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: 15-1306 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 1:16 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2022 1:16 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:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] 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 PAOLI HOSPITAL (15-1306) 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	ANCIAL 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	HIT	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-386, 908	-1, 289, 886	0	0	1. 00
2.00 Subprovider - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing Bed - SNF	0	-17, 286	0		0	5. 00
6.00 Swing Bed - NF	0				0	6. 00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00 RURAL HEALTH CLINIC I	0		31, 226		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200. 00 Total	0	-404, 194	-1, 258, 660	0	0	200. 00
The above amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above comple	ex 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.

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI C	ATION DATA	Provid	ler CCN	l: 15-1306	Period: From 01/01/ To 12/31/	′2021 ′2021	Workshe Part I Date/Ti 5/26/20	me Pre	pared:
	1.00		2. 00		3. 00			4. 00			
	Hospital and Hospital Health Care Co	omplex Ado									
1.00	Street: 642 WEST HOSPITAL ROAD		PO Box:								1.00
2.00	City: PAOLI		State: IN	Zi p Cod			ty: ORANGE	l D	1.6.1	(D	2. 00
		Comp	oonent Name	CCN Number	CBS/ Number		Date Certified		nt Syst 0, or		
				Number	Nullibe	ei iype	Certified	V ,	XVIII		-
			1. 00	2.00	3.00	0 4.00	5. 00	6.00	7. 00		1
	Hospital and Hospital-Based Componer	nt Identii		2.00	J 3. 0.	0 4.00	3.00	0.00	7.00	0.00	
3.00	Hospi tal	IU HEALT		151306	9991	5 1	07/01/2001	N	0	Р	3.00
	'	HOSPI TAL									
4.00	Subprovi der - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovi der - (Other)										6.00
7.00	Swing Beds - SNF	IUHP SWI	NG BEDS	15Z306	9991	5	07/01/2001	N	0	N	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	Hospital-Based Health Clinic - RHC		H PAOLI FAMILY	158557	9991	5	12/07/2020	N	0	0	15. 00
		AND INTE	RNAL								
	Hospital-Based Health Clinic - FQHC										16. 00
	Hospital-Based (CMHC) I										17. 00
	Renal Dialysis										18. 00
19. 00	Other										19. 00
							From:		To		-
20.00	Cost Reporting Period (mm/dd/yyyy)						1.00		12/31		20. 00
	Type of Control (see instructions)						2	021	12/31/	2021	21.00
21.00	Type of control (see this tructions)										21.00
					H	1. 00	2. 00		3. (<u> </u>	1
	Inpatient PPS Information					1.00	2.00		J. (
22. 00	Does this facility qualify and is it	currentl	v receiving nav	ments for	- T	N	N				22. 00
22.00	disproporti onate share hospi tal adju										22.00
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo	or yes or	"N" for no.								
22. 01	Did this hospital receive interim un	compensat	ed care payment	ts for thi	s	N	N				22. 01
	cost reporting period? Enter in colu	ımn 1, "Y'	for yes or "N'	' for no f	or						
	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					N	N				22. 02
	payments to be determined at cost re				ns)						
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob				- 1						
	or "N" for no, for the portion of th	ie cost re	eporting period	on or aft	er						
22.02	October 1.		ol floot! f	ab - :- '		N.I	,				22.00
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 reporting				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. 100) f E	arcer in corumn	J, I IC	"						
22. 04	Did this hospital receive a geograph	nic reclas	sification from	n urhan to	,	N	l N		N		22. 04
22.04	rural as a result of the revised OMB					IN	i.i.		IV		22.04
	adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reporting										
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft										
	Does this hospital contain at least		•	,	as						
		ce with 42 CFR 412.105)? Enter in column 3, "Y" for									
	Counted in accordance with 42 Circ 41	/.			-						I
	yes or "N" for no.						1	1			
23. 00		edicaid da	ys on lines 24	and/or 25	5		3 N				23. 00
23. 00	yes or "N" for no.						3 N				23. 00
23. 00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method	of admiss of identi	sion, 2 if censu fying the days	us days, c in this c	or 3		3 N				23. 00
23. 00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of admiss of identi method us	sion, 2 if censu fying the days sed in the prion	us days, c in this c cost	or 3		3 N				23. 00
23. 00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method	of admiss of identi method us	sion, 2 if censu fying the days sed in the prion	us days, c in this c cost	or 3		3 N				23. 00

					10 12,0	717 2021		022 1: 1	
		In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medicai HMO day	d 0 s Med	ther di cai d days	
		1.00	2. 00	3. 00	4. 00	5. 00		5. 00	-
24. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0				3. 00	0	C	24. 00
25. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0		D	0		25. 00
					1.	Rural S [2.		_
26. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the beg	ginning of	the	2			26. 00
	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r ication in (ural. If ap column 2.	pplicable,		2			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status i	ו	0			35. 00
					Begi n		Endi 2.		
36. 00	Enter applicable beginning and ending dates of SCH s		cript line	36 for numb		00	2.	JU	36. 00
37. 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente		r of period	ds MDH statu	ıs	0			37. 00
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" for	he MDH tran:	sitional pa	ayment in					37. 01
38. 00	<pre>instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.</pre>								38. 00
					1.		Y/ 2.		
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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum nts in	ume N nn		N		39. 00
40. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y			ı			40. 00
						V 1. 00	2. 00		
	Prospective Payment System (PPS)-Capital								
45. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	accordance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46. 00
47. 00	Is this a new hospital under 42 CFR §412.300(b) PPS			,		N	N	N	47. 00
48. 00	Is the facility electing full federal capital paymen Teaching Hospitals	t? Enter "	Y" for yes	or "N" for	no.	N	N	N	48. 00
56. 00 57. 00	Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or applienter "Y" for yes; otherwise, enter "N" for no in colf line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo	e to column rograms in cable CRs) l lumn 2. period duri	1 is "Y", the prior y MA direct G ng which re	or if this year or pend GME payment esidents in	hospital ultimate reduction?				56. 00 57. 00
58. 00	is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim	th of this of Y", completo I, if applio	cost report e Worksheet cable.	ing period E-4. If co	? Enter "Y' olumn 2 is				58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.			NI NI			
	Are costs claimed on line 100 of Worksheet A? If ye	s, comprete	WKSL. D-2,	rt. I.		l N	1	1	59. 00

settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Fr	eriod: rom 01/01/2021				
				To		5/26/2022 1:1	6 pm		
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEsin Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
				Si te	nospi tai	4))			
65. 00	Enter in column 1, if line 63	1. 00	2. 00	3.00	4.00	5. 00 0. 000000	/F 00		
	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)			Unwei ghted	Unwei ghted	Ratio (col. 1/			
				FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))			
				Si te	·				
	Section 5504 of the ACA Current	Year FTE Residents in	Nonprovider Settino	1.00 gsEffective fo	2.00 or cost reporti	na periods			
// 00	beginning on or after July 1, 20	10	·						
66. 00	Enter in column 1 the number of FTEs attributable to rotations of			0.00	0. 00	0. 000000	66.00		
	Enter in column 2 the number of FTEs that trained in your hospit.								
	(column 1 divided by (column 1 +	column 2)). (see ins	tructions)	Upwai ahtad	Upwai abtad	Datio (asl 2/			
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
		1. 00	2. 00	3. 00	4. 00	5. 00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0. 00	0. 00	0. 000000	37.00		
					1. 00	0 2.00 3.00			
70.00	Inpatient Psychiatric Facility P		DE) or door it cont	tain an LDE cuba			70. 00		
70. 00	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no			·					
71. 00	If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indices instructions)	efore November 15, 20 Lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	04? Enter "Y" for y lity train residents (D)? Enter "Y" for y	/es or "N" for n s in a new teach /es or "N" for n	o. (see i ng o.	0	71. 00		
75. 00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re	habilitation Facility	(IRF), or does it o	contain an IRF	N		75. 00		
76. 00	subprovider? Enter "Y" for yes If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	the facility have an ing on or before Nove train residents in a r "Y" for yes or "N"	mber 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes or n in accordance f column 2 is Y,	"N" for	0	76. 00		

ealth Financial Systems IU HEALTH PAOLI OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-1306	Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part I Date/Time Pi 5/26/2022 1:	- repared:
				1.00	
Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 1.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			g period? Enter	N N	80.00
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (excluded)		,		N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 Is this hospital an extended neoplastic disease care hospital	cl assi fi ed u	under section		N	87. 0
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XIX	
Title V and XIX Services			1. 00	2. 00	
0.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	nter "Y" for	N	Y	90. 0
1.00 Is this hospital reimbursed for title V and/or XIX through th			N	N	91.00
full or in part? Enter "Y" for yes or "N" for no in the appli 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dua				N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicable 3.00 Does this facility operate an ICF/IID facility for purposes of	ole column.		N	N	93. 00
"Y" for yes or "N" for no in the applicable column.					
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	and "N" for no	o in the	N	N	94. 0
5.00 If line 94 is "Y", enter the reduction percentage in the appl 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			O. 00 N	0. 00 N	95. 0 96. 0
7.00 If line 96 is "Y", enter the reduction percentage in the appl 8.00 Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	erns and resi	dents post	0. 00 N	0. 00 Y	97. 0 98. 0
column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the rep. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit				Y	98. 0
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			N	Y	98. 0
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critireimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. 0
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 0
in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 0
column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 0
Rural Providers 05.00 Does this hospital qualify as a CAH?			Y		105. 0
06.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)	nclusive meth	nod of paymen	t N		106. 0
07.00 Column 1: If line 105 is Y, is this facility eligible for costraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do yapproved medical education program in the CAH's excluded IPF	1. (see inst ou train I&Rs	tructions) s in an	N		107. 0
Enter "Y" for yes or "N" for no in column 2. (see instruction 08.00 is this a rural hospital qualifying for an exception to the CCFR Section §412.113(c). Enter "Y" for yes or "N" for no.	ons)		Y		108. 0
	Physi cal	Occupationa		Respiratory	_
09.00 f 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.	1.00 N	2. 00 N	3. 00 N	4.00 N	109. 00
, , , , , , , , , , , , , , , , , , ,			1	1.00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y				1. 00 N	110.00

Health Financial Systems IU HEALTH PAOLI H	OSPI TAL		In Lie	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet S Part I Date/Time P	repared:
				5/26/2022 1	: 16 pm
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost in "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is particified Enter all that apply: "A" for Ambulance services; "B" for additing for tele-health services.	reporting p n 1 is Y, e ipating in	period? Enter enter the column 2.	1.00 N	2.00	111.00
		1. 00	2. 00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Memonstration for any portion of the current cost reporting perienter "Y" for yes or "N" for no in column 1. If column 1 is "Y" in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	i od? ", enter	N			112. 00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93"; for short term hospital or "98" percent for long term care (inclusive psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	r E only) percent ludes based on	N			0 115. 00
116.00 s this facility classified as a referral center? Enter "Y" for "N" for no.	yes or	N			116. 00
117.00 Is this facility legally-required to carry malpractice insurance "Y" for yes or "N" for no.	e? Enter	N			117. 00
118.00 Is the mal practice insurance a claims-made or occurrence policy			1		118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence	e.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 37, 79	2.00	3.00	0 118. 01
110. OTLETS Calliburities of marphaetice premirums and pard rosses.		31, 13	71		0118.01
118.02 Are mal practice premiums and paid losses reported in a cost cen-	ter other t	han the	1. 00 Y	2.00	118. 02
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ham §3121 and applicable amendments? (see instructions) Enter in col "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	listing co rmless prov lumn 1, "Y" fies for th	vision in ACA for yes or ne Outpatient	N	N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantal	ble devices	charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.			Y	5. 00	122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for ye yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter to column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in column 132.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0P0), enter the Oland termination date, if applicable, in column 2.	the certifi the certifi the certific er the cert 2. nter the ce 2. the certifi	cation date cation date cation date cation date in the cation date in the cation date in the cation date	N N		125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00 132. 00 133. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as define chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, are claimed, enter in column 2 the home office chain number. (see	, and home	office costs	Y	15H059	140. 00

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1306 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: To 12/31/2021 5/26/2022 1:16 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: INDIANA UNIVERSITY HEALTH Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 08101 141 00 SERVI CES 142.00 Street: 340 WEST TENTH STREET PO Box: 142.00 143.00 City: INDIANAPOLIS State: ΙN Zip Code: 46204 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 Υ 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146, 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 Υ 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160.00 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Name County Zip Code **CBSA** State | 0 1.00 2 00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.
168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 167.00 Υ 168.00 reasonable cost incurred for the HIT assets (see instructions)

168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1. 00 2.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in 51 171. 00 section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

OSPI T	Financial Systems IU HEALTH PAOL AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	_I HOSPITAL Provider C	CN: 15-1306	Peri od:	u of Form CMS- Worksheet S-	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pro 5/26/2022 1:	
				Y/N	Date	TO PIII
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ente	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1. (
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3. 00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2. (
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3. (
	Torut onships. (366 That dott ons)		Y/N	Type	Date	
			1.00	2.00	3. 00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for	or Compiled,	Y	A	02/25/2022	4.0
. 00	or "R" for Reviewed. Submit complete copy or enter date avaicalumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit records.	rent from	N			5. 0
	those on the fired financial statements: If yes, submit reco	oner i atron.	1	Y/N	Legal Oper.	
				1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2	2. If yes is	the provide	- N I		6.0
	is the legal operator of the program?		s the provider			
. 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.		ved during the	N N		7. 0 8. 0
. 00	Are costs claimed for Interns and Residents in an approved of program in the current cost report? If yes, see instructions		cal education	N		9. 0
0. 00	was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	N		10.0
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. 0
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. (
4. 00	If line 12 is yes, were patient deductibles and/or co-payment Bed Complement	nts waived? If	yes, see ins	structi ons.	N	14.
5. 00	Did total beds available change from the prior cost reporti				N	15.
		Y/N	t A Date	Par Y/N	Date Date	
		1.00	2.00	3. 00	4. 00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.0
7. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for all against 2.1f	Υ	04/01/2022	Y	04/01/2022	17. (
0.00	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)	Al				10
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	N		N		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.

	Financial Systems IU HEALTH PAC	OLI HOSPITAL		In Li∈	eu of Form CN	IS-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 15-1306	Peri od: From 01/01/2021 To 12/31/2021		Prepared:
		Descri	pti on	Y/N	Y/N	
		()	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N	Date	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2. 00	3. 00 N	4.00	21. 00
21.00	records? If yes, see instructions.	IN		IV		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS H	OSPI TALS)			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			l N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into during	this cost re	eporting period?	N	24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period?	'lf yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reportin	N	27. 00		
	copy. Interest Expense	·				
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into dur	ing the cost	reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or		bt Service F	Reserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see	N	30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see	N	31. 00
	instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app. no, see instructions.		g to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physi ci ans?	Y	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	Y	35. 00
	physicians during the cost reporting period? If yes, see in	istructions.		Y/N	Date	
				1. 00	2.00	
	Home Office Costs			7. 00		
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		36. 00 37. 00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off					38. 00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	ffi ce.			
39. 00	see instructions.	•	,	s, N N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.		40. 00			
		00				
	Cost Report Preparer Contact Information	1.	UTTER			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		41.00		
42. 00	respectively. Enter the employer/company name of the cost report	INDIANA UNIVER	SITY HEALTH			42. 00
43. 00	preparer.	317-962-1093		RUTTER@I UHEALT	H. ORG	43. 00
	report preparer in columns 1 and 2, respectively.	10,0			5	.5.55

Heal th	Financial Systems IU HEALTH PA	AOLI	OLI HOSPITAL			In Lieu of Form CMS-2552-1				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der C	CN: 15-1306	Peri	od: 01/01/2021	Worksheet S-2 Part II)		
					To		Date/Time Pre 5/26/2022 1:1	epared: 6 pm		
			3.	00						
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the title/position	DIF	RECTOR					41.00		
	held by the cost report preparer in columns 1, 2, and 3,									
	respectively.									
42.00	Enter the employer/company name of the cost report							42. 00		
	preparer.									
43.00	Enter the telephone number and email address of the cost							43.00		
	report preparer in columns 1 and 2, respectively.									

