
26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 0 26.00					7.1	
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 41 27.00 1 1 1 1 1 1 1 1 1						
Instructions		l e	•	,		
28.00 Direct graduate medical education payments (From Wkst. E-4, line 50) 0 28.00 0 29.00 29.00 SbD direct medical education costs (From Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 41 30.00 31.00 7 mary payer payments 0 31.00 31.00 7 mary payer payments 41 32.00 31.00 32.00 Subtotal (line 30 minus line 31) 41 32.00 33.00 Composite rate ESRD (From Wkst. I5, line 11) 0 33.00 34.00	27. 00		olus the sum of lines 22	and 23] (see	41	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.00 Subtotal (sum of lines 27 through 29) 41 30.00 30.00 30.00 30.00 20.00 30.00	28. 00	1	ne 50)		0	28. 00
31.00			,			
32.00	30.00	Subtotal (sum of lines 27 through 29)			41	30. 00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 34.00 All owable bad debts (see instructions) 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 41 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.90 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 99.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or						
33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 All lowable bad debts (see instructions) 0 34.00 35.00 All lowable bad debts (see instructions) 0 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 41 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 Demonstration payment adjustment distance (see instructions) 29.50 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 41 40.00 40.01 Sequestration adjustment (see instructions) 41 40.00 40.01 Sequestration adjustment amount after sequestration 40.01 Sequestration adjustment amount after sequestration 40.01 Sequestration adjustment amount after sequestration 40.01 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 42.01 Tentative settlement (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 44.00 45.01	32. 00		YEC)		41	32.00
34.00	33 00	·	LES)		0	33 00
35.00					1	
37.00 Subtotal (see instructions) 41 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.90 39.90						
38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 97 39. 98 Prital or full credits received from manufacturers for replaced devices (see instructions) 0 39. 97 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 00 Subtotal (see instructions) 41 40. 00 40. 01 Sequestration adjustment (see instructions) 41 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment for amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments 41. 01 Interim payments 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement (for contractor use only) 42. 01 43. 00 8al ance due provider/program (see instructions) 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44. 00 From the contractor of the cont		,	ructions)			
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39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 41 40.00 40.01 40.01 40.01 40.00 40.01 40						
39.97 Demonstration payment adjustment amount before sequestration 0 39.97		, , , , ,	s)		١	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 41 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 01 Interim payments 41 41. 00 42. 01 Tentative settlement (for contractors use only) 42. 00 42. 01 Tentative settlement -PARHM (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 0 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Fortested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 93. 00 <t< td=""><td></td><td>, , , , , , , , , , , , , , , , , , , ,</td><td>3)</td><td></td><td>0</td><td></td></t<>		, , , , , , , , , , , , , , , , , , , ,	3)		0	
40.00 Subtotal (see instructions) 41 40.00 40.01 Sequestration adj ustment (see instructions) 5 Sequestration adj ustment (see instructions) 5 Sequestration payment adj ustment amount after sequestration 5 Sequestration adj ustment-PARHM pass-throughs 6 Auril 1 Auril 2		, , , , , , , , , , , , , , , , , , , ,	ced devices (see instruct	tions)		
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40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 44. 00 Protested amounts (nonallowable cost report items) 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 94. 00 93. 00					1	
40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 41. 01 Interim payments-PARHM 41. 01 Tentative settlement (for contractors use only) 42. 00 Tentative settlement (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 44. 00 Protested amounts (nonallowable cost report items) 44. 00 Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 The rate used to calculate the Time Value of Money 92. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 93. 00						
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43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	42.00	Tentative settlement (for contractors use only)			0	42. 00
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 O 93.00		1			_	
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{91} 15.2 \\ \text{TO BE COMPLETED BY CONTRACTOR} \\ 90.00 Original outlier amount (see instructions) \$\ \text{91.00} \\ 91.00 The rate used to calculate the Time Value of Money (see instructions) \$\ \text{92.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ \text{93.00} \\ 93.00 Time Value of Money (see instructions) \$\ 93		· · · · · · · · · · · · · · · · · · ·			١	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 pl.00 1 The rate used to calculate the Time Value of Money 0.00 pl.00 1 Time Value of Money (see instructions) 0 pl.00 0		, , , , , , , , , , , , , , , , , , , ,	nce with CMS Dub 15.2	chanter 1	۱ ۸	
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00	44.00		ice with two rub. 15-2, (chapter I,	ا	44.00
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,				
93.00 Time Value of Money (see instructions) 0 93.00		,				
		1				
				l	٥١	

Total Interim payments paid to provider 1.00			Title	XVIII	Hospi tal	PPS	
1.00			Inpatien	t Part A	Par	t B	
1.00			·				
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1.00	2.00	3. 00	4.00	
InterIm payments' payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	1. 00	Total interim payments paid to provider		45, 194, 866		32, 982, 572	1. 00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero							2.00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.							
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3 00						3 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01		for the cost reporting period. Also show date of each					
Program to Provider		nayment If none write "NONE" or enter a zero (1)					
ADJUSTMENTS TO PROVIDER							
3.02	2 01			0			2 01
3.03 3.04 3.05 3.06 3.07 3.07 3.08 3.09 3.00		ADJUSTIMENTS TO PROVIDER					
3.04				_		- 1	
3.05				-			
Provider to Program							
ADJUSTMENTS TO PROGRAM	3. 05			0		0	3. 05
3.51 3.52 0							
3.52 3.53 3.54 3.59 3.50		ADJUSTMENTS TO PROGRAM		_		1	
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.54 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 45,194,866 32,982,572 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 45,194,866 32,982,572 4.00 45,194,866 32,982,572 4.00 45,194,866 32,982,572 4.00 45,194,866 32,982,572 4.00 45,194,866 32,982,572 4.00 45,194,866 32,982,572 4.00 45,194,866	3. 51			0			
3.54 3.99 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 45, 194, 866 32, 982, 572 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.52			0		0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09 3.59 3.50-3.98) 45,194,866 32,982,572 4.00	3.53			0		0	3. 53
3.50-3.98 Total Interim payments (sum of lines 1, 2, and 3.99)	3.54			0		0	3. 54
A.00 Total inferim payments (sum of lines 1, 2, and 3.99) A5, 194, 866 32, 982, 572 A.00	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		l ol	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		3. 50-3. 98)					
Contractor	4.00	Total interim payments (sum of lines 1, 2, and 3.99)		45, 194, 866		32, 982, 572	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
TO BE COMPLÉTED BY CONTRACTOR		appropri ate)					
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5. 00
Write "NONE" or enter a zero. (1) Program to Provider TENTATI VE TO PROVI DER 0 0 0 5. 02							
Program to Provider		write "NONF" or enter a zero (1)					
TENTATI VE TO PROVIDER		Program to Provider					
Solidar to Program	5 01			0		0	5 01
Tentative to Program S. 50 S		TENNITY TO THOUSEN		-			
Provider to Program							
TENTATI VE TO PROGRAM	5.05	Provider to Program					3. 03
5.51	5 50			0		0	5 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 6.00 Subtot		TENTATI VE TO TROOKAW		-			
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 809,071 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 31,657 6.02 7.00 Total Medicare program liability (see instructions) 46,003,937 32,950,915 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				-			
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		Subtatal (sum of lines E O1 E 40 minus sum of lines		_		- 1	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 809,071 0 31,657 6.02 46,003,937 Contractor NPR Date (Mo/Day/Yr) Number 0 1.00 2.00	5. 99			٥			5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00							, 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	. 01			000 071			, 04
7.00 Total Medicare program liability (see instructions) 46,003,937 32,950,915 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						- 1	
Contractor NPR Date (Mo/Day/Yr) NVM Date (Mo/Day/Yr) 0 1.00 2.00				_			
Number (Mo/Day/Yr) 0 1.00 2.00	7. 00	Total Medicare program liability (see instructions)		46, 003, 937			7. 00
0 1.00 2.00							
	0		()	1. 00	2.00	
8.00 Name of Contractor	8.00	Name of Contractor					8. 00

Peri od: From 01/01/2021 To 12/31/2021 Component CCN: 15-T051

		Title	XVIII	Subprovider - IRF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		1, 006, 27	6	41 0	1. 00 2. 00
3.00	services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				o	l ol	3. 02
3.03				o	ol	3. 03
3.04				0	o	3. 04
3.05				o	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	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
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 006, 27	6	41	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5. 03	Provider to Program			<u>U</u>	U	5. 03
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 50	ILIVIALIVE TO FROUGRAM			0		5. 50
5. 51				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
6. 00	5. 50-5. 98) Determined net settlement amount (balance due) based on			O		6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		9, 56	6	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 015, 84		41	7. 00
				Contractor	NPR Date (Mo/Day/Yr)	
0.00		()	1. 00	2. 00	0.05
8.00	Name of Contractor					8. 00