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

					''	0 12/31/2021	5/26/2022 1:10	
							I/P Days / O/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		24	8, 760	36, 360. 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 I RF Subprovi der							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			2.4	0.7/0	2/ 2/0 00	0	6. 00
7. 00	Total Adults and Peds. (exclude observation			24	8, 760	36, 360. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00		0	0	0.00	o	8. 00
9. 00	CORONARY CARE UNIT	31.00		U	0	0.00	U	9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					o	13. 00
14. 00	Total (see instructions)	43.00		24	8, 760	36, 360. 00		14. 00
15. 00	CAH visits			24	0, 700	30, 300. 00	0	15. 00
16. 00	SUBPROVI DER - I PF						Ĭ	16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					l ol	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC	88. 00					35	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			24				27.00
28. 00	Observation Bed Days						0	28. 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)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges		l		l			33. 01

				T	o 12/31/2021	Date/Time Pre 5/26/2022 1:1	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	qui val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	614	36	1, 515			1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	338	323				2.00
3. 00	HMO IPF Subprovider	ol	0				3. 00
4. 00	HMO IRF Subprovider	ol	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	64	0	64			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	71			6.00
7.00	Total Adults and Peds. (exclude observation	678	36	1, 650			7. 00
	beds) (see instructions)			·			
8.00	INTENSIVE CARE UNIT	o	0	0			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		12	156			13. 00
14.00	Total (see instructions)	678	48	1, 806	0.00	135. 22	14. 00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			31			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	651	0	7, 150		3. 50	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0. 00	
27. 00	Total (sum of lines 14-26)		_		0.00	138. 72	1
28. 00	,		5	474			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30. 00				0			30.00
31. 00	Employee discount days - IRF		_	0			31.00
32. 00	, , , , , , , , , , , , , , , , , , , ,	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	,	0					33. 00 33. 01
33.01	LTCH site neutral days and discharges	٠Į	l				33.01

				T	o 12/31/2021	Date/Time Pre 5/26/2022 1:1	
		Full Time Equivalents		Di sch	arges		,
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0			430	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)			76	129		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0 00
8. 00 9. 00	INTENSIVE CARE UNIT						8. 00 9. 00
	CORONARY CARE UNIT						10.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT						11. 00
12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	174	9	430	
15. 00	CAH visits	0.00	O	174	7	430	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 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
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
22.00	outpatient days (see instructions)			_			22.00
33.00	LTCH non-covered days LTCH site neutral days and discharges			0			33. 00 33. 01
33. UI	LIGHT SI LE HEULT AT UAYS AND UI SCHAFGES	I I	l	ı		I	33.01

Health Financial Systems	IU HEALTH PAC	OLI HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	-	Provi der C	CN: 15-1306	Peri od:	Worksheet S-8	
		Component	CCN: 15-8557	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:1	
				RHC I	Cost	о рііі
				1.	00	
Clinic Address and Identification 1.00 Street						1.00
1.00 Street		Ci	ty	State	ZIP Code	1.00
			00	2. 00	3. 00	
2.00 City, State, ZIP Code, County						2. 00
					1. 00	
3.00 HOSPITAL-BASED FOHCS ONLY: Designation - En	ter "R" for rura	al or "U" for u	ırban		1.00	3. 00
				nt Award	Date	
				1.00	2. 00	
Source of Federal Funds	IC 4-+)		I			4 00
4.00 Community Health Center (Section 330(d), PH 5.00 Migrant Health Center (Section 329(d), PHS						4. 00 5. 00
6.00 Health Services for the Homeless (Section 3						6. 00
7.00 Appalachian Regional Commission	,					7. 00
8. 00 Look-Alikes						8.00
9.00 OTHER (SPECIFY)	_					9. 00
				1. 00	2. 00	
10.00 Does this facility operate as other than a yes or "N" for no in column 1. If yes, indi 2. (Enter in subscripts of line 11 the type	cate number of o	other operation	s in column	N	0	10. 00
hours.)						
		day I .		londay	Tuesday	
	1.00	2. 00	from 3.00	4. 00	from 5.00	
Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
11. 00 CLINIC						11. 00
				4.00	0.00	
12.00 Have you received an approval for an except	ion to the produ	ictivity standa	ırd?	1. 00	2. 00	12. 00
13.00 Is this a consolidated cost report as defin 30.8? Enter "Y" for yes or "N" for no in co number of providers included in this report numbers below.	ned in CMS Pub. 1 Dlumn 1. If yes,	100-04, chapter enter in colum	9, section in 2 the	N	0	
Humber 3 ber ow.			Prov	ider name	CCN number	
				1.00	2. 00	
14.00 RHC/FOHC name, CCN number	\/ /N	V	20/11/1	VIV	T 1 1 1/2 11	14. 00
	1. 00	2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	n I			4.00	3. 00	15. 00
			inty			
2.00 City, State, ZIP Code, County		4.	00			2.00
2.00 of ty, State, ZIF code, county	Tuesday	Wedn	esday	Thur	sdav	2.00
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1) 11.00 CLINIC						11. 00
·	•	•	•		•	

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1306	Peri od:	Worksheet S-8	1
			00N 4E 0EE7	From 01/01/2021	D 1 (T' D	
		Component	CCN: 15-8557	To 12/31/2021	Date/Time Pre 5/26/2022 1:1	6 pm
				RHC I	Cost	
	Fric	lay	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

LICCOLT	Financial Systems IU HEALTH PAOLI HOSPIT			u of Form CMS-2	
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 15-1306	Peri od: From 01/01/2021	Worksheet S-10	0
			To 12/31/2021	Date/Time Prep 5/26/2022 1:10	pared: 6 pm
				1. 00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 colum	n 8)	0. 339220	1.0
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			7, 249, 275	2.0
3. 00	Did you receive DSH or supplemental payments from Medicaid?			7, 249, 273 Y	3.0
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental pa	ai d?	Ϋ́	4. 0	
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Me		0		
6. 00	Medi cai d charges			22, 267, 577	
7.00	Medicaid cost (line 1 times line 6)	76 1:	2 5 : 6	7, 553, 607	
8. 00	Difference between net revenue and costs for Medicaid program (line < zero then enter zero)	304, 332	8. 0		
	Children's Health Insurance Program (CHIP) (see instructions for each	h line)			
9. 00	Net revenue from stand-alone CHIP			0	
10.00	Stand-al one CHIP charges			0	
11.00	Stand-alone CHIP cost (line 1 times line 10)	11 minus lins O	if . zoro thon	0	
12. 00	Difference between net revenue and costs for stand-alone CHIP (line enter zero)	II IIII nus II ne 9;	ii < zero then	U	12.0
	Other state or local government indigent care program (see instructi	ons for each line)		1
13.00	Net revenue from state or local indigent care program (Not included	·	,	6, 530	13.0
14. 00	Charges for patients covered under state or local indigent care prog	gram (Not included	in lines 6 or	51, 582	14. 0
IE 00	10)			17 400	15 0
15. 00 16. 00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent	care program (Li	ne 15 minus line	17, 498 10, 968	1
10. 00	13; if < zero then enter zero)	care program (11	ne 15 minus inne	10, 700	10.0
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	state/local indi	gent care program	ns (see	
17. 00		charity care		0	17. 0
18. 00	Government grants, appropriations or transfers for support of hospit			0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indi 8, 12 and 16)	gent care program	s (sum of lines	315, 300	19. 0
	0, 12 and 10)	Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	1, 491, 1	48 256, 978	1, 748, 126	20 0
20.00	(see instructions)	1, 471,	250, 770	1, 740, 120	20.0
21. 00	Cost of patients approved for charity care and uninsured discounts (see 505, 8	256, 978	762, 805	21. 0
	instructions)				
22. 00	Payments received from patients for amounts previously written off	is	0 0	0	22. 0
23. 00	charity care Cost of charity care (line 21 minus line 22)	505, 8	256, 978	762, 805	23 0
20.00	Tools or chartly dark (Trill 21 minus Trill 22)	1 0007	200/ 770	7027000	20.0
				1. 00	
24. 00	Does the amount on line 20 column 2, include charges for patient day		of stay limit	N	24.00
25. 00	imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the ind	m's length of	0	25. 0	
26. 00	stay limit Total bad debt expense for the entire hospital complex (see instruct	ions)		2, 850, 333	26. 0
27. 00	Medicare reimbursable bad debts for the entire hospital complex (see			612, 437	1
27. 01	Medicare allowable bad debts for the entire hospital complex (see in			942, 211	
	Non-Medicare bad debt expense (see instructions)			1, 908, 122	
28. 00 29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense	(see instructions	5)	977, 047	
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line 30)	977, 047 1, 739, 852 2, 055, 152	30.0

	Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2021 Fo 12/31/2021	Date/Time Pre	nared·
						5/26/2022 1:1	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	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 & FLXT		0		571, 488	571, 488	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0		911, 663	911, 663	2. 00
3.00	00300 OTHER CAP REL COSTS		0		0 0	0	3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	83, 139	83, 139	1, 933, 779	2, 016, 918	
5.00	00500 ADMINISTRATIVE & GENERAL	499, 015	5, 799, 011			6, 257, 585	
7.00	00700 OPERATION OF PLANT	431, 205	1, 551, 087	1, 982, 292	-752, 399	1, 229, 893	7. 00
7. 01	00701 UTI LI TI ES	0	0	(371, 388	371, 388	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	2	2	71, 587	71, 589	
9. 00	00900 HOUSEKEEPI NG	237, 043	352, 979			442, 913	
10. 00	01000 DI ETARY	167, 532	322, 703	490, 235		250, 338	
11. 00	01100 CAFETERI A	0	0	(178, 872	178, 872	
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 363, 548	503, 659	1		1, 216, 386	1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	240 275	41, 342			236, 793	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	260, 375	2, 218, 637	2, 479, 012	-2, 038, 120	440, 892 0	
17. 00	01700 SOCIAL SERVICE		0			0	17. 00
	01900 NONPHYSICIAN ANESTHETISTS	391, 317	299, 698	691, 015	-79, 660	611, 355	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	071,017	277,070	071,010	77,000	011,000	17.00
30.00	03000 ADULTS & PEDIATRICS	1, 377, 723	1, 707, 910	3, 085, 633	-471, 528	2, 614, 105	30.00
31.00	03100 INTENSIVE CARE UNIT	O	0	(0	0	31.00
43.00	04300 NURSERY	145, 340	17, 518	162, 858	-117, 136	45, 722	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	469, 887	511, 200	981, 087	-364, 132	616, 955	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	33, 596	985			198, 405	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	921, 314	944, 857			1, 400, 678	
60.00	06000 LABORATORY	0	1, 886, 691			1, 888, 560	
64. 00	06400 I NTRAVENOUS THERAPY	122, 558	68, 139			155, 124	
65. 00	06500 RESPIRATORY THERAPY	293, 368	182, 076			426, 871	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	570, 826	420, 234	991, 060	-438, 860 116, 294	552, 200 116, 294	
68. 00	06800 SPEECH PATHOLOGY		0		77, 985	77, 985	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	0		75, 139		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0		28, 613		
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0		2, 077, 598		
74.00	07400 RENAL DIALYSIS	O	0		0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	O	0	(0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			1			
88. 00	08800 RURAL HEALTH CLINIC	1, 180, 045	639, 743	1, 819, 788	-414, 614	1, 405, 174	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	40.070	0	70.00	0	0	
90.00	09000 CLINIC	42, 379	29, 944		-226	72, 097 239, 243	90.00
90.01	09001 VISITING SPECIALTY CLINIC 09002 PAOLI PRIMARY CARE CLINIC	182, 857	141, 521	324, 378	-85, 135	239, 243	1
	09100 EMERGENCY	1, 407, 740	1, 868, 215	3, 275, 955	-384, 197	2, 891, 758	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,407,740	1,000,213	3, 273, 730	304, 177	2,071,730	92. 00
,2,00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVI CES	0	0	(0	0	95. 00
	10100 HOME HEALTH AGENCY	О	0		0		101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE		0		0		113. 00
118.00		10, 097, 668	19, 591, 290	29, 688, 958	1, 636	29, 690, 594	118. 00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(190. 00
	19001 VISITING SPECIALTY CLINIC	0	203	1			190. 01
	19002 OUTREACH 19003 FOUNDATION	0	0		2		190. 02 190. 03
	19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE	0	0				190. 03
	19004 SPRING VALLEY FAMILY PRACTICE		4, 536	4, 536	-264		190. 04
	19006 OTHER PROPERTY	ا	+, 530 ∩	4, 550) -204		190.05
	19100 RESEARCH	ا	0				191.00
	19200 PHYSICIANS' PRIVATE OFFICES	l ől	1, 393	1, 393	-1, 374		192. 00
	19300 NONPALD WORKERS	ol	0	,	0		193. 00
200.00		10, 097, 668	19, 597, 422	29, 695, 090	o	29, 695, 090	200. 00

| Period: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/26/2022 1:16 pm

				5/26/2022 1:	:16 pm
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
	January 2007	6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	1		I	
1.00	00100 CAP REL COSTS-BLDG & FLXT	0	571, 488		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	911, 663	•	2.00
3.00	00300 OTHER CAP REL COSTS	12 001	0	l .	3.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	-13, 081 1, 072, 331	2, 003, 837	•	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	1,072,331	7, 329, 916 1, 229, 893	•	7. 00
7. 00	00700 OPERATION OF PEANT		371, 388	•	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	71, 589	•	8. 00
9. 00	00900 HOUSEKEEPI NG	0	442, 913	•	9. 00
10. 00	01000 DI ETARY	0	250, 338	•	10. 00
11. 00	01100 CAFETERI A	-29, 258	149, 614	•	11. 00
13. 00	01300 NURSING ADMINISTRATION	4, 913	1, 221, 299	1	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	236, 793	1	14. 00
15. 00	01500 PHARMACY	72, 144	513, 036	•	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	1	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	-357, 533	253, 822		19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-909, 141	1, 704, 964		30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0		31. 00
43.00	04300 NURSERY	0	45, 722		43. 00
	ANCILLARY SERVICE COST CENTERS				
50. 00	05000 OPERATI NG ROOM	225	617, 180		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	198, 405		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 983	1, 426, 661		54. 00
60.00	06000 LABORATORY	25, 000	1, 913, 560	•	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	155, 124	•	64. 00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	426, 871	•	65. 00
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	65, 534 0	617, 734	•	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	116, 294 77, 985	•	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		77, 3 83 75, 139	•	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	28, 613	•	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 077, 598	•	73. 00
74. 00	07400 RENAL DIALYSIS	0	2,077,070		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	l o	Ö	•	76. 97
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	-27, 280	1, 377, 894		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00	09000 CLI NI C	-12, 210	59, 887		90. 00
90. 01	09001 VISITING SPECIALTY CLINIC	-220	239, 023		90. 01
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0	0		90. 02
91. 00	09100 EMERGENCY	-238, 267	2, 653, 491		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	OTHER REIMBURSABLE COST CENTERS	I			
	09500 AMBULANCE SERVI CES	0		1	95. 00
101.00	10100 HOME HEALTH AGENCY	0	0		101. 00
440.00	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE	0	0	1	113.00
118.00	9 /	-320, 860	29, 369, 734	·	118. 00
100.00	NONREI MBURSABLE COST CENTERS				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC	0	0 203	1	190. 00 190. 01
	2 19002 OUTREACH	0	203		190. 01
	19002 OUTREACTI	0	0		190. 02
	19004 SPRING VALLEY FAMILY PRACTICE		0	l .	190. 03
	19005 PAOLI FAMILY PRACTICE		4, 272	l .	190. 04
	19006 OTHER PROPERTY		7, 2/2		190.03
	19100 RESEARCH		0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	19	l .	192. 00
	19300 NONPALD WORKERS	0	0		193. 00
200.00		-320, 860	_	l .	200. 00
					•