llool +b	Financial Systems IU HEALTH BLOOM	NCTON HOSDITAL	In Lie	u of Form CMS-	2552 10
	Financial Systems IU HEALTH BLOOM ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0051	Period:	Worksheet E-1	
CALCUL	ATTOM OF RETWINDORSEMENT SETTEEMENT FOR THE	Frovider CCN. 15-0051	From 01/01/2021		
			To 12/31/2021	Date/Time Pre	
Title XVIII Hospital					
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT				4
1.00	Total hospital discharges as defined in AARA §4102 from Wk				1.00
2.00	2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost				2. 00
3. 00	reporting periods beginning on or after 10/01/2013, line 32) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4. 00					4. 00
4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)				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.				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase o		Wkst S_2 Dt I		7.00
7.00	line 168	r certified iii r tecillorogy	WKSt. 3-2, Ft. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9. 00	Sequestration adjustment amount (see instructions)	,			9.00
10.00	Calculation of the HIT incentive payment after sequestration	on (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(======================================			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31. 00					31.00
32. 00		d line 31) (see instruction	ıs)		32. 00
		, ;	,		

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2021	Worksheet E-3
	Component CCN: 15-T05		
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der -	PPS	
			I RF		
	L			1. 00	
1 00	PART III - MEDICARE PART A SERVICES - IRF PPS		T	920 101	1.00
1. 00 2. 00	Net Federal PPS Payment (see instructions) Medicare SSI ratio (IRF PPS only) (see instructions)			839, 101 0. 0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			44, 388	3. 00
4.00	Outlier Payments			135, 941	4. 00
5.00	Unweighted intern and resident FTE count in the most recent co	nst reporting period en	ding on or prior	0.00	5. 00
0.00	to November 15, 2004 (see instructions)	sst reporting period en	aring on or prior	0.00	0.00
5. 01	Cap increases for the unweighted intern and resident FTE coun- program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	5. 01
6.00	New Teaching program adjustment. (see instructions)			0.00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7. 00
	teaching program" (see instructions)				
8. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)		eriod of a "new	0. 00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions)		0. 00	
10.00	Average Daily Census (see instructions)			3. 717808	
11.00	Teaching Adjustment Factor (see instructions)		-	0. 000000	
12.00	Teaching Adjustment (see instructions)			1 010 420	12.00
13.00	Total PPS Payment (see instructions)	(an)		1, 019, 430	
14. 00 15. 00	Nursing and Allied Health Managed Care payments (see instruction Organ acquisition (DO NOT USE THIS LINE)	on)	•	0	14. 00 15. 00
16. 00	Cost of physicians' services in a teaching hospital (see insti	cuctions)		0	16. 00
17. 00	Subtotal (see instructions)	detrons)		1, 019, 430	
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			1, 019, 430	
20. 00	Deducti bl es			0	20. 00
21.00	Subtotal (line 19 minus line 20)			1, 019, 430	21. 00
22. 00	Coinsurance			5, 936	22. 00
23. 00	Subtotal (line 21 minus line 22)			1, 013, 494	23. 00
24.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		2, 879	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)			1, 871	
26. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)			1, 015, 365	
28. 00	Direct graduate medical education payments (from Wkst. E-4, Ii	ne 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			477	29. 00
30. 00 31. 00	Outlier payments reconciliation			0	30. 00 31. 00
31.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	-)		0	31. 50
31. 98	Recovery of accelerated depreciation.	3)		0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32. 00	Total amount payable to the provider (see instructions)			1, 015, 842	
32. 01	Sequestration adjustment (see instructions)			0	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			1, 006, 276	33. 00
34.00	Tentative settlement (for contractor use only)			0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02	2, 33, and 34)		9, 566	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	18, 880	36. 00
	TO BE COMPLETED BY CONTRACTOR		,		
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			135, 941	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52. 00	The rate used to calculate the Time Value of Money			0. 00	
53. 00	Time Value of Money (see instructions)	DECLANMING DEFODE THE EN	D OF THE COVER 10	0	53. 00
99. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND				00 00
99. 00 99. 01	Teaching Adjustment Factor for the cost reporting period immedical culated Teaching Adjustment Factor for the current year. (J .	1 y 27, 2020.	0. 000000 0. 000000	
77.01	Tour our accounting has a senior tractor for the current year. (soo riisti doti Olis)	I	5. 000000	, ,,, 01

	Financial Systems IU HEALTH BLOOMINGT		N 4E 00E1		u of Form CMS-2	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CC		Period: From 01/01/2021	Worksheet E-4	
	E 2500 (110) 30015			Го 12/31/2021	Date/Time Prep 5/26/2022 1:09	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
1 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT	6			0.00	1 00
1. 00	Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.	programs for	cost reportii	ng perioas	0. 00	1. 00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFF		1) (see instr	uctions)	0.00	
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MMA Direct GME cap reduction amount under ACA §5503 in accordance		8413 79 (m)	(see	0. 00 0. 00	
4. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and o		. ,	•	0. 00	
4.00	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		. 0		0.00	4.00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instrateddling 7/1/2011)	ructions for	cost reporti	ng periods	0.00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots	s (see insti	ructions for (cost reporting	0. 00	4. 02
5. 00					0. 00	5. 00
4.02 plus applicable subscripts 6.00 Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your				year from your	0. 00	6. 00
7. 00	records (see instructions) Enter the lesser of line 5 or line 6				0.00	7. 00
7.00	Litter the resser of fille 5 of fille 0		Primary Care	Other	Total	7.00
	lw		1.00	2. 00	3.00	
8. 00	Weighted FTE count for physicians in an allopathic and osteopa program for the current year.	ithi c	0.0	0.00	0.00	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amou		0. 0	0.00	0. 00	9. 00
10. 00	6. Weighted dental and podiatric resident FTE count for the curre	ent vear		0.00		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cur			0.00		10. 01
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	vear (see	0.0			11. 00 12. 00
13. 00	instructions) Total weighted resident FTE count for the penultimate cost rep		0. 0			13. 00
14 00	year (see instructions)	,	0.00	0.00		14.00
14. 00 15. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	by 3).	0. 0			14. 00 15. 00
15. 01	Unweighted adjustment for residents in initial years of new pr	ograms	0. 0			15. 01
16. 00	Adjustment for residents displaced by program or hospital clos		0.0			16. 00
16. 01	Unweighted adjustment for residents displaced by program or holds	ospi tal	0.0	0.00		16. 01
17. 00			0.0	0.00		17. 00
	Per resident amount		0.0		_	18. 00
19. 00	Approved amount for resident costs			0	0	19. 00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FT	E resident	cap slots rec	eived under 42	0.00	20. 00
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc	ctions)			0. 00	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instru				0.00	
23. 00	Enter the locality adjustment national average per resident am	nount (see i	nstructions)		0.00	
	Multiply line 22 time line 23				0	1
25.00	Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed Care	0 Total	25. 00
			А	J J		
	COMPUTATION OF PROGRAM PATIENT LOAD		1. 00	2. 00	3. 00	
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX 3.02, column 2)	(, line	19, 38	12, 114		26. 00
27. 00	Total Inpatient Days (see instructions)		62, 58	62, 583		27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 30974	0. 193567		28. 00
29. 00 29. 01	Program direct GME amount Percent reduction for MA DGME		'	ار ا	0	29. 00 29. 01
∠7. UI				1		
30.00	Reduction for direct GME payments for Medicare Advantage	I		0	0	30.00

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAI	In lie	u of Form CMS-2	2552_10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0051	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 1:0	
		Title XVIII	Hospi tal	PPS	
	DUDGOT NEDLONG EDUCATION COOTS FOR FORD COMPOSITE DATE. TITLE	- W. W. L. C. W. V. (N. 1901 NO. 99	000444 4445 54544455	1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	•		OI CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	d 23, lines 74	0	32. 00	
33.00					33. 00
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line	34 x line 35)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37. 00				60, 346, 256	1
38. 00				0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)			483	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		60, 345, 773	41. 00
40.00	Part B Reasonable Cost			44 470 400	
	Reasonable cost (see instructions)			44, 478, 139	1
43.00	Primary payer payments (see instructions)			10, 404	1
44.00	Total Part B reasonable cost (line 42 minus line 43)			44, 467, 735	l
	Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (lin-	o 41 . Lino 45)		104, 813, 508 0. 575744	1
	Ratio of Part A reasonable cost to total reasonable cost (IIII)			0. 575744	l
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			U. 424250	47.00
48 00	Total program GME payment (line 31)	KI D		0	48. 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		0	•
	Part B Medicare GME payment (line 40 x 40) (title xVIII only)	,		0	•
55. 66	Trait b modification sine payment (Title 47 x 40) (title xviii only)	(See Thisti detroils)	ļ.	١	1 55. 66