Provider COIL 15-1300	Heal th	Financial Systems		IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS	S-2552-10
	RECLAS	SIFICATIONS			Provi der C	CN: 15-1306		Worksheet A	-6
Cost_Conter								Date/Time Pi	repared:
COST CORNECT LIPS # SAB ARY OTHER			Increases				1.	5/26/2022 1:	: 16 pm
A - ENUTY - BORDET IS		Cost Center		Salary	Other				
1.00 1.									
2.00									
3.00 4.00 5.00 5.00 6.00 6.00 6.00 6.00 6.00 6		EMPLOYEE BENEFITS DEPARTMENT		•					
4.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00									1
6.00			•	•	0				1
7. 00				•	0				1
8 00				•	0				1
9.00 11.00 1				•	-				1
11.00 13.00 13.00 13.00 14.00 15.00 16.00			•	•	O				1
12.00				•	-				
13.00 0.00 0.00 0 0 13.00 13.00 15.00			•	•	-				1
14.00 16.00				•	0				1
16.00				•	Ö				1
17.00			•		0				1
18. 00					-				
1.00					0				
1.00	10.00				1, 882, 889				10.00
2.00 4.00 4.00 5.00 6.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9									
3.00		DRUGS CHARGED TO PATIENTS							1
4.00					-				1
0.00					-				1
7. 00 8. 00 9. 00 10. 00 10. 00 10. 00 11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00		0. 00	О	0				1
8.00 9.00 10.00 10.00 10.00 10.00 10.00 0 0 0 0 0 10.00 11.00 0 0 0 0 0 0 11.00 11.00 0 0 0 0 0 0 0 11.00 11.00 0 0 0 0 0 0 0 11.00 11.00 0 0 0 0 0 0 0 11.00 11.00 0 0 0 0 0 0 0 0 11.00 11.00 0 0 0 0 0 0 0 0 11.00 11.00 0 0 0 0 0 0 0 0 0 11.00 11.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				- 1	0				1
9.00 11.00 11.00 0.00 0.00 0.00 0.00 0.0				-1	0				
10.00			•	-1	0				
1.00 MCDI CAL SUPPLIES 1.00 75, 139 1.00 2,077,598 2.00 3.00 4.00 6.00	10.00		•	О	0				10. 00
C - BILLABLE SUPPLIES	11. 00		0.00		0				11. 00
1.00		C - BILLARIE SUPPLIES		O _I	2, 077, 598				
2.00 2.00 2.00 4.00 4.00 5.00 6.00 6.00 6.00 7.00 9.00 9.00 9.00 9.00 9.00 9.00 9	1.00		71.00		75, 139				1.00
3.00 4.00 5.00 6.00 7.00 6.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9		1							
4.00 0.00		CLINIC		0					1
5.00									1
7. 00					O				1
8. 00 0. 0				- 1	0				1
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 12.00 13.00 0					-				1
10.00					-				
12. 00			•		-				4
13.00				•	-				
D - IMPLANT SUPPLIES 1.00 T6,714					0				
1.00 IMPLANT SUPPLIES IMPL DEV. CHARGED TO 72.00 28,613	13.00			+	$$ $$ $\frac{0}{76}$ $\frac{1}{714}$				13.00
PATI ENTS		D - IMPLANT SUPPLIES		91					
2. 00 3. 00	1.00		72. 00		28, 613				1. 00
3.00 0 0 0 0 28,613	2 00	PATTENTS	0.00						2 00
C			l l						1
1.00 PHARMACY 15.00 0 86,800 2.00 2.00 2.00 343 2.00 3.00 3.00 RURAL HEALTH CLINIC 88.00 0 3.20 3.00 4.00 5.00 0 0 0 5.00 6.00 7.00 0 0 0 0 7.00 0 0 0 7.00 0 0 0 0 0 0 0 0 0		0			28, 613				
2.00 CENTRAL SERVICES & SUPPLY 14.00 0 343 20 3.00 4.00 5.00 0.00 0 0 0 0 5.00 6.00 5.00 6.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.0-			-1					
3. 00				•					
4. 00 5. 00 6. 00 7. 00 The state of the st				•					
6.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00		0.00	- 1					4. 00
7. 00 O					0				
The state of the				-1	0				
F - NON-BILLABLE MED SUPPLIES 1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 203, 901 1. 00 2. 00 OPERATION OF PLANT 7. 00 0 5 2. 00 3. 00 HOUSEKEEPING 9. 00 0 368 3. 00 4. 00 DIETARY 10. 00 0 20 4. 00 5. 00 NURSING ADMINISTRATION 13. 00 626 5. 00 6. 00 OPERATING ROOM 50. 00 331 6. 00 6. 00 PHYSICAL THERAPY 66. 00 0 119 7. 00 8. 00 OUTREACH 190. 02 0 2 8. 00	7.00				<u> 0</u> 87. 463				7.00
2. 00 OPERATI ON OF PLANT 7. 00 0 5 3. 00 HOUSEKEEPI NG 9. 00 0 368 4. 00 DI ETARY 10. 00 0 20 4. 00 5. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 626 5. 00 6. 00 OPERATI NG ROOM 50. 00 0 331 6. 00 7. 00 PHYSI CAL THERAPY 66. 00 0 119 7. 00 8. 00 OUTREACH 190. 02 0 2 8. 00				<u> </u>					
3. 00 HOUSEKEEPI NG 9. 00 0 368 3. 00 4. 00 DI ETARY 10. 00 0 20 4. 00 5. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 626 5. 00 6. 00 OPERATI NG ROOM 50. 00 0 331 6. 00 7. 00 PHYSI CAL THERAPY 66. 00 0 119 7. 00 8. 00 OUTREACH 190. 02 0 2 8. 00				•			<u> </u>		
4. 00 DI ETARY 10. 00 0 20 4. 00 5. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 626 5. 00 6. 00 OPERATI NG ROOM 50. 00 0 331 6. 00 7. 00 PHYSI CAL THERAPY 66. 00 0 119 7. 00 8. 00 OUTREACH 190. 02 0 2 8. 00		1	•						
5. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 626 6. 00 OPERATI NG ROOM 50. 00 0 331 6. 00 7. 00 PHYSI CAL THERAPY 66. 00 0 119 7. 00 8. 00 OUTREACH 190. 02 0 2 8. 00									1
6. 00 OPERATING ROOM 50. 00 331 6. 00 7. 00 PHYSI CAL THERAPY 66. 00 0 119 7. 00 8. 00 OUTREACH 190. 02 0 2 8. 00									
8. 00 OUTREACH 190. 02 0 2 8. 00	6.00	OPERATING ROOM	50. 00	- 1	331				6. 00
<u> </u>		OUTKEACH							
		1	3. 33	<u> </u>	9				1 7.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/26/2022 1:16 pm Provider CCN: 15-1306

					10 1	2/31/2021	5/26/2022 1:16 pm
		Increases			<u> </u>		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
10. 00	2.00	0.00	4.00	0	,		10.00
11. 00		0.00	0	0			11. 00
12. 00		0. 00	0	0			12. 00
13. 00		0.00	•	0			13. 00
	G - CAPITAL RELATED COSTS		0	205, 372			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	O	457, 978			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	O	911, 663			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 7. 00		0. 00 0. 00	0	0			6. 00 7. 00
8. 00		0.00	o	Ö			8. 00
9. 00		0.00	0	0			9. 00
10.00		0. 00	0	0			10.00
11.00		0.00	0	0			11. 00
12. 00 13. 00		0. 00 0. 00	0	0			12. 00 13. 00
14. 00		0.00	0	o			14. 00
15. 00		0.00	0	0			15. 00
16. 00		0. 00	0	0			16. 00
17. 00		0.00	0	0			17. 00
18. 00 19. 00		0. 00 0. 00	0	0			18. 00 19. 00
19.00				1, 369, 641			17.00
	H - LEASE EXPENSE	<u> </u>	<u> </u>	1,007,011			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11 <u>3, 5</u> 10			1. 00
	0		0	113, 510			
1. 00	I - COO/CNO ADMI NI STRATI VE & GENERAL	5. 00	191, 485	0			1.00
1.00	0		191, 485	0			1.00
	J - UTILITIES		1717 100	<u> </u>			
1.00	UTILITIES	7. 01	0	371, 388			1. 00
2.00		0.00	0	0			2. 00
	K - LAUNDRY		U	371, 388			
1. 00	LAUNDRY & LINEN SERVICE	8. 00	0	71, 587			1.00
	TOTALS			71, 587			
	L - OBSTETRI CS						
1. 00 2. 00	DELIVERY ROOM & LABOR ROOM	52. 00 0. 00	124, 310	39, 563 0			1.00
2.00			124, 310	39, 563			2.00
	M - CAFETERIA		121,010	07, 000			
1.00	CAFETERI A	11. 00	67, 908	110, 964			1. 00
	0		67, 908	110, 964			
1 00	N - OT AND ST OCCUPATIONAL THERAPY	67.00	00 (12	25 (02			1 00
1. 00 2. 00	SPEECH PATHOLOGY	68.00	90, 612 60, 763	25, 682 17, 222			1.00
2.00	0		151, 375	42, 904			2.00
	O - ACCRUED PTO						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	51, 693	0			1. 00
2. 00 3. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	681 7, 054	0			2. 00 3. 00
4.00	NURSING ADMINISTRATION	13. 00	5, 323	0			4. 00
5. 00	PHARMACY	15. 00	6, 115	Ö			5. 00
6.00	RESPI RATORY THERAPY	65.00	3, 542	0			6. 00
7. 00	PHYSI CAL THERAPY	66.00	10, 802	0			7. 00
8.00	RURAL HEALTH CLINIC	88.00	6, 482	0			8.00
9. 00	TOTALS	<u>91. 00</u>	1 <u>0, 1</u> 08 101, 800	0			9. 00
	Q - BLOOD STORAGE		101,000	<u> </u>			
1.00	LABORATORY	60.00	0	4, 504			1.00
	TOTALS		0	4, 504			
4 60	R - PREMIUM WAGES	20.0=	/= ^=!	4 0 4 5			
1.00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	67, 271	4, 945 2, 429			1.00
2.00 3.00	RESPIRATORY THERAPY	65. 00	33, 039 44, 912	2, 429 3, 302			3.00
4. 00	EMERGENCY	91.00	71, 541	5, 259			4.00
							1
	TOTALS Grand Total: Increases		216, 763 853, 641	15, 935 6, 498, 645			500. 00

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 1:16 pm

		Decreases				5/26/2022 1:1	lo pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - EMPLOYEE BENEFITS	7.00	0.00	7.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5.00		60, 337	0		1.00
2.00	OPERATION OF PLANT	7.00		103, 503	o		2. 00
3.00	HOUSEKEEPI NG	9. 00		68, 514			3. 00
4.00	DI ETARY	10.00		50, 369	1		4. 00
5. 00	NURSI NG ADMI NI STRATI ON	13.00		221, 812	1		5. 00
6.00	PHARMACY	15. 00		48, 633	I I		6. 00
7.00	NONPHYSI CI AN ANESTHETI STS	19.00		28, 818	I I		7.00
8. 00 9. 00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00		330, 632	I I		8. 00 9. 00
10. 00	RADI OLOGY-DI AGNOSTI C	54.00		98, 524 127, 997	1		10.00
11. 00	INTRAVENOUS THERAPY	64. 00		23, 522	1		11.00
12. 00	RESPIRATORY THERAPY	65.00		35, 715			12.00
13. 00	PHYSI CAL THERAPY	66.00		108, 596	1		13. 00
14.00	RURAL HEALTH CLINIC	88.00		216, 671	1		14. 00
15.00	CLINIC	90.00		1, 801	0		15. 00
16.00	VISITING SPECIALTY CLINIC	90. 01		56, 515	0		16. 00
17. 00	EMERGENCY	91.00		299, 556	0		17. 00
18. 00	PHYSICIANS' PRIVATE OFFICES	192.00		1, 374			18. 00
	0		0	1, 882, 889			
1 00	B - BILLABLE DRUGS	14.00					1 00
1. 00 2. 00	CENTRAL SERVICES & SUPPLY PHARMACY	15. 00	0	l .	1		1. 00 2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	1	1		3.00
4.00	NURSERY	43.00	0	1	1		4. 00
5. 00	OPERATING ROOM	50.00	0		1		5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1	1		6. 00
7.00	INTRAVENOUS THERAPY	64.00	O	1	1		7. 00
8.00	RESPI RATORY THERAPY	65.00	0	953	0		8. 00
9.00	PHYSI CAL THERAPY	66.00	0	80	0		9. 00
10.00	VISITING SPECIALTY CLINIC	90. 01	0		1		10.00
11. 00	EMERGENCY	91.00	0				11. 00
	0		0	2, 077, 598			
1 00	C - BILLABLE SUPPLIES	0.00		1 22			1 00
1. 00 2. 00	HOUSEKEEPI NG NURSI NG ADMI NI STRATI ON	9. 00 13. 00		33 708	1		1. 00 2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00		7, 153	1		3.00
4.00	PHARMACY	15. 00		42	1		4. 00
5. 00	ADULTS & PEDIATRICS	30.00		7, 639			5. 00
6. 00	NURSERY	43.00		946	1		6. 00
7.00	OPERATING ROOM	50.00		40, 178	o		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00		1, 013	o		8. 00
9.00	INTRAVENOUS THERAPY	64.00		782	. 0		9. 00
10.00	RESPI RATORY THERAPY	65.00		417	1		10.00
11. 00	PHYSI CAL THERAPY	66.00		4, 589			11. 00
12.00	VISITING SPECIALTY CLINIC	90. 01		4, 986	1		12.00
13. 00	EMERGENCY	91.00		8, 228			13. 00
	D - IMPLANT SUPPLIES		0	76, 714			
1.00	NURSING ADMINISTRATION	13.00		5, 025	0		1.00
2. 00	OPERATING ROOM	50.00		22, 679			2. 00
3.00	EMERGENCY	91.00		909			3. 00
	E - NON-BILLABLE DRUGS						
1.00	NONPHYSICIAN ANESTHETISTS	19. 00	O	1	1		1.00
2.00	ADULTS & PEDIATRICS	30.00	0		1		2. 00
3.00	NURSERY	43.00	0				3. 00
4.00	OPERATING ROOM	50.00	0				4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	.,	I I		5. 00
6.00	INTRAVENOUS THERAPY EMERGENCY	64. 00 91. 00	0				6.00
7. 00	D	91.00	0	5 <u>3, 2</u> 59 87, 463			7. 00
	F - NON-BILLABLE MED SUPPLIES	S		07, 403	1		1
1.00	ADMINISTRATIVE & GENERAL	5.00		2, 564	. 0		1.00
2. 00	PHARMACY	15. 00		5, 386	1		2. 00
3.00	NONPHYSICIAN ANESTHETISTS	19. 00		1, 651			3. 00
4.00	ADULTS & PEDIATRICS	30.00		45, 180	1		4. 00
5.00	NURSERY	43.00		4, 640	0		5. 00
6.00	DELIVERY ROOM & LABOR ROOM	52.00		49	1		6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00		17, 427	1		7. 00
8.00	LABORATORY	60.00		2, 635	1		8. 00
9.00	I NTRAVENOUS THERAPY	64.00		2, 640	1		9.00
10. 00 11. 00	RESPIRATORY THERAPY RURAL HEALTH CLINIC	65. 00 88. 00		56, 038 1, 166	1		10. 00 11. 00
11.00	INDIAL HEALTH CLIMIC	00.00		1, 100	· _I		11.00

Heal th	Financial Systems		IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	-2552-10
RECLAS	SIFI CATIONS			Provi der (Peri od:	Worksheet A-	6
						From 01/01/2021 Fo 12/31/2021	Date/Time Pro	epared:
							5/26/2022 1:	
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.	I		
	6. 00	7.00	8. 00	9. 00	10.00			
12. 00	VISITING SPECIALTY CLINIC	90. 01		5, 929				12. 00
13.00	EMERGENCY	91.00		6 <u>0, 0</u> 67				13. 00
	O CARLEAL RELATER COSTS		0	205, 372	2			
1.00	G - CAPITAL RELATED COSTS EMPLOYEE BENEFITS DEPARTMENT	4.00		803	9	I		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		56, 196		1		2. 00
3. 00	OPERATION OF PLANT	7. 00		325, 755				3. 00
4.00	HOUSEKEEPI NG	9. 00		948				4. 00
5.00	DI ETARY	10.00		6, 091				5. 00
6.00	NURSING ADMINISTRATION	13.00		5, 042				6. 00
7. 00 8. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00		1, 265 69, 420				7. 00 8. 00
9. 00	NONPHYSICIAN ANESTHETISTS	19.00	•	7, 854				9. 00
10.00	ADULTS & PEDIATRICS	30.00		66, 143				10.00
11. 00	NURSERY	43. 00		597	0			11. 00
12. 00	OPERATING ROOM	50.00		213, 609				12. 00
13.00	RADI OLOGY-DI AGNOSTI C	54.00		264, 422				13.00
14. 00 15. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00		7, 206 142, 237				14. 00 15. 00
16. 00	RURAL HEALTH CLINIC	88.00		157, 887				16. 00
17. 00	VISITING SPECIALTY CLINIC	90. 01		4, 313				17. 00
18.00	EMERGENCY	91.00		39, 589	0			18. 00
19. 00	PAOLI FAMILY PRACTICE	1 <u>90.</u> 05		<u> </u>				19. 00
	0		0	1, 369, 641				
1.00	H - LEASE EXPENSE ADMINISTRATIVE & GENERAL	5.00	0	113, 510	10			1.00
1.00	0		— —)	113, 510				1.00
	I - COO/CNO	L	-1	,	1			
1.00	NURSING ADMINISTRATION	1300	191, 485	0	0			1.00
	0		191, 485	C)			
1.00	J - UTILITIES OPERATION OF PLANT	7.00	0	325, 696	0			1.00
2. 00	RURAL HEALTH CLINIC	88.00	0	45, 692		1		2. 00
	0			371, 388				
	K - LAUNDRY							
1.00	HOUSEKEEPI NG	9.00	•	7 <u>1, 5</u> 87				1. 00
	TOTALS L - OBSTETRI CS		0	71, 587				
1.00	ADULTS & PEDIATRICS	30.00	15, 360	38, 670	0			1.00
2. 00	NURSERY	43.00	108, 950	893		•		2. 00
	0 — — — — —		124, 310	39, 563	3			
	M - CAFETERIA				_	T		
1. 00	DI ETARY	10.00	6 <u>7, 908</u> 67, 908	110, 964				1.00
	N - OT AND ST		67, 908	110, 964				
1.00	PHYSI CAL THERAPY	66.00	151, 375	42, 904	0			1.00
2.00		0.00	0	C	0	l e		2. 00
	0		151, 375	42, 904				
4 00	O - ACCRUED PTO	0.00	, 205			I		4 00
1. 00 2. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	6, 395 4, 585	0	0			1. 00 2. 00
3.00	NONPHYSICIAN ANESTHETISTS	19. 00	40, 979	0	0			3. 00
4. 00	ADULTS & PEDIATRICS	30.00	19, 704	Ö	0			4. 00
5.00	OPERATING ROOM	50.00	17, 031	C	0			5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	2, 560	C	0			6. 00
7.00	INTRAVENOUS THERAPY	64.00	712	C	0			7. 00
8. 00 9. 00	VISITING SPECIALTY CLINIC	90. 01 0. 00	9, 834	0	0			8. 00 9. 00
7.00	TOTALS — — — —		101, 800	0	<u>-</u>			7.00
	Q - BLOOD STORAGE	l l	,					
1.00	OPERATION OF PLANT	7.00	0	<u>4, 5</u> 04				1.00
	TOTALS		0	4, 504				
1 00	R - PREMIUM WAGES	12.00	21/ 7/2	15 025		I		1 00
1. 00 2. 00	NURSING ADMINISTRATION	13. 00 0. 00	216, 763 0	15, 935 0	0	•		1. 00 2. 00
3.00		0.00	o	C	o o			3. 00
4.00		0.00	0		0			4. 00
F00 0-	TOTALS		216, 763	15, 935				F00 05
500.00	Grand Total: Decreases	l l	853, 641	6, 498, 645	P	l		500. 00

				T	0 12/31/2021	Date/Time Pre 5/26/2022 1:1	
				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	Γ BALANCES					
1.00	Land	183, 505	0	0	0	0	1. 00
2.00	Land Improvements	438, 464	187, 140	0	187, 140	0	2. 00
3.00	Buildings and Fixtures	4, 741, 722	3, 789, 830	0	3, 789, 830	0	3. 00
4.00	Building Improvements	1, 939, 739	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	11, 151, 354	1, 056, 677	0	1, 056, 677	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	18, 454, 784	5, 033, 647	0	5, 033, 647	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	18, 454, 784	5, 033, 647	0	5, 033, 647	0	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	183, 505	0				1. 00
2.00	Land Improvements	625, 604	258, 464				2. 00
3.00	Buildings and Fixtures	8, 531, 552	2, 449, 205				3. 00
4.00	Building Improvements	1, 939, 739	791, 602				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	12, 208, 031	4, 019, 110				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	23, 488, 431	7, 518, 381				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	23, 488, 431	7, 518, 381				10.00

Health Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Period: From 01/01/2021	Worksheet A-7 Part II	
				To 12/31/2021	Date/Time Prep 5/26/2022 1:10	
		SL	JMMARY OF CAP	TAL	37 207 2022 1. 10	о ріп
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
	9.00	10. 00	11.00	instructions) 12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FRO				12.00	13.00	
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0)	0 0	0	2. 00
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3. 00
	SUMMARY OF	CAPI TAL				
Cost Center Description	Other T	otal (1) (sum	_			
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14.00	15. 00	L			
PART II - RECONCILIATION OF AMOUNTS FRO	M WORKSHEET A, COLUMN	I 2, LINES 1 a	ind 2			
1. 00 CAP REL COSTS-BLDG & FLXT	0	0	1			1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0	1			2.00
3.00 Total (sum of lines 1-2)	ا	0	1		ļ	3. 00

Health Financial Systems	IU HEALTH PAC	OLI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021	Worksheet A-7 Part III	
				o 12/31/2021	Date/Time Pre	
	TIOS	ALLOCATION OF	5/26/2022 1: 10 OTHER CAPITAL	o piii		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col .			
	1.00	2.00	2) 3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COS		2.00	3.00	4.00	3.00	
1. 00 CAP REL COSTS-BLDG & FLXT	11, 280, 400	0	11, 280, 400	0. 480253	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	12, 208, 031	•	12, 208, 031		0	2. 00
3.00 Total (sum of lines 1-2)	23, 488, 431	0	23, 488, 431	1.000000	0	3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	-	1 0	1			
Cost Center Description	Taxes	Other Capital-Relate	Total (sum of cols. 5	Depreciation	Lease	
		d Costs	through 7)			
	6, 00	7.00	8. 00	9, 00	10.00	
PART III - RECONCILIATION OF CAPITAL COS			9.00			
1.00 CAP REL COSTS-BLDG & FLXT	C	0	C	445, 935	125, 553	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		0	C	911, 663	0	2. 00
3.00 Total (sum of lines 1-2)	C	0	C	1, 357, 598	125, 553	3. 00
		Sl	JMMARY OF CAPIT	ΓAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
cost center bescription	Tillerest			Capi tal -Rel ate		
		Tristructions)	Tristructions)	d Costs (see	through 14)	
				instructions)	in ough in	
	11. 00	12.00	13.00	14.00	15. 00	
PART III - RECONCILIATION OF CAPITAL COS	TS CENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	C		1		571, 488	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	C	1	1	-	911, 663	
3.00 Total (sum of lines 1-2)	C	0	d c	0	1, 483, 151	3. 00

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-1306 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 1:16 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 12.043 CAP REL COSTS-BLDG & FIXT 1. 00 В 1.00 10 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 9.00 0.00 -2, 917, 608 10.00 10.00 Provider-based physician A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 5, 562, 259 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -29, 258 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 0 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) OPHYSICAL THERAPY 24.00 Adjustment for physical A-8-3 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 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 ONONPHYSICIAN ANESTHETISTS 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 OCAP REL COSTS-MVBLE EQUIP 32.00 Α 2.00 Depreciation and Interest 33. 00 MI SCELLANEOUS INCOME

4, 594 ADMINI STRATI VE & GENERAL

5 00

0 33.00

В

Peri od: | WUI KSHE | From 01/01/2021 | Ta | 12/21/2021 | Date/Ti

				To	0 12/31/2021	Date/Time Pre 5/26/2022 1:1	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
33. 01	MI SCELLANEOUS I NCOME	В	·	PHARMACY	15. 00		
33. 02	MI SCELLANEOUS I NCOME	В		OPERATING ROOM	50. 00		33. 02
33. 03	MI SCELLANEOUS I NCOME	В		PHYSI CAL THERAPY	66. 00		33. 03
33. 04	MI SCELLANEOUS I NCOME	В	·	RURAL HEALTH CLINIC	88. 00		33. 04
33. 05	MI SCELLANEOUS I NCOME	В		VISITING SPECIALTY CLINIC	90. 01		33. 05
33. 06	HAF	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	BENEFITS	A	-1, 882, 438	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 07
33. 08	CRNA	A	-357, 533	NONPHYSICIAN ANESTHETISTS	19. 00	0	33. 08
33. 09	MARKETI NG	A	-252	RURAL HEALTH CLINIC	88.00	0	33. 09
33. 10	CLINIC START UP AMORTIZIATION	A	41, 430	RURAL HEALTH CLINIC	88. 00	0	33. 10
33. 11	UNWONTED SITUATIONS	A	-1, 250	NURSING ADMINISTRATION	13.00	0	33. 11
33. 12	TELEPHONE EXPENSE	A	-13	RURAL HEALTH CLINIC	88.00	0	33. 12
33. 13	MEDICAL DIRECTOR FEE	A	25, 000	LABORATORY	60.00	0	33. 13
50.00	TOTAL (sum of lines 1 thru 49)		-320, 860				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽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

Provi der CCN: 15-1306

Peri od: Worksheet A-8-1 From 01/01/2021 Pari CT: Peri Od: Worksheet A-8-1

				To 12/31/2021	Date/Time Pre 5/26/2022 1:1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	<u> </u>
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	-12, 043	0	1. 00
2.00			HOME OFFICE ALLOCATION	1, 819, 379		2. 00
3.00		ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4, 931, 869	4, 194, 234	
3. 01	1	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	250, 489	0	3. 01
3.02	88. 00	RURAL HEALTH CLINIC	HOME OFFICE ALLOCATION	0	63, 937	3. 02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	90, 210	40, 232	3. 03
3.04	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1, 256, 450	398, 633	3. 04
3.05	13. 00	NURSING ADMINISTRATION	RELATED PARTY	36, 789	29, 379	3. 05
3.06	15. 00	PHARMACY	RELATED PARTY	191, 912	105, 926	3. 06
3.07	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	25, 983	0	3. 07
3.08	66.00	PHYSI CAL THERAPY	RELATED PARTY	163, 592	97, 458	3. 08
3.09	90.00	CLINIC	RELATED PARTY	13, 243	25, 453	3. 09
3. 10	91.00	EMERGENCY	SIP ER ALLOCATION	2, 806, 323	1, 056, 685	3. 10
3. 11	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	2, 463	2, 463	3. 11
3. 12	5. 00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	26, 088	26, 088	3. 12
3. 13	10.00	DI ETARY	SHARED EMPLOYEES	5, 723	5, 723	3. 13
3.14	15. 00	PHARMACY	SHARED EMPLOYEES	-27, 173	-27, 173	3. 14
3. 15	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	38, 916	38, 916	3. 15
3. 16	60.00	LABORATORY	SHARED EMPLOYEES	1, 853, 780	1, 853, 780	3. 16
3. 17	65. 00	RESPI RATORY THERAPY	SHARED EMPLOYEES	7, 875	7, 875	3. 17
3. 18	66.00	PHYSI CAL THERAPY	SHARED EMPLOYEES	-26, 866	-26, 866	3. 18
3. 19	88. 00	RURAL HEALTH CLINIC	SHARED EMPLOYEES	3, 745	3, 745	3. 19
4.00	91.00	EMERGENCY	SHARED EMPLOYEES	-23, 446	-23, 446	4. 00
5.00	TOTALS (sum of lines 1-4).			13, 435, 301	7, 873, 042	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nuo	not bec	in posted to norkaneet n,	cordinas i dilayor 2, the diled	il airowabi c sii	dara be inarcated in cordiiir i	or till 5 part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Name	Percentage of	Name	Percentage of	
				Ownershi p		Ownershi p	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	В	0.00 I U HEALTH BLOOM 0.0	6.00
7.00	В	0.00 IU HEALTH 100.0	7.00
8.00	C	0.00 I UH SI P 0.0	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

OFFICE	00515				To 12/31/2021	Date/Time Pre	
		h				5/26/2022 1:1	6 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*	7.00					
	6. 00	7.00	AENTO DECLUEDED AC A DECLUET OF TDA	NCACTIONS WITH DELATED O	DOANI ZATLONG OD	OLALMED.	
	HOME OFFICE CO		MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED U	RGANIZATIONS OR	CLAIMED	
1. 00	-12, 043						1.00
2. 00	1, 819, 379						2.00
3.00	737, 635	1					3.00
3. 00	250, 489						3. 00
3. 01	-63, 937						3. 01
3. 02	49, 978						3. 02
3. 03	857, 817						3. 03
3. 04	7, 410						3. 04
							1
3.06	85, 986						3.06
3. 07	25, 983						3. 07
3.08	66, 134						3.08
3.09	-12, 210						3. 09
3. 10	1, 749, 638						3. 10
3. 11 3. 12							3. 11
3. 12							3. 12 3. 13
3. 13							3. 13
3. 14							3. 14
3. 16							3. 16
3. 10							3. 10
3. 17							3. 17
3. 10							3. 19
4.00							4.00
5. 00	5, 562, 259						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	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOSPI TAL	6. 00
7.00	HOME OFFICE	7. 00
8.00	PHYSICIAN GROUP	8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1306