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

Provider CCN: 15-0051 | Period: From 01/01/20

Peri od: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:09 pm

onl y)			1	0 12/31/2021	5/26/2022 1:0	
		General Fund		Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	173, 041, 870	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	
3.00	Notes receivable	0	1	0	0	1
4.00	Accounts receivable	59, 910, 886	1	0	0	
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	6, 463, 815		0	0	
7. 00	Inventory	13, 980, 782		0	0	
8. 00	Prepaid expenses	9, 184, 933	1	0	0	
9. 00	Other current assets	0	Ō	0	0	
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	262, 582, 286	0	0	0	11. 00
	FI XED ASSETS					
12.00	Land	19, 741, 447	1	0	0	1
13. 00 14. 00	Land improvements Accumulated depreciation	2, 058, 207 -2, 050, 505	1	0	0	13. 00 14. 00
15. 00	Buildings	505, 070, 099	1	0	0	
16. 00	Accumulated depreciation	-152, 256, 867	1	ő	Ö	1
17. 00	Leasehold improvements	7, 104, 821	1	0	0	1
18.00	Accumul ated depreciation	-6, 441, 534	0	0	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	466, 247	1	0	0	21. 00
22. 00 23. 00	Accumulated depreciation Major movable equipment	-364, 128 190, 836, 984	1	0	0	
24. 00	Accumulated depreciation	-110, 758, 804	1	0	0	1
25. 00	Mi nor equipment depreciable	0	ő	o	0	
26.00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	C	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	452 405 077	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	453, 405, 967	0	0	0	30.00
31. 00	Investments	45, 901, 929	0	O	0	31. 00
32. 00	Deposits on Leases	0,701,727	1	ő	0	
33. 00	Due from owners/officers	C	0	0	0	
34.00	Other assets	279, 814, 098	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	325, 716, 027		0	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	1, 041, 704, 280	0	0	0	36. 00
37. 00	CURRENT LIABILITIES	55, 782, 687	0	O	0	37. 00
38. 00	Accounts payable Salaries, wages, and fees payable	8, 543, 502	1	0	0	
39. 00	Payroll taxes payable	0,010,002	Ö	ő	Ö	1
40.00	Notes and Loans payable (short term)	O	0	0	0	
41.00	Deferred income	48, 077, 423	0	0	0	41. 00
42. 00	Accel erated payments	24, 409, 622				42. 00
43. 00	Due to other funds	0 050 (00	1	0	0	
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	8, 859, 608 145, 672, 842			0	
43.00	LONG TERM LIABILITIES	143, 072, 042	0	0	0	43.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47. 00
48. 00	Unsecured Loans	C	0	0	0	
49. 00	Other long term liabilities	3, 145, 625	1	0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	3, 145, 625	1	0	0	
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	148, 818, 467	0	0	0	51.00
52. 00	General fund balance	892, 885, 813				52. 00
53. 00	Specific purpose fund	072,000,010	l o			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	892, 885, 813	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	1, 041, 704, 280	1	Ö	Ö	
	59)					

Provider CCN: 15-0051

| Period: | Worksheet G-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

					То	12/31/2021	Date/Time Pre 5/26/2022 1:0	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	·
		1. 00	2.00	3.00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0 0 0	758, 547, 119 145, 338, 696 903, 885, 815 0 903, 885, 815		0 0 0 0	C	0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	UNRESTRICTED FUND BALANCE TEMPORARILY RESTRICTED PERM RESTRICTED ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	878, 592 4, 511, 963 5, 609, 445 2 0	11, 000, 002 892, 885, 813		0 0 0 0 0	C	0 0 0 0 0	12. 00 13. 00 14. 00 15. 00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8.00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) UNRESTRICTED FUND BALANCE TEMPORARILY RESTRICTED PERM RESTRICTED ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems 10 H Provider CCN: 15-0051