						To 12/31/2021	Date/Time Pre 5/26/2022 1:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·			Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	19, 315	19, 315	5 0	_		1. 00
2.00		NURSING ADMINISTRATION	1, 247			_		
3.00		ADULTS & PEDIATRICS	909, 141				0	0.00
4.00		EMERGENCY	2, 578, 847	1, 987, 905	590, 942	0	0	1 00
5.00	0.00		0	(0	0	0	5. 00
6. 00	0.00		0	(0	0	0	0.00
7. 00	0.00		0	(0	0	0	7. 00
8.00	0.00		0	(0	0	0	8. 00
9. 00	0. 00		0	(0	0	0	9. 00
10.00	0.00		0	(0	0	0	10.00
200.00			3, 508, 550					200.00
	Wkst. A Line #		Unadjusted RCE			Provi der	Physician Cost	
		ldenti fi er	Limit		Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	8.00	9. 00	Educati on	12 13. 00	14.00	
1. 00	1.00	2.00 ADMINISTRATIVE & GENERAL	8.00		12.00		14.00	1. 00
2. 00		NURSING ADMINISTRATION		1		_	_	
3. 00		ADULTS & PEDIATRICS		1	٥	_		1
4. 00		EMERGENCY						1
5. 00	0.00							1
6. 00	0.00							i
7. 00	0.00							1
8. 00	0.00							8. 00
9. 00	0.00		0			0	0	
10. 00	0.00		0			0	0	1
200.00	0.00		0			0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	-	
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 00	ADMINISTRATIVE & GENERAL	0	(0	19, 315		1. 00
2.00	13. 00	NURSING ADMINISTRATION	0	(0	1, 247		2. 00
3.00		ADULTS & PEDIATRICS	0	(0			3. 00
4.00		EMERGENCY	0	(0	1, 987, 905		4. 00
5.00	0.00		0	(0	0		5. 00
6.00	0.00		0	(0	0		6. 00
7.00	0. 00		0		0	0		7. 00
8.00	0. 00		0		0	0		8. 00
9.00	0.00		0	(0	0		9. 00
10.00	0.00		0	(0	0		10.00
200.00			0	(o	2, 917, 608		200. 00

Heal th	Financial Systems	IU HEALTH PAOL	I HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der CO		eri od:	Worksheet B	
					rom 01/01/2021	Part I	
				1	o 12/31/2021	Date/Time Pre	pared:
						5/26/2022 1:1	6 pm
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)					
		0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	U	1.00	2.00	4.00	44	
4 00		F74 400	F74 400				4 00
1. 00	00100 CAP REL COSTS-BLDG & FIXT	571, 488	571, 488				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	911, 663		911, 663			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 003, 837	6, 740	11, 347	2, 021, 924		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 329, 916	32, 884	55, 363	139, 112	7, 557, 275	5. 00
7.00	00700 OPERATION OF PLANT	1, 229, 893	40, 295	67, 839	88, 207	1, 426, 234	7. 00
7. 01	00701 UTI LI TI ES	371, 388	0	(371, 388	
8.00	00800 LAUNDRY & LINEN SERVICE	71, 589	2, 718	-	-	78, 882	
9. 00	00900 HOUSEKEEPING	442, 913	8, 026				
	1	1				510, 874	
10.00	01000 DI ETARY	250, 338	16, 116			312, 715	
11. 00	01100 CAFETERI A	149, 614	8, 851	14, 901		187, 034	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 221, 299	16, 977	28, 581	193, 342	1, 460, 199	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	236, 793	18, 671	31, 434	0	286, 898	14.00
15.00	01500 PHARMACY	513, 036	10, 590	17, 829	53, 636	595, 091	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	6, 821	11, 484		18, 305	
17. 00	01700 SOCIAL SERVICE	ا	0, 5	,	1	0	17. 00
	01900 NONPHYSICIAN ANESTHETISTS	253, 822	0			324, 333	
19.00		203, 022	U		70, 311	324, 333	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	4 704 044	/= /04			0.470.0/4	
30. 00	03000 ADULTS & PEDI ATRI CS	1, 704, 964	67, 681	113, 944	283, 772	2, 170, 361	
31. 00	03100 INTENSIVE CARE UNIT	0	0	(0	0	31. 00
43.00	04300 NURSERY	45, 722	2, 265	3, 813	7, 324	59, 124	43.00
	ANCILLARY SERVICE COST CENTERS]
50.00	05000 OPERATI NG ROOM	617, 180	54, 599	91, 921	97, 795	861, 495	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	198, 405	4, 539			242, 366	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 426, 661	54, 227	91, 296		1, 757, 099	
60.00	06000 LABORATORY	1, 913, 560	17, 248			1, 959, 847	
64. 00	06400 I NTRAVENOUS THERAPY	155, 124	6, 957	11, 713		198, 318	1
65.00	06500 RESPI RATORY THERAPY	426, 871	4, 412	7, 428	68, 797	507, 508	65.00
66.00	06600 PHYSI CAL THERAPY	617, 734	37, 477	63, 096	86, 596	804, 903	66.00
67.00	06700 OCCUPATI ONAL THERAPY	116, 294	7, 890	13, 284	18, 237	155, 705	67.00
68. 00	06800 SPEECH PATHOLOGY	77, 985	5, 290	8, 907		104, 412	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	75, 139	0, 2, 0	(75, 139	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	28, 613	0		-	28, 613	
			0	_	-		
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 077, 598	0	(-	2, 077, 598	
74. 00	07400 RENAL DI ALYSI S	0	0	C	-	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	(1	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	1, 377, 894	45, 277	75, 770	238, 809	1, 737, 750	88. 00
89 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				1
	09000 CLINIC	59, 887	344				90.00
90. 01	09001 VISITING SPECIALTY CLINIC	239, 023	27, 530			347, 727	
		237, 023	27, 550	40, 330	34, 024		
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0 (50 (0)	07.050		0	0	
	09100 EMERGENCY	2, 653, 491	37, 350	62, 882	299, 765	3, 053, 488	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	C	0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	·					1
113 00	11300 NTEREST EXPENSE						113. 00
118.00		29, 369, 734	541, 775	911, 663	2, 021, 924	29, 340, 021	
110.00	NONREI MBURSABLE COST CENTERS	27, 307, 734	341, 773	711,000	2,021,724	27, 340, 021	1110.00
400.00			0		ار	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(190. 00
	19001 VISITING SPECIALTY CLINIC	203	0	C			190. 01
	19002 OUTREACH	2	4, 058	() 0		190. 02
190. 03	19003 FOUNDATI ON	0	0	C	0	0	190. 03
190.04	19004 SPRING VALLEY FAMILY PRACTICE	0	0	C	0	0	190. 04
	19005 PAOLI FAMILY PRACTICE	4, 272	0	C	ol ol	4. 272	190. 05
	19006 OTHER PROPERTY	1,72,72	25, 6 55		ا ما		190.06
	19100 RESEARCH		23, 300		Jl Ä		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	19	0	,			192.00
		19	0		(
	19300 NONPAI D WORKERS	0	U	('l '		193. 00
200.00							200. 00
201.00			0	(0		201. 00
202.00	TOTAL (sum lines 118 through 201)	29, 374, 230	571, 488	911, 663	2, 021, 924	29, 374, 230	202. 00

					0 12/31/2021	5/26/2022 1:1	parea: 6 nm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	O pili
	, , , , , , , , , , , , , , , , , , ,	& GENERAL	PLANT		LINEN SERVICE		
		5. 00	7. 00	7. 01	8. 00	9. 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	7, 557, 275	4 000 074				5. 00
7.00	00700 OPERATION OF PLANT	494, 040	1, 920, 274				7. 00
7. 01	00701 UTI LI TI ES	128, 647	10.005	500, 035			7. 01
8.00	00800 LAUNDRY & LI NEN SERVI CE	27, 324	12, 835			733, 980	8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	176, 964	37, 905				
10. 00 11. 00	01100 CAFETERI A	108, 323	76, 109			27, 791 15, 262	
13. 00		64, 788 505, 806	41, 798 51, 296			29, 275	1
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	99, 380	88, 174			29, 275	1
15. 00	01500 PHARMACY	206, 137	50, 012			0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 341	32, 215			11, 763	
17. 00	01700 SOCIAL SERVICE	0, 341	32, 213 N	7,001		0	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	112, 347	0			0	1
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	112, 547			,		17.00
30. 00	03000 ADULTS & PEDIATRICS	751, 802	319, 623	69, 459	110, 456	116, 711	30.00
31. 00	03100 NTENSI VE CARE UNI T	0	0.7,620	0,7,10,7	0	0	1
43. 00	04300 NURSERY	20, 480	10, 696	2, 324	11, 374		1
	ANCILLARY SERVICE COST CENTERS			_,	,		1
50.00	05000 OPERATI NG ROOM	298, 418	257, 848	56, 033	0	94, 151	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	83, 954	21, 434	4, 658	0	7, 826	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	608, 650	256, 094			93, 511	1
60.00	06000 LABORATORY	678, 881	81, 457	17, 701	0	29, 743	60.00
64.00	06400 I NTRAVENOUS THERAPY	68, 696	32, 857	7, 140	0	11, 997	64. 00
65.00	06500 RESPI RATORY THERAPY	175, 798	20, 835	4, 528	0	7, 608	65. 00
66.00	06600 PHYSI CAL THERAPY	278, 814	6, 289	38, 461	0	64, 626	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	53, 935	1, 326		0	13, 606	67. 00
68. 00	06800 SPEECH PATHOLOGY	36, 168	898	5, 429	0	9, 123	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 028	0	C	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 911	0	C	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	719, 670	0	C	0	0	
74. 00	07400 RENAL DI ALYSI S	0	0	C	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS		010 511	1 44 405		77 (00	
88. 00	08800 RURAL HEALTH CLINIC	601, 948	212, 541	46, 187		1	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	·	_	1	
90.00	09000 CLINIC	24, 019	1, 626			594	1
90. 01 90. 02	09001 VISITING SPECIALTY CLINIC	120, 451	130, 015	28, 253	0	47, 474	1
90. 02	09002 PAOLI PRIMARY CARE CLINIC 09100 EMERGENCY	1 057 705	174 201	20 221	0	64 400	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 057, 705	176, 391	38, 331	U	64, 408	91.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95 00	09500 AMBULANCE SERVICES	O	0		0	0	95. 00
	10100 HOME HEALTH AGENCY		0				101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			,		101.00
113 00	11300 I NTEREST EXPENSE						113. 00
118. 00		7, 545, 425	1, 920, 274	473, 706	121, 830	726, 982	
110.00	NONREI MBURSABLE COST CENTERS	7,010,120	1, 720, 271	170,700	121,000	720, 702	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
	19001 VISITING SPECIALTY CLINIC	70	0	C	0		190. 01
	19002 OUTREACH	1, 406	0	l c	0	6, 998	190. 02
190. 03	19003 FOUNDATION	0	0	l c	0		190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	o	0	l c	0	0	190. 04
190.05	19005 PAOLI FAMILY PRACTICE	1, 480	0	C	0	0	190. 05
	19006 OTHER PROPERTY	8, 887	0	26, 329	0	0	190. 06
	19100 RESEARCH	0	0	C	0	0	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	7	0	C	0	0	192. 00
	19300 NONPALD WORKERS	0	0	C	0		193. 00
200.00							200.00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	7, 557, 275	1, 920, 274	500, 035	121, 830	733, 980	202. 00

				10	12/31/2021	Date/IIme Pre 5/26/2022 1:1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	J Pill
		10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7.00
7. 01 8. 00	00701 UTILITIES 00800 LAUNDRY & LINEN SERVICE						7. 01 8. 00
9. 00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY	541, 477					10.00
11. 00	01100 CAFETERI A	0	317, 965				11.00
13. 00	01300 NURSING ADMINISTRATION	l ol	30, 012	1			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	o	0	0	493, 613		14. 00
15. 00	01500 PHARMACY	o	10, 471	0	8, 334	880, 913	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	o	0	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	5, 651	0	2, 806	146	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	541, 477	50, 543		66, 182	6, 102	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
43. 00	04300 NURSERY	0	1, 137	20, 054	8, 003	273	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	14, 468	205, 847	39, 954	1, 962	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 933	1	39, 934 70	1, 902	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		34, 847	1	27, 130	2. 946	54.00
60. 00	06000 LABORATORY		32, 555	I	3, 872	2, 710	60.00
64. 00	06400 I NTRAVENOUS THERAPY	o	3, 902	·	4, 056	2, 488	1
65.00	06500 RESPIRATORY THERAPY	o	9, 753		80, 402	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	16, 781	0	804	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	3, 418	0	170	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	2, 450	0	114	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	107, 249	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	40, 838	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	845, 326	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 76. 97	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION	0	0		U O	0	75. 00 76. 97
70. 97	OUTPATIENT SERVICE COST CENTERS	l ol	0	ı <u>ı</u> 0	<u>U</u>	0	70.97
88. 00	08800 RURAL HEALTH CLINIC	0	34, 219	166, 003	6, 163	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	l ol	0.72.7	0	0, 100	0	89. 00
90.00	09000 CLI NI C	o	892	0	0	0	90.00
90. 01	09001 VISITING SPECIALTY CLINIC	o	10, 553	41, 116	9, 422	0	90. 01
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90. 02
91.00	09100 EMERGENCY	0	51, 380	605, 940	88, 044	21, 670	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00	OTHER REIMBURSABLE COST CENTERS				ما	0	05 00
95. 00		0	0	0	0	0	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	l ol	0	ıj Oj	······································	U	101. 00
113 00	11300 INTEREST EXPENSE						113. 00
118. 00		541, 477	317, 965	2, 094, 010	493, 613	880, 913	
	NONREI MBURSABLE COST CENTERS	3117177	0177700	2,0,1,0.0	170,010	3337 713	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190. 01	19001 VISITING SPECIALTY CLINIC	0	0	0	0	0	190. 01
190. 02	19002 OUTREACH	0	0	0	0	0	190. 02
	19003 FOUNDATI ON	0	0	0	0		190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
	19005 PAOLI FAMILY PRACTICE	0	0	0	0		190. 05
	19006 OTHER PROPERTY	0	0	<u> </u>	0		190.06
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES		0		0		191. 00 192. 00
	19200 PHYSICIANS PRIVATE OFFICES		0		0		192.00
200.00			U	ή	٩	U	200.00
201.00		n	Ω	0	0	n	201. 00
202.00		541, 477	317, 965	2, 094, 010	493, 613	880, 913	

Un Lieu of Form CMS-2552-10
Worksheet B
Part I
Date/Time Prepared:
5/26/2022 1:16 pm
Otal Intern &
Residents Cost Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH PAOLI HOSPITAL Provider CCN: 15-1306 Peri od: From 01/01/2021 To 12/31/2021 SOCI AL SERVI CE NONPHYSI CI AN ANESTHETI STS Cost Center Description MEDI CAL Subtotal RECORDS &

		RECORDS & LI BRARY		ANESTHETI STS		Residents Cost & Post	
		LIDIAKI				Stepdown	
		14.00	17.00	10.00		Adj ustments	
	GENERAL SERVI CE COST CENTERS	16. 00	17. 00	19. 00	24. 00	25. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 UTI LI TI ES						7. 01
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00							14. 00
15. 00							15. 00
	01600 MEDICAL RECORDS & LIBRARY	75, 625					16. 00
17. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	C				17. 00 19. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U U		445, 265			1 7. 00
30. 00		5, 703	C	0	5, 065, 284	0	30.00
31.00		0	C	o	0	0	31. 00
43.00		223	C	0	137, 593	0	43. 00
	ANCI LLARY SERVI CE COST CENTERS				0 004 474		
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	5, 717 837	C		2, 281, 176	0	50.00
54. 00	1 1	13, 559	C	1	453, 114 2, 891, 804	0	52. 00 54. 00
60.00	06000 LABORATORY	7, 051	C		2, 811, 107	0	60.00
64. 00		2, 142	C	Ö	400, 428	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	1, 599	C	0	808, 031	0	65. 00
66. 00	+ I	1, 682	C		1, 212, 360	0	66. 00
67. 00	+ I	325	C		236, 583	0	67. 00
68. 00	1	180	C	1	158, 774	0	68. 00
71. 00 72. 00	+ I	162 46	C	1	208, 578 79, 408	0	71. 00 72. 00
73. 00	1	12, 369	C		3, 654, 963	0	73. 00
74. 00	I I	0	C		0	0	74. 00
75. 00		O	C	0	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			.l al	0 000 500		
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	1, 109	C		2, 883, 528	0	88. 00 89. 00
90.00		64	C	1	96, 888	0	90.00
90. 00	09001 VISITING SPECIALTY CLINIC	872			735, 883	0	90.00
90. 02		0	C	o o	0	0	90. 02
91.00	09100 EMERGENCY	21, 985	C	0	5, 179, 342	0	91. 00
92. 00						0	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS			ار	0	0	05.00
95. 00 101. 0	09500 AMBULANCE SERVICES 0 10100 HOME HEALTH AGENCY	0	C	1	0	0	95. 00 101. 00
101.0	SPECIAL PURPOSE COST CENTERS	9		,			101.00
113. 0	11300 I NTEREST EXPENSE						113. 00
118. 0		75, 625	C	445, 283	29, 294, 844	0	118. 00
100.0	NONREI MBURSABLE COST CENTERS			J	0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC	0	C		0 273		190. 00 190. 01
	2 19002 OUTREACH		C		12, 464		190. 02
	3 19003 FOUNDATI ON	Ö	C	Ö	0		190. 03
190.0	4 19004 SPRING VALLEY FAMILY PRACTICE	o	C	0	0		190. 04
	19005 PAOLI FAMILY PRACTICE	0	C		5, 752		190. 05
	6 19006 OTHER PROPERTY	0	C	0	60, 871		190. 06
	0 19100 RESEARCH 0 19200 PHYSI CI ANS' PRI VATE OFFI CES				0		191. 00 192. 00
	019300 NONPALD WORKERS				26 0		192.00
200. 0					0		200. 00
201. 0		0	C	o	0	0	201. 00
202. 0	TOTAL (sum lines 118 through 201)	75, 625	C	445, 283	29, 374, 230	0	202. 00