Description			T T	12/31/2021	Date/Time Pre 5/26/2022 1:0	
PART I - PATIENT REVENUES 1.00 2.00 3.00		Cost Center Description	Inpati ent	Outpati ent) piii
Seneral Inpattient Routine Services 173, 668, 371 173, 668, 371 173, 668, 371 1.00						
1.00		PART I - PATIENT REVENUES	•			
2. 00 3.00 3.00 3.00 3.00 3.00 3.00 3.00		General Inpatient Routine Services				
3.00 SUBPROVIDER - IRF	1.00	Hospi tal	173, 668, 371		173, 668, 371	
4.00 SUBPROVIDER 0 0 4.00 0 5.00 0 0 5.00 0 0 5.00 0 0 0 0 0 0 0 0 0	2.00	SUBPROVI DER - I PF				2. 00
5.00			3, 396, 448			
Swing bod - NF Swing bod - Swing			0			
7. 00			0		_	
8.00 NURSING FACILITY			0		0	
9, 00 OTHER LONG TERM CARE 177, 064, B19 177, D64, B19						
10. 0 Total general inpatient care services (sum of lines 1-9) 177, 064, 819 177, 064, 819 10. 00						
Intensive Care Type Inpatient Hospital Services			477 0/4 040		477 0/4 040	
11.00 INTENSIVE CARE UNIT 30, 845, 931 30, 845, 931 11.00 27, 647, 790 27, 647, 790 12.00 20, 00 20,	10.00		177, 064, 819		177, 064, 819	10.00
12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 15.00 NEONATAL INTENSIVE CARE UNIT 15.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 17.00 Total intensive care type inpatient hospital services (sum of lines 175, 373, 397	11 00	, , , , , , , , , , , , , , , , , , ,	20 045 021		20 04E 021	11 00
13. 00 BURN INTENSIVE CARE UNIT 13. 00 15. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 00 16. 879, 676 15. 00 16. 00 16. 879, 676 15. 00 16. 00 16. 879, 676 15. 00 16. 00 16. 879, 676 15. 00 16. 00 16. 879, 676 15. 00 16. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 17. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 15. 00 16. 879, 676 16. 00 16. 879, 676 16. 00 16. 879, 676 16. 00 16. 879, 676 16. 00 16. 879, 676 17. 00 16. 879, 676 17. 00 16. 879, 676 17. 00 16. 879, 676 17. 00 16. 879, 676 17. 00 16. 879, 676 17. 00 16. 879, 676 17. 00 1			1			
14. 00 SURGICAL INTENSIVE CARE UNIT 15.00 NEONATAL INTENSIVE CARE UNIT 16.00 Total intensive care type inpatient hospital services (sum of lines 75, 373, 397			27, 047, 790		27, 647, 790	
15. 00 NEONATAL INTENSIVE CARE UNIT 16. 879, 676 16. 879, 676 16. 00 Total intensive care type inpatient hospital services (sum of lines 75, 373, 397 75, 373, 397 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 252, 438, 216						
16. 00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 252, 438, 216 507, 072, 770 873, 397 16. 00 Uptatient services 57, 341, 803 266, 106, 633 323, 448, 496 19. 00 Uptatient services 57, 341, 803 266, 106, 633 323, 448, 496 19. 00 0 Uptatient services 57, 341, 803 266, 106, 633 323, 448, 496 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			16 879 676		16 879 676	
11-15						
17. 00 Total inpatient routine care services (sum of lines 10 and 16) 252, 438, 216 507, 072, 770 867, 341, 803 1, 374, 413, 853 18. 00 00 00 00 00 00 00 00	10.00	1	70,070,077		70,070,077	10.00
18.00 Ancillary services 507,072,770 867,341,083 1,374,413,853 18.00 19.00 20.00 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0	17. 00		252, 438, 216		252, 438, 216	17. 00
20. 00 RURAL HEALTH CLINIC 0 0 0 0 0 20. 00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21. 00 22. 00 HOME HEALTH AGENCY 0 0 0 21. 00 23. 00 AMBULANCE SERVICES 138, 803 28, 618, 366 28, 757, 169 23. 00 24. 00 CMHC CMHC CMHC CMHC CMHC CMHC 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 24. 00 26. 00 HOSPICE 0 0 0 0 0 27. 00 OTHER NRCC 0 6, 751, 974 6, 751, 974 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 816, 991, 652 1, 168, 818, 056 1, 985, 809, 708 29. 00 ADD (SPECIFY) 0 421, 713, 958 29. 00 30. 00 33. 00 33. 00 33. 00 33. 00 34. 00 0 0 33. 00 34. 00 35. 00 36. 00 0 0 35. 00 36. 00 Total additions (sum of lines 30-35) 0 0 0 36. 00 Total deductions (sum of lines 37-41) 0 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 44. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 44. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 44. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 44. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 44. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 421, 713, 958 43. 00 44. 00 Total operating expenses (sum of line				867, 341, 083		
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 22.00 0 0 22.00 0 0 22.00 0 0 0 22.00 0 0 0 22.00 0 0 0 22.00 0 0 0 0 0 0 0 0 0	19. 00	Outpati ent servi ces	57, 341, 863	266, 106, 633	323, 448, 496	19. 00
22. 00 HOME HEALTH AGENCY 0 23. 00 AMBULANCE SERVICES 138, 803 28, 618, 366 28, 757, 169 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 25. 00 26. 00 HOSPICE 0 0 0 6, 751, 974 6, 751, 974 27. 00 27. 00 TOTAL patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 816, 991, 652 1, 168, 818, 056 1, 985, 809, 708 28. 00 70 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
23. 00 AMBULANCE SERVICES 24. 00 CMHC CMHC CMHC CMHC CMHC CMHC CMHC CMHC	21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
24. 00 25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 26. 00 27. 00 28. 00 27. 00 28. 00 29. 00 20	22.00	HOME HEALTH AGENCY		0	0	22. 00
25. 00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 0 0 0 0	23.00	AMBULANCE SERVICES	138, 803	28, 618, 366	28, 757, 169	23. 00
26. 00						
27. 00 OTHER NRCC Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1) PART II - OPERATING EXPENSES 29. 00 ADD (SPECIFY) ADD (SPECIFY) Total additions (sum of lines 30-35) DEDUCT (SPECIFY) Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer dumn 3 to Wkst. Saite, 971, 974, 1, 168, 818, 056, 1, 985, 809, 708, 1, 985, 809, 708, 1, 985, 809, 708, 28. 00 816, 991, 652, 1, 168, 818, 056, 1, 985, 809, 708, 28. 00 816, 991, 652, 1, 168, 818, 056, 1, 985, 809, 708, 28. 00 421, 713, 958, 809, 708, 28. 00 421, 713, 958, 809, 708, 28. 00 421, 713, 958, 809, 708, 28. 00 421, 713, 958, 809, 708, 28. 00 421, 713, 958, 809, 708, 28. 00 421, 713, 958, 809, 708, 28. 00 421, 713, 958, 809, 708, 28. 00 421, 713, 958, 809, 708, 28. 00 422, 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 47. 00 48. 00 47. 00 48. 00 48. 00 49. 00 49. 00 40. 00 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer)			0	0	0	
28. 00			0	-	_	
G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) OD 30.00 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) OD 30.00 31.00 00 00 00 00 00 00 00 00 00 00 00 00			0			
PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (per Wkst. A, column 3, line 200) 421, 713, 958 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 0 36. 00 37. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00		816, 991, 652	1, 168, 818, 056	1, 985, 809, 708	28. 00
29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (per Wkst. A, column 3, line 200) 421, 713, 958 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 421, 713, 958 421, 713, 958 421, 713, 958						
30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 33.00 32.00 33	20.00			421 712 OEO		20.00
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 31.00 32.00 33.00 33.00 33.00 33.00 33.00 34.00 35.00 37.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 42.00 43.00 42.00 43.00 43.00				421, 713, 958		
32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 32.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 421,713,958		ADD (SELCTIT)				
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 33.00 0 34.00 0 35.00 0 36.00 0 37.00 0 0 0 0 0 40.00 41.00 42.00 421,713,958						
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 34.00 35.00 36.00 37.00 36.00 37.00 38.00 0 0 0 40.00 41.00 42.00 421,713,958						
35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 35.00 36.00 37.00 37.00 37.00 0 38.00 0 39.00 41.00 42.00 42.00 42.00 421,713,958			_			
36.00 Total additions (sum of lines 30-35) 0 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 0 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 421, 713, 958 43.00			0			
37. 00 38. 00 39. 00 0 37. 00 38. 00 39. 00 0 39. 00 40. 00 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 421, 713, 958 43. 00 43. 00 43. 00 44.		Total additions (sum of lines 30-35)		0		
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 37.41, 713, 958 43.00	37. 00	,	0			37. 00
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 421, 713, 958 43.00	38.00		0			38. 00
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 421, 713, 958 43.00	39.00		0			39. 00
42.00 Total deductions (sum of lines 37-41) 0 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 421,713,958 43.00	40.00		0			40. 00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 421,713,958 43.00	41.00		0			
				0		
to Wkst. G-3, line 4)	43. 00			421, 713, 958		43. 00
		to Wkst. G-3, line 4)	1		I	