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

Provider CCN: 15-1306

		To 12/31/2021 Date/Time Pro 5/26/2022 1: 7	
Cost Center Description	Total	372072022 1.	TO pill
	26. 00		
GENERAL SERVI CE COST CENTERS			
1. 00 00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL			4. 00 5. 00
7. 00 00700 OPERATION OF PLANT			7. 00
7. 01 00701 UTI LI TI ES			7. 01
8. 00 00800 LAUNDRY & 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 O1300 NURSING ADMINISTRATION			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00 01500 PHARMACY			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY			16.00
17. 00 01700 SOCIAL SERVICE			17. 00
19. 00 O1900 NONPHYSICIAN ANESTHETISTS I NPATIENT ROUTINE SERVICE COST CENTERS			19. 00
30. 00 03000 ADULTS & PEDIATRICS	5, 065, 284		30.00
31. 00 03100 NTENSI VE CARE UNI T	0,000,204		31.00
43. 00 04300 NURSERY	137, 593		43. 00
ANCI LLARY SERVI CE COST CENTERS			
50.00 05000 OPERATING ROOM	2, 281, 176		50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	453, 114		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 891, 804		54. 00
60. 00 06000 LABORATORY	2, 811, 107		60.00
64. 00 06400 I NTRAVENOUS THERAPY	400, 428		64. 00
65. 00 06500 RESPI RATORY THERAPY	808, 031		65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 212, 360		66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	236, 583 158, 774		67. 00 68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	208, 578		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	79, 408		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 654, 963		73. 00
74.00 07400 RENAL DIALYSIS	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		75. 00
76. 97 O7697 CARDIAC REHABILITATION	0		76. 97
OUTPATIENT SERVICE COST CENTERS			
88. 00 08800 RURAL HEALTH CLINIC	2, 883, 528		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		89. 00
90. 00 09000 CLI NI C	96, 888		90.00
90.01 09001 VISITING SPECIALTY CLINIC 90.02 09002 PAOLI PRIMARY CARE CLINIC	735, 883 0		90. 01 90. 02
91. 00 09100 EMERGENCY	5, 179, 342		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 177, 542		92. 00
OTHER REIMBURSABLE COST CENTERS			72.00
95. 00 09500 AMBULANCE SERVICES	0		95. 00
101.00 10100 HOME HEALTH AGENCY	0		101.00
SPECIAL PURPOSE COST CENTERS			
113. 00 11300 I NTEREST EXPENSE			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	29, 294, 844		118. 00
NONREI MBURSABLE COST CENTERS			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	273		190. 01
190. 02 19002 OUTREACH 190. 03 19003 FOUNDATI ON	12, 464		190. 02 190. 03
190. 03 19003 FOUNDATION 190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0		190. 03
190. 05 19005 PAOLI FAMILY PRACTICE	5, 752		190. 04
190. 06 19006 OTHER PROPERTY	60, 871		190. 05
191. 00 19100 RESEARCH	00, 071		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	26		192. 00
193. 00 19300 NONPALD WORKERS	0		193. 00
200.00 Cross Foot Adjustments	0		200. 00
201.00 Negative Cost Centers	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	29, 374, 230		202. 00

	Financial Systems	IU HEALIH PAO		N 45 4007 D		u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CO		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 1:1	pared: 6 pm
			CAPI TAL REI	_ATED_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	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 7. 01	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 UTILITIES	0 250, 489 0		11, 347 55, 363 67, 839 0	18, 087 338, 736 108, 134	18, 087 1, 244 789 0	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	2, 718	4, 575	7, 293	0	8.00
9. 00	00900 HOUSEKEEPI NG	0	8, 026	13, 513	21, 539	415	1
10.00	01000 DI ETARY	0	16, 116	27, 133	43, 249	171	
11.00	01100 CAFETERI A	0	8, 851	14, 901	23, 752	122	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	16, 977 18, 671	28, 581 31, 434	45, 558 50, 105	1, 729 0	13. 00 14. 00
15. 00	01500 PHARMACY	0		17, 829	28, 419	480	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	6, 821	11, 484	18, 305	0	16. 00
17. 00	01700 SOCIAL SERVICE	0		0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	631	19. 00
30. 00	03000 ADULTS & PEDIATRICS	0	67, 681	113, 944	181, 625	2, 538	30.00
31. 00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
43. 00	04300 NURSERY	0	2, 265	3, 813	6, 078	66	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	54, 599	01 021	144 520	875	50.00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		· ·	146, 520 12, 180	284	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0		91, 296	145, 523	1, 654	1
60.00	06000 LABORATORY	0	17, 248		46, 287	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	6, 957	11, 713	18, 670	219	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	4, 412 37, 477	7, 428 63, 096	11, 840 100, 573	615 774	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	7, 890		21, 174	163	1
68. 00	06800 SPEECH PATHOLOGY	0	5, 290	8, 907	14, 197	109	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	ō	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	45, 277	75, 770	121, 047	2, 136	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		75, 770	121, 047	2, 130	1
90.00	09000 CLI NI C	0		580	924	76	
90. 01	09001 VISITING SPECIALTY CLINIC	0	·	46, 350	73, 880	311	
90. 02 91. 00	09002 PAOLI PRIMARY CARE CLINIC 09100 EMERGENCY	0	_	0 62, 882	0 100, 232	0 2, 686	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	37, 330	02, 002	100, 232	2, 000	92.00
	OTHER REIMBURSABLE COST CENTERS	1			- 1		
	09500 AMBULANCE SERVICES	0			0	0	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113 00	11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	250, 489	541, 775	911, 663	1, 703, 927		118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. 00
	19001 VISITING SPECIALTY CLINIC 19002 OUTREACH	0	_	0	0 4, 058		190. 01 190. 02
	19002 OUTREACH 3 19003 FOUNDATION	0	4, USO 0		4, USO		190. 02
	19004 SPRING VALLEY FAMILY PRACTICE	0	Ö	O	Ö	0	190. 04
	19005 PAOLI FAMILY PRACTICE	0	0	0	o		190. 05
	19006 OTHER PROPERTY	0	25, 655	0	25, 655		190.06
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	0) 0 n		0		191. 00 192. 00
	19300 NONPALD WORKERS		0		ol		193. 00
200.00	Cross Foot Adjustments				o		200. 00
201.00		050 400	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	250, 489	571, 488	911, 663	1, 733, 640	18, 087	202. 00

Provider CCN: 15-1306

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 1:16 pm |

				'	0 12/31/2021	5/26/2022 1:1	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	PLANT	7.04	LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	7. 01	8. 00	9. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	339, 980					5. 00
7. 00	00700 OPERATION OF PLANT	22, 225	131, 148				7. 00
7. 01	00701 UTI LI TI ES	5, 787	0	5, 787			7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	1, 229	877	32			8. 00
9.00	00900 HOUSEKEEPI NG	7, 961	2, 589			32, 599	9. 00
10.00	01000 DI ETARY	4, 873	5, 198	191	0	1, 234	10. 00
11.00	01100 CAFETERI A	2, 915	2, 855	105	0	678	11. 00
13.00	01300 NURSING ADMINISTRATION	22, 754	3, 503	202	0	1, 300	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	4, 471	6, 022	222	0	0	14. 00
15. 00	01500 PHARMACY	9, 273	3, 416	126	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	285	2, 200	81	0	522	1
17. 00	01700 SOCI AL SERVI CE	0	0	C	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	5, 054	0	C	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			1		
30.00	03000 ADULTS & PEDIATRICS	33, 821	21, 828	•		5, 184	
31. 00	03100 I NTENSI VE CARE UNI T	0	0			0	31.00
43. 00	04300 NURSERY	921	730	27	880	173	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	12 425	17 410	4.40	0	4 102	E0 00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	13, 425 3, 777	17, 610 1, 464	•		4, 182 348	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	27, 381	17, 490	•		l	1
60.00	06000 LABORATORY	30, 540	5, 563			1, 321	
64. 00	06400 NTRAVENOUS THERAPY	3, 090	2, 244	•		1	
65. 00	06500 RESPI RATORY THERAPY	7, 908	1, 423	•		338	1
66. 00	06600 PHYSI CAL THERAPY	12, 543	430			2, 870	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 426	91	94		604	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 627	61	63		405	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 171	0	l c		0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	446	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	32, 375	0	C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	C	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				1		
88. 00	08800 RURAL HEALTH CLINIC	27, 079	14, 516			-,	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
90.00	09000 CLINIC	1, 081	111	4	0	26	90.00
90. 01	09001 VISITING SPECIALTY CLINIC	5, 419	8, 880	1		2, 109	
90. 02	09002 PAOLI PRIMARY CARE CLINIC 09100 EMERGENCY	47 500	12.047	0	_	0	90.02
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	47, 590	12, 047	444	0	2, 861	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95 00	09500 AMBULANCE SERVICES		0		0	0	95. 00
	10100 HOME HEALTH AGENCY		0	Ö			101.00
101.00	SPECIAL PURPOSE COST CENTERS	٩					101.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		339, 447	131, 148	5, 482	9, 431	32, 288	118. 00
	NONREI MBURSABLE COST CENTERS					•	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
190.01	19001 VISITING SPECIALTY CLINIC	3	0	C	0	0	190. 01
190. 02	19002 OUTREACH	63	0	C	0	311	190. 02
	19003 FOUNDATI ON	0	0	C	0	•	190. 03
	19004 SPRING VALLEY FAMILY PRACTICE	0	0	C	0	l	190. 04
	19005 PAOLI FAMILY PRACTICE	67	0	C	_	l	190. 05
	19006 OTHER PROPERTY	400	0	305	0		190. 06
	19100 RESEARCH	0	0	C	0	l .	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192. 00
	19300 NONPAI D WORKERS	0	0	C	0	0	193. 00
200.00			^		_	_	200.00
201.00		339, 980	121 140	F 707	0 421		201. 00 202. 00
202.00	p TOTAL (Suill TITIES TTO LITEOUGH 201)	337, 780	131, 148	5, 787	9, 431	J 3∠, 399	J2U2. UU

| 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: 15-1306

				To	12/31/2021	Date/Time Pre 5/26/2022 1:1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	J piii
		10. 00	11. 00	13. 00	14. 00	15. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 UTILITIES 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						1. 00 2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00
11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	54, 916 0 0 0 0 0 0 0	30, 427 2, 872 0 1, 002 0 0 541		60, 820 1, 027 0 0 346	43, 743 0 0 7	10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00
30.00	03000 ADULTS & PEDIATRICS	54, 916	4, 837	31, 883	8, 155	303	30. 00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	0 109	0 746	0 986	0 14	31. 00 43. 00
52. 00 54. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97 88. 00 89. 00 90. 00 90. 01	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 VISITING SPECIALTY CLINIC	0 0 0 0 0 0 0 0 0 0 0 0	1, 384 472 3, 335 3, 115 373 933 1, 606 327 234 0 0 0 0 0 0	1, 575 0 2, 561 0 0 0 0 0 0 0 0 0 0 0	4, 923 9 3, 343 477 500 9, 907 99 21 14 13, 213 5, 032 0 0 0 0 759 0	97 0 146 0 124 0 0 0 0 0 41, 976 0 0 0	60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	4, 917	22, 547	10, 848	1, 076	91. 00 92. 00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0 0	0		95. 00 101. 00
113. 00 118. 00	11300 I NTEREST EXPENSE	54, 916	30, 427	77, 918	60, 820	43, 743	113. 00 118. 00
190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 191. 00 192. 00 193. 00 200. 00 201. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC 19002 OUTREACH 19003 FOUNDATION 19004 SPRING VALLEY FAMILY PRACTICE 19005 PAOLI FAMILY PRACTICE 19006 OTHER PROPERTY 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 191. 00 192. 00 193. 00 200. 00 201. 00
202. 00	TOTAL (sum lines 118 through 201)	54, 916	30, 427	77, 918	60, 820	43, 143	202. 00

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1306 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/26/2022 1:16 pm Cost Center Description MEDI CAL SOCIAL SERVICE NONPHYSI CI AN Subtotal Intern & RECORDS & Residents Cost **ANESTHETI STS** LI BRARY & Post Stendown Adjustments 19.00 16.00 17.00 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 UTI LI TI ES 7.01 7 01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 21, 393 16.00 01700 SOCIAL SERVICE 17.00 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 6, 579 19.00 19 00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 356, 059 0 30.00 1.615 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 04300 NURSERY 0 43.00 43.00 10 793 0 63 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 198, 943 0 50.00 1,619 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 22,064 0 52.00 237 05400 RADI OLOGY-DI AGNOSTI C 54 00 0 209, 083 54 00 3.839 0 06000 LABORATORY 60.00 1, 996 0 89, 504 0 60.00 06400 INTRAVENOUS THERAPY 0 29,003 64.00 606 0 64.00 06500 RESPIRATORY THERAPY 0 33, 469 65.00 453 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 476 119,816 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 92 24, 992 0 67.00 06800 SPEECH PATHOLOGY 16, 761 68.00 51 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 14, 430 71.00 46 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 13 C 5.491 0 72 00 77, 853 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 3,502 07400 RENAL DIALYSIS 74.00 0 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 0 0 0 07697 CARDIAC REHABILITATION 76. 97 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 179, 285 0 88.00 314 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 0 Λ 90.00 09000 CLI NI C 18 0 2, 325 0 90.00 90. 01 09001 VISITING SPECIALTY CLINIC 247 0 94, 874 90.01 09002 PAOLI PRIMARY CARE CLINIC 90.02 90.02 0 0 0 91.00 09100 EMERGENCY 6, 206 C 211, 454 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95. 00 09500 AMBULANCE SERVICES C 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 21, 393 0 1, 696, 199 0 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 01 19001 VISITING SPECIALTY CLINIC 0 0 Ω 0 190.01 190. 02 19002 OUTREACH 4, 432 0 190, 02 0 190. 03 19003 FOUNDATI ON 0 0 190. 03 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 190. 04 0 0 0 0 190. 05 19005 PAOLI FAMILY PRACTICE 0 190. 05 0 67 0 190.06 190.06 19006 OTHER PROPERTY 0 26, 360 191. 00 19100 RESEARCH 0 0 0 191.00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00

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21.393

6,579

6.579

6, 579

1, 733, 640

0 193.00

0 200. 00 0 201.00

0 202. 00

193. 00 19300 NONPALD WORKERS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS IU HEALTH PAOLI HOSPITAL

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 1:16 pm | Provider CCN: 15-1306

			5/26/2022 1	
	Cost Center Description	Total		
	<u> </u>	26. 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	00700 OPERATION OF PLANT			7. 00
7. 01	00701 UTI LI TI ES			7. 01
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10. 00
11. 00	01100 CAFETERI A			11. 00
13.00	01300 NURSI NG ADMINI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS			19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDI ATRI CS	356, 059		30. 00
31. 00	03100 INTENSIVE CARE UNIT	0		31. 00
43. 00	04300 NURSERY	10, 793		43. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	198, 943		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22, 064		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	209, 083		54. 00
60. 00	06000 LABORATORY	89, 504		60. 00
64. 00	06400 I NTRAVENOUS THERAPY	29, 003		64. 00
65. 00	06500 RESPI RATORY THERAPY	33, 469		65. 00
66. 00	06600 PHYSI CAL THERAPY	119, 816		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	24, 992		67. 00
68. 00	06800 SPEECH PATHOLOGY	16, 761		68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 430		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 491		72. 00
	07300 DRUGS CHARGED TO PATIENTS	77, 853		73. 00
74.00	07400 RENAL DIALYSIS	0		74. 00
75. 00	O7500 ASC (NON-DISTINCT PART)	0		75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	170 205		
	08800 RURAL HEALTH CLINIC	179, 285		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		89. 00
90.00	09000 CLINIC	2, 325		90.00
90. 01	09001 VISITING SPECIALTY CLINIC	94, 874		90. 01
	09002 PAOLI PRIMARY CARE CLINIC	١		90. 02
91.00	09100 EMERGENCY	211, 454		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0		95. 00
	10100 AMBULANCE SERVICES	0		101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		101.00
112 00	11300 INTEREST EXPENSE			113. 00
118.00	1 1	1, 696, 199		118.00
110.00	NONREI MBURSABLE COST CENTERS	1,070,179		110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19001 VISITING SPECIALTY CLINIC	3		190.00
	19002 OUTREACH	4, 432		190. 02
	19003 FOUNDATION	4, 432		190. 02
	19004 SPRING VALLEY FAMILY PRACTICE	0		190. 03
	19005 PAOLI FAMILY PRACTICE	67		190. 04
	19006 OTHER PROPERTY	26, 360		190. 06
	19100 RESEARCH	20, 300		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
	19300 NONPALD WORKERS			193. 00
200.00		6, 579		200. 00
201.00	1 1	0,0,7		201. 00
202.00		1, 733, 640		202. 00
202.00	1 1.01.12 (04 1.1.100 110 till odgir 201)	.,.55,570		1-02.00

COCT	n Financial Systems ALLOCATION – STATISTICAL BASIS	IU HEALTH PAC		N. 1E 1204 F	Peri od:	u of Form CMS-	
CUS1 /	ALLUCATION - STATISTICAL BASIS		Provi der C	F	From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre	pared:
		CAPITAL RE	LATED COSTS			5/26/2022 1:1	6 pm
		DI DO A FLVT	MANDLE FOLLO	EMDL OVEE		ADMINI CEDATINE	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	•
		(Secritic FEET)	(SQO/IKE TEET)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		,	
		1.00	2.00	SALARI ES)	ΕΛ	F 00	-
	GENERAL SERVICE COST CENTERS	1.00	2. 00	4. 00	5A	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT	63, 085	i				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		59, 775				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	744	1			04 04 / 055	4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	3, 630 4, 448				21, 816, 955 1, 426, 234	
7. 01	00700 OF ERATION OF FEATURE	4, 440		430, 23			
8.00	00800 LAUNDRY & LINEN SERVICE	300	l control of the cont	C	0	78, 882	8.00
9.00	00900 HOUSEKEEPI NG	886	l control of the cont			510, 874	
10. 00 11. 00	1	1, 779 977				312, 715 187, 034	
13. 00	1 1	1, 874	l control of the cont			1, 460, 199	
14.00	1 1	2, 061		C		286, 898	14.00
15. 00	1 1	1, 169				595, 091	
16. 00 17. 00	1 1	753	1		0		16. 00 17. 00
	01900 NONPHYSICIAN ANESTHETISTS		1	350, 338			1
	INPATIENT ROUTINE SERVICE COST CENTERS	5		3337333	-	, , , , , , , , , , , , , , , , , , , ,	1
30.00	1 1	7, 471		1, 409, 930		1	
31. 00 43. 00	1	250	'l	36, 390	1	•	1
43.00	ANCI LLARY SERVI CE COST CENTERS	250	<u>/ </u> 250	30, 390	<u>)</u>	59, 124	43.00
50. 00		6, 027	6, 027	485, 895	5 0	861, 495	50.00
52.00	1	501	1	157, 906			
54.00	1	5, 986					
60. 00 64. 00		1, 904 768			-	1, 959, 847 198, 318	
65. 00	1 1	487	l l	341, 822		507, 508	
66.00	1 1	4, 137	4, 137	430, 253		804, 903	
67.00	1 1	871	1	90, 612		155, 705	
68. 00 71. 00	1 1	FNTS 584	l e	60, 763			
72.00	1 1	LINIS				1	
73. 00		0	Ö	d	Ö	1	1
74. 00		0	0	C	0	0	
75. 00 76. 97		0	1			0	
76. 97	OUTPATIENT SERVICE COST CENTERS		η) 0	0	76.9
88. 00		4, 998	4, 968	1, 186, 527	7 0	1, 737, 750	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTE		B .			l .	1
90. 00 90. 01	09000 CLINIC	38					
90. 01	1 1	3, 039	3, 039	173, 023	0	347, 727 0	1
91.00	09100 EMERGENCY	4, 123	4, 123	1, 489, 389	o o	3, 053, 488	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT F	ART					92.00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES						05 0
101 00	0 10100 HOME HEALTH AGENCY	0	l control of the cont				95. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS		,		<u>, </u>		101.00
	0 11300 I NTEREST EXPENSE						113. 00
118.00		h 117) 59, 805	59, 775	10, 045, 975	-7, 557, 275	21, 782, 746	118.00
100 00	NONREI MBURSABLE COST CENTERS O 19000 GIFT, FLOWER, COFFEE SHOP & CANT	EEN 0					190. 00
	1 1900 VISITING SPECIALTY CLINIC	EEN 0				1	190. 0
	2 19002 OUTREACH	448	s o	ď			190. 0
	3 19003 FOUNDATI ON	0	0	C		l	190. 0
	4 19004 SPRING VALLEY FAMILY PRACTICE	0	0		0		190. 0
	5 19005 PAOLI FAMILY PRACTICE 6 19006 OTHER PROPERTY	2, 832				25, 655	190. 0
	0 19100 RESEARCH	2, 832	o o		o o		191. 0
192.00	0 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	19	192. 0
	0 19300 NONPAI D WORKERS	0	0		0	0	193. 0
200.00							200. 0 201. 0
201.00		В, 571, 488	911, 663	2, 021, 924	1	7, 557, 275	
	Part I)		, , 500	_, 52., 72			
	O Unit cost multiplier (Wkst. B, F	art I) 9. 059016	15. 251577	0. 201267	7	0. 346395	203.00
203. 00 204. 00				18, 087	-	339, 980	

Heal th Financial	l Systems	IU HEALTH PAOLI HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION	COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2021	Worksheet B-1		
					To 12/31/2021	Date/Time Pre 5/26/2022 1:1		
		CAPITAL REL	ATED COSTS				·	
Cos	st Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL		
				DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)		
		1. 00	2. 00	4. 00	5A	5. 00		
205. 00 Uni	it cost multiplier (Wkst. B, Part)			0. 00180)	0. 015583	205. 00	
	HE adjustment amount to be allocated er Wkst. B-2)						206. 00	
207. 00 NAHI	HE unit cost multiplier (Wkst. D, rts III and IV)						207. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1306

					11	0 12/31/2021	Date/lime Pre 5/26/2022 1:1	
		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	O pili
			(SQUARE TEET)		DAYS)			
	OENED	AL CERVI OF COCT OFFITERS	7. 00	7. 01	8. 00	9. 00	10. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2. 00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00		ADMINISTRATIVE & GENERAL	44 005					5. 00
7. 00 7. 01		OPERATION OF PLANT UTILITIES	44, 885	53, 785				7. 00 7. 01
8. 00		LAUNDRY & LINEN SERVICE	300	300				8. 00
9. 00		HOUSEKEEPI NG	886	886		46, 985		9. 00
10.00	1	DIETARY	1, 779	1, 779		1, 779	l	ı
11. 00 13. 00	1	CAFETERIA NURSI NG ADMI NI STRATI ON	977 1, 199	977 1, 874		977 1, 874	0	
14. 00		CENTRAL SERVICES & SUPPLY	2, 061	2, 061	0	1, 074	0	
15.00		PHARMACY	1, 169	1, 169	0	0	0	15. 00
16.00		MEDICAL RECORDS & LIBRARY	753	753		753	0	16.00
17. 00 19. 00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0		0	0	17. 00 19. 00
17.00		I ENT ROUTINE SERVICE COST CENTERS	<u> </u>		0	0	0	17.00
30.00	03000	ADULTS & PEDIATRICS	7, 471	7, 471	1, 515	7, 471	7, 564	30. 00
31. 00		INTENSIVE CARE UNIT	0	0	_	0	0	
43. 00		NURSERY LARY SERVICE COST CENTERS	250	250	156	250	0	43. 00
50. 00		OPERATING ROOM	6, 027	6, 027	0	6, 027	0	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	501	501		501	ő	
54.00		RADI OLOGY-DI AGNOSTI C	5, 986	5, 986		5, 986	0	54. 00
60.00		LABORATORY	1, 904	1, 904		1, 904	0	60.00
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	768 487	768 487		768 487	0	64. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	147	4, 137		4, 137	0	1
67. 00	1	OCCUPATI ONAL THERAPY	31	871		871	0	67. 00
68. 00		SPEECH PATHOLOGY	21	584		584	0	1
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATTENTS	0	0	0	0	0	73.00
74.00		RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	1	ASC (NON-DISTINCT PART)	0	0		0	0	
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	0	0	0	0	0	76. 97
88. 00		RURAL HEALTH CLINIC	4, 968	4, 968	0	4, 968	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	1	CLINIC	38	38		38	0	90.00
90. 01 90. 02	1	VISITING SPECIALTY CLINIC PAOLI PRIMARY CARE CLINIC	3, 039	3, 039 0		3, 039	0	90. 01 90. 02
91. 00	1	EMERGENCY	4, 123	4, 123		4, 123		91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART	,					92. 00
05 00	-	REIMBURSABLE COST CENTERS	ام				_	
		AMBULANCE SERVICES HOME HEALTH AGENCY	0	0				95. 00 101. 00
101.00		AL PURPOSE COST CENTERS	<u> </u>		0	0	0	101.00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44, 885	50, 953	1, 671	46, 537	7, 564	118. 00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	0	0	0	0	190. 00
	1	VISITING SPECIALTY CLINIC	0	0		0	l	190. 00
190.02	19002	OUTREACH	0	0	0	448		190. 02
		FOUNDATI ON	0	0		0		190. 03
		SPRING VALLEY FAMILY PRACTICE PAOLI FAMILY PRACTICE	0	0	0	0		190. 04 190. 05
	1	OTHER PROPERTY	0	2, 832	0	0	l	190.05
		RESEARCH	0	0	0	0	l	191. 00
		PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193.00 200.00		NONPALD WORKERS Cross Foot Adjustments		0	0	0	0	193. 00 200. 00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B,	1, 920, 274	500, 035	121, 830	733, 980	541, 477	1
202 27		Part I)	40 70005	0.00/0==	70.000.55	45 /0450:	74 50/0::	202 65
203. 00 204. 00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	42. 782088 131, 148			15. 621581 32, 599	71. 586066	203. 00 204. 00
204.00		Part II)	131, 140	3,767	7, 431	32, 379	34, 710	204.00
205.00		Unit cost multiplier (Wkst. B, Part	2. 921867	0. 107595	5. 643926	0. 693817	7. 260180	205. 00
		11)			I			l

Heal th Finan	cial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2021	D . (T) D	
					Γο 12/31/2021		
						5/26/2022 1:1	6 pm
	Cost Center Description	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT	(SQUARE FEET)	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)		(TOTAL PATIEN	Г		
				DAYS)			
		7. 00	7. 01	8. 00	9. 00	10.00	
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	TU HEALTH PAG	OLI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre	epared:
	Cost Center Description	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	5/26/2022 1:1 MEDI CAL RECORDS & LI BRARY	6 pm
			(DI RECT NRSI NG	(COSTED		(GROSS	
		11.00	HRS) 13.00	REQUI S.) 14. 00	15. 00	CHARGES) 16. 00	\vdash
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 UTI LI TI ES						7. 01
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	234, 085	1				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	22, 095	87, 190	245 022			13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	7, 709		345, 832 5, 839			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	,,,,,,	o	0,007		86, 359, 337	
17. 00	01700 SOCIAL SERVICE	C	1 1	0		0	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	4, 160) 0	1, 966	358	0	19.00
30. 00	03000 ADULTS & PEDIATRICS	37, 210	35, 678	46, 368	14, 996	6, 510, 152	30.00
31. 00	03100 NTENSI VE CARE UNI T	07,210	1	0		0, 010, 102	1
43. 00	04300 NURSERY	837	835	5, 607	672	255, 097	43.00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	10, 651	0 571	27, 992	4 022	/ F2/ 2F4	FO 00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 632		27, 992 49		6, 526, 354 955, 181	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	25, 654	1	19, 008		15, 478, 149	
60. 00	06000 LABORATORY	23, 967		2, 713		8, 048, 836	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 873	1	2, 842		2, 445, 450	
66. 00	06600 PHYSI CAL THERAPY	7, 180 12, 354	1	56, 331 563		1, 825, 236 1, 920, 350	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 516	1	119		371, 185	1
68. 00	06800 SPEECH PATHOLOGY	1, 804	1	80		205, 292	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		1	75, 139 28, 612		184, 687 52, 474	1
73. 00	07300 DRUGS CHARGED TO PATIENTS			20, 012		14, 120, 064	
74. 00	07400 RENAL DIALYSIS	C	0	0		0	1
75.00	07500 ASC (NON-DISTINCT PART)	C		0		0	
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		y U	0	0	0	76. 97
88. 00	08800 RURAL HEALTH CLINIC	25, 192	6, 912	4, 318	0	1, 266, 115	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	1 1	0	_	0	
	09000 CLINIC 09001 VISITING SPECIALTY CLINIC	657 7, 769		0 6, 601		73, 272 995, 520	90.00
	09002 PAOLI PRIMARY CARE CLINIC	7,769	1, / 12	0, 60 1	0	995, 520	90.01
91.00	09100 EMERGENCY	37, 825	25, 230	61, 685	53, 259	25, 125, 923	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES		ol	0	0	0	95. 00
	10100 HOME HEALTH AGENCY		1	0			101. 00
	SPECIAL PURPOSE COST CENTERS				1		4
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	234, 085	87, 190	345, 832	2, 165, 060	86, 359, 337	113.00
110.00	NONREI MBURSABLE COST CENTERS	254,000	07, 170	343, 032	2, 103, 000	00, 337, 337] 10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	1	0			190. 00
	19001 VISITING SPECIALTY CLINIC 19002 OUTREACH	C		0			190. 01
	19002			0			190. 02 190. 03
	19004 SPRING VALLEY FAMILY PRACTICE			0			190. 04
	19005 PAOLI FAMILY PRACTICE	C	0	0	О		190. 05
	19006 OTHER PROPERTY 19100 RESEARCH			0	0		190. 06 191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES			0	0		191.00
	19300 NONPALD WORKERS	C	0	0	0		193. 00
200.00	, ,						200.00
201. 00 202. 00	9	317, 965	2, 094, 010	493, 613	880, 913	75, 625	201.00
202.00	Part I)	317, 903	2,074,010	473, 013	000, 713	73, 023	202.00
	1 1 '	1	1	1. 427320		0. 000876	
203.00		20 427	77, 918	60, 820	43, 743	21, 393	204. 00
203. 00 204. 00		30, 427	77,710	00,020		•	
	Part II)	0. 129983		0. 175866	0. 020204	0. 000248	