111 41-	Figure in Contract	CTON HOCDLTAI	la lia	6 F CMC 6	NEE2 40
	Financial Systems I U HEALTH BLOOMIN ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0051	Peri od:	u of Form CMS-2 Worksheet G-3	2552-10
O I / (I E II	ENT OF REVENUES AND EXILENSES	11001401 0001 10 0001	From 01/01/2021		
			To 12/31/2021	Date/Time Prep 5/26/2022 1:09	
				072072022 1107	, p
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			1, 985, 809, 708	1. 00
2.00	Less contractual allowances and discounts on patients' accou	ınts		1, 470, 159, 936	2. 00
3.00	Net patient revenues (line 1 minus line 2)			515, 649, 772	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		421, 713, 958	
5.00	Net income from service to patients (line 3 minus line 4)			93, 935, 814	5. 00
	OTHER I NCOME			_	
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	n services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12. 00
13. 00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and guests			- 1	14. 00
15. 00	Revenue from rental of living quarters			- 1	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other	than patients			16. 00
17. 00	Revenue from sale of drugs to other than patients				17.00
18. 00	Revenue from sale of medical records and abstracts				18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			39, 746, 986	24.00
24. 50	COVI D-19 PHE Fundi ng			11, 655, 896	24.50
25.00	Total other income (sum of lines 6-24)			51, 402, 882	25.00
26. 00	Total (line 5 plus line 25)			145, 338, 696	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			145, 338, 696	29. 00

CALCUL	ATION OF CAPITAL PAYMENT P	Provider CCN: 15-0051	Peri od:	Worksheet L	
			From 01/01/2021	Parts I-III	
			To 12/31/2021	Date/Time Prep 5/26/2022 1:09	
-		Title XVIII	Hospi tal	PPS	<i>y</i> piii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			3, 083, 140	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			40, 876	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost repor	rting period (see inst	ructions)	167. 74	3. 00
4.00	Number of interns & residents (see instructions)			0. 00	
5.00	Indirect medical education percentage (see instructions)			0. 00	
6.00	Indirect medical education adjustment (multiply line 5 by the su	um of lines 1 and 1.01	, columns 1 and	0	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A pati	ient days (Worksheet E	, part A line	6. 09	7. 00
0.00	30) (see instructions)			00.04	0.00
8.00	Percentage of Medicaid patient days to total days (see instructi	ons)		29.06	
9.00	Sum of lines 7 and 8			35. 15	
10. 00 11. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			7. 38 227, 536	
12. 00	Total prospective capital payments (see instructions)			3, 351, 552	
12.00	Total prospective capital payments (see mistructions)			3, 331, 332	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
1.00	Program inpatient capital costs (see instructions)	(see instructions)		0	1.00
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances	(see instructions)		_	2. 00
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2)	(see instructions)		0	2. 00 3. 00
2.00 3.00 4.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	(see instructions)		0	2. 00 3. 00 4. 00
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	,		0 0 0. 00	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instru	ructions)	(line 6)	0 0 0. 00 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	ructions)	cline 6)	0 0 0. 00 0 0. 00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary ci	ructions) ircumstances (line 2 x	(line 6)	0 0 0.00 0 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instradjustment to capital minimum payment level for extraordinary ci Capital minimum payment level (line 5 plus line 7)	ructions) ircumstances (line 2 x ble)	ŕ	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instradjustment to capital minimum payment level for extraordinary ci Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable)	ructions) ircumstances (line 2 x ble) ital payments (line 8	less line 9)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary ci Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicat Current year comparison of capital minimum payment level to capi	ructions) ircumstances (line 2 x ble) ital payments (line 8	less line 9)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (see instructions) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicated current year comparison of capital minimum payment level to capital carryover of accumulated capital minimum payment level over capital worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment	ructions) rcumstances (line 2 x pole) ital payments (line 8 ital payment (from pri ents (line 10 plus lir	less line 9) or year ne 11)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instradjustment to capital minimum payment level for extraordinary ci Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicat Current year comparison of capital minimum payment level to capi Carryover of accumulated capital minimum payment level over capi Worksheet L, Part III, line 14)	ructions) ircumstances (line 2 x ole) ital payments (line 8 ital payment (from pri cents (line 10 plus line amount on this line	less line 9) or year ne 11)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00

15.00 0 16. 00 0 17. 00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)