Health Financial Systems	IU HEALTH PAG	OLI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
				From 01/01/2021	5	
				To 12/31/2021	Date/Time Pre 5/26/2022 1:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	(MAN HOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LI BRARY	
		(DIRECT NRSING	(COSTED		(GROSS	
		HRS)	REQUIS.)		CHARGES)	
	11.00	13.00	14.00	15. 00	16. 00	
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1306

				To 12/31/2021 Date/Time Pre	
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN	0,23,2522	, p
		(TIME CDENT)	ANESTHETI STS		
		(TIME SPENT)	(ASSIGNED TIME)		
		17. 00	19. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT				2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
7. 01	00701 UTI LI TI ES				7. 01
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON				11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCIAL SERVICE	0			17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	100		19. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	O	0] 30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		31.00
43. 00	04300 NURSERY	o	0		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	100		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		54.00
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY		0		60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY		0		65. 00
66. 00	06600 PHYSI CAL THERAPY	o o	0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		72. 00 73. 00
	07400 RENAL DIALYSIS	0	0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	o	0		75. 00
76. 97	07697 CARDI AC REHABILITATION	0	0		76. 97
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		89. 00 90. 00
90. 01	09001 VISITING SPECIALTY CLINIC	0	0		90.00
90. 02	09002 PAOLI PRIMARY CARE CLINIC	o	0		90. 02
91.00	09100 EMERGENCY	0	0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES		0		05 00
	10100 HOME HEALTH AGENCY	0 0	0		95. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS		U		1.01.00
113.00	11300 I NTEREST EXPENSE				113. 00
118.00		0	100		118. 00
100.00	NONREI MBURSABLE COST CENTERS				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 VISITING SPECIALTY CLINIC	0 0	0		190. 00 190. 01
	1900 VISITING SPECIALTY CLINIC		0		190. 01
	19003 FOUNDATION	o	0		190. 03
190. 04	19004 SPRING VALLEY FAMILY PRACTICE	0	O		190. 04
	19005 PAOLI FAMILY PRACTICE	0	0		190. 05
	19006 OTHER PROPERTY	0	0		190. 06
	19100 RESEARCH	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS		0		192. 00 193. 00
200.00	1	١			200. 00
201.00	1 1				201. 00
202.00	Cost to be allocated (per Wkst. B,	О	445, 283		202. 00
000 -	Part I)		4 450 0		000 -
203.00		0. 000000	4, 452. 830000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	ا	6, 579		204. 00
205.00	1 1	0. 000000	65. 790000		205. 00
	117			I	1

Heal th	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 15-1306		CN: 15-1306	Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:1	
	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN				
			ANESTHETI STS				
		(TIME SPENT)	(ASSI GNED				
			TIME)				
		17. 00	19. 00				
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	IU HEALTH PAOLI HOSPI	TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Prov	vider CCN: 15-1306	Peri od:	Worksheet C

	OMPUTATION	TOF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 1:1	
				Title	XVIII	Hospi tal	Cost	
						Costs		
		Cost Center Description	Total Cost T (from Wkst. B, Part I, col.	herapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
			26)					
			1.00	2. 00	3.00	4. 00	5. 00	
	INPA	TIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30		O ADULTS & PEDI ATRI CS	5, 065, 284		5, 065, 28	4 0	0	30.00
		O INTENSIVE CARE UNIT	0			0 0	0	31. 00
43		0 NURSERY	137, 593		137, 59	3 0	0	43.00
	ANCI	LLARY SERVICE COST CENTERS						
50	0.00 0500	O OPERATING ROOM	2, 281, 176		2, 281, 17	6 0	0	50.00
52	2.00 0520	O DELIVERY ROOM & LABOR ROOM	453, 114		453, 11	4 0	0	52.00
54	4.00 0540	O RADI OLOGY-DI AGNOSTI C	2, 891, 804		2, 891, 80	0	0	54.00
60	0.00 0600	O LABORATORY	2, 811, 107		2, 811, 10	0	0	60.00
64		O INTRAVENOUS THERAPY	400, 428		400, 42		0	64. 00
6!		O RESPIRATORY THERAPY	808, 031	0	808, 03	1 0	0	65. 00
	- 1	O PHYSI CAL THERAPY	1, 212, 360	0	1, 212, 36		0	66. 00
		O OCCUPATIONAL THERAPY	236, 583	0	236, 58		0	67. 00
		O SPEECH PATHOLOGY	158, 774	0	158, 77		0	68. 00
		O MEDICAL SUPPLIES CHARGED TO PATIENTS	208, 578		208, 57		0	71. 00
		O IMPL. DEV. CHARGED TO PATIENTS	79, 408		79, 40		0	72. 00
		O DRUGS CHARGED TO PATIENTS	3, 654, 963		3, 654, 96		0	73. 00
		O RENAL DIALYSIS	0			0	0	74. 00
		O ASC (NON-DISTINCT PART)	0			0	0	75. 00
76		7 CARDIAC REHABILITATION	0			0 0	0	76. 97
_		ATIENT SERVICE COST CENTERS						
		O RURAL HEALTH CLINIC	2, 883, 528		2, 883, 52		0	88. 00
		O FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89. 00
		O CLINIC	96, 888		96, 88		0	90.00
		1 VISITING SPECIALTY CLINIC	735, 883		735, 88		0	90. 01
		2 PAOLI PRIMARY CARE CLINIC O EMERGENCY	F 170 242		F 170 24	0 0	0	90. 02 91. 00
		O OBSERVATION BEDS (NON-DISTINCT PART	5, 179, 342		5, 179, 34		0	91.00
9.		R REIMBURSABLE COST CENTERS	1, 165, 694		1, 165, 69	4	U	92.00
O!		O AMBULANCE SERVICES	0			0 0	0	95. 00
		O HOME HEALTH AGENCY				0		101. 00
1 1	SPEC	I AL PURPOSE COST CENTERS	<u> </u>			<u> </u>		101.00
1		O INTEREST EXPENSE						113. 00
	00.00	Subtotal (see instructions)	30, 460, 538	0	30, 460, 53	8 0	0	200. 00
	01. 00	Less Observation Beds	1, 165, 694	· ·	1, 165, 69			201. 00
	02. 00	Total (see instructions)	29, 294, 844	0				202. 00
	•		•		•			

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Li	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-13	306 Peri od:	Worksheet C

From 01/01/2021 To 12/31/2021 Part I Date/Time Prepared: 5/26/2022 1:16 pm Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 3, 612, 291 3, 612, 291 31.00 03100 INTENSIVE CARE UNIT 31.00 04300 NURSERY 255, 097 255, 097 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 5, 832, 735 0.349533 0.000000 50.00 05000 OPERATING ROOM 693, 619 6, 526, 354 52.00 05200 DELIVERY ROOM & LABOR ROOM 610, 798 344, 383 955, 181 0.474375 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 502, 563 14, 975, 586 15, 478, 149 0.186831 0.000000 54.00 6, 989, 509 0.349256 06000 LABORATORY 8, 048, 836 0.000000 60.00 1,059,327 60.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 2, 445, 450 2, 445, 450 0.163744 64 00 65.00 06500 RESPIRATORY THERAPY 643, 280 1, 181, 956 1, 825, 236 0.442699 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 180, 480 1, 739, 870 1, 920, 350 0.631322 0.000000 66.00 06700 OCCUPATIONAL THERAPY 92, 926 278, 259 0.000000 67.00 371, 185 0.637372 67.00 68.00 06800 SPEECH PATHOLOGY 19,977 185, 315 205, 292 0.773406 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 13, 496 171, 191 184, 687 1. 129359 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 52, 474 52, 474 1.513283 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.258849 73 00 3, 631, 827 10, 488, 237 14, 120, 064 0.000000 73 00 74.00 07400 RENAL DIALYSIS 0 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 0 75.00 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 1, 266, 115 1, 266, 115 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90 00 09000 CLI NI C 0 73 272 73 272 1 322306 0 000000 90 00 09001 VISITING SPECIALTY CLINIC 90.01 0 995, 520 995, 520 0.739195 0.000000 90.01 90.02 09002 PAOLI PRIMARY CARE CLINIC 0 0.000000 0.000000 90.02 91.00 09100 EMERGENCY 385, 739 24, 740, 184 25, 125, 923 0. 206135 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 12, 238 2, 885, 623 2, 897, 861 0.402260 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0.000000 95.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 11, 713, 658 74, 645, 679 86, 359, 337 200.00 201.00 Less Observation Beds 201. 00 Total (see instructions) 202.00 11, 713, 658 74, 645, 679 86, 359, 337 202.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1306	Peri od: From 01/01/2021	Worksheet C Part I
			To 12/31/2021	Date/Time Prepared:

			To 12/31/2021	Date/Time Prepared: 5/26/2022 1:16 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
60. 00 06000 LABORATORY	0. 000000			60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74.00 07400 RENAL DIALYSIS	0. 000000			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLINIC	0. 000000			90.00
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000			90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000			90. 02
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	·			

Health Financial Systems	IU HEALTH PAOLI HOSPI	TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Prov	vider CCN: 15-1306	Peri od:	Worksheet C

From 01/01/2021 To 12/31/2021 Part I Date/Time Prepared: 5/26/2022 1:16 pm Title XIX Hospi tal PPS Costs Total Cost Therapy Limit Cost Center Description Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 5, 065, 284 5.065.284 5, 065, 284 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04300 NURSERY o 43.00 137, 593 137, 593 137, 593 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 281, 176 2, 281, 176 0 2, 281, 176 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 453, 114 453, 114 0 0 0 453, 114 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 891, 804 2, 891, 804 2, 891, 804 54.00 60.00 06000 LABORATORY 2, 811, 107 2, 811, 107 2, 811, 107 60 00 64.00 06400 I NTRAVENOUS THERAPY 400, 428 400, 428 400, 428 64.00 65.00 06500 RESPIRATORY THERAPY 808, 031 808, 031 0 0 0 808, 031 65.00 06600 PHYSI CAL THERAPY 1, 212, 360 1, 212, 360 66.00 66.00 1, 212, 360 06700 OCCUPATIONAL THERAPY 67.00 236, 583 236, 583 236, 583 67.00 68.00 06800 SPEECH PATHOLOGY 158, 774 158, 774 158, 774 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 208, 578 71.00 208, 578 208, 578 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 79 408 79 408 79 408 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 654, 963 3, 654, 963 3, 654, 963 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 0 07697 CARDIAC REHABILITATION 76.97 0 O 76. 97 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 2, 883, 528 2, 883, 528 2, 883, 528 88.00 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 C 0 0 90.00 09000 CLI NI C 96,888 96,888 96,888 90.00 90.01 09001 VISITING SPECIALTY CLINIC 735, 883 735, 883 0 735, 883 90.01 09002 PAOLI PRIMARY CARE CLINIC 0 90.02 90.02 0 5, 179, 342 5, 179, 342 5, 179, 342 91 00 09100 EMERGENCY 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 1, 165, 694 1, 165, 694 1, 165, 694 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 200.00 Subtotal (see instructions) 30, 460, 538 30, 460, 538 0 30, 460, 538 200. 00 0 1, 165, 694 201. 00 201.00 Less Observation Beds 1, 165, 694 1, 165, 694 202.00 Total (see instructions) 29, 294, 844 29, 294, 844 29, 294, 844 202. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 1	d: \\	Worksheet C

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der CO	1	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 1:1	
				e XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 612, 291		3, 612, 29	1		30.00
31. 00	03100 INTENSIVE CARE UNIT	0			O		31. 00
43.00	04300 NURSERY	255, 097		255, 09	7		43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	693, 619	5, 832, 735				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	610, 798	344, 383			0.000000	
54.00	05400 RADI OLOGY - DI AGNOSTI C	502, 563	14, 975, 586			0.000000	
60.00	06000 LABORATORY	1, 059, 327	6, 989, 509			0.000000	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	(42, 200	2, 445, 450			0. 000000 0. 000000	
	06600 PHYSI CAL THERAPY	643, 280	1, 181, 956 1, 739, 870			0.000000	
66. 00 67. 00	06700 OCCUPATIONAL THERAPY	180, 480 92, 926	1, 739, 870 278, 259			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	19, 977	185, 315			0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 496	171, 191			0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 470	52, 474			0.000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 631, 827	10, 488, 237			0. 000000	
74. 00	07400 RENAL DIALYSIS	3,031,027	10, 400, 237	1	0. 000000	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)		0	•	0. 000000	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON		0		0. 000000	0. 000000	
	OUTPATIENT SERVICE COST CENTERS	-1	-				
88. 00	08800 RURAL HEALTH CLINIC	0	1, 266, 115	1, 266, 11	5 2. 277461	0.000000	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.000000	0.000000	89. 00
90.00	09000 CLI NI C	0	73, 272	73, 27	2 1. 322306	0.000000	90.00
90. 01	09001 VISITING SPECIALTY CLINIC	O	995, 520	995, 52	0. 739195	0.000000	90. 01
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0	0		0. 000000	0. 000000	90. 02
91. 00	09100 EMERGENCY	385, 739	24, 740, 184	25, 125, 92	0. 206135	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 238	2, 885, 623	2, 897, 86	0. 402260	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0		0. 000000	0. 000000	
101.00	10100 HOME HEALTH AGENCY	0	0		O		101. 00
440 5	SPECIAL PURPOSE COST CENTERS						440.00
	11300 INTEREST EXPENSE	11 710 /50	74 /45 /70	0/ 250 22			113. 00
200.00	, ,	11, 713, 658	74, 645, 679	86, 359, 33	/		200. 00
201. 00 202. 00		11 712 / 50	74, 645, 679	86, 359, 33	7		201. 00 202. 00
202.00	p Total (see Histructions)	11, 713, 658	14,045,619	80, 359, 33	/	I	J2U2. UU

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1306	From 01/01/2021	Worksheet C Part I Date/Time Prepared:

			10 12/31/2021	5/26/2022 1:16 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS	T			
50. 00 05000 OPERATI NG ROOM	0. 349533			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 474375			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 186831			54.00
60. 00 06000 LABORATORY	0. 349256			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 163744			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 442699			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 631322			66.00
67. 00 06700 OCCUPATIONAL THERAPY	0. 637372			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 773406			68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 129359			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1. 513283			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 258849			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0.000000			75. 00 76. 97
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	2. 277461			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0. 000000 1. 322306			89. 00 90. 00
90. 00 09000 CLINIC 90. 01 09001 VISITING SPECIALTY CLINIC	0. 739195			90.00
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0. 739193			90.01
91. 00 09100 EMERGENCY	0. 206135			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 402260			92.00
OTHER REIMBURSABLE COST CENTERS	0. 402200			72.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95, 00
101. 00 10100 HOME HEALTH AGENCY	0.00000			101.00
SPECIAL PURPOSE COST CENTERS				131.00
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00
	1			1232. 00

Health Financial Systems		IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE	COST TO CHARGE	RATIOS NET OF	Provider CCN: 15-1306	Peri od:	Worksheet C
DEDUCTIONS FOR MEDICALD ONLY				From 01/01/2021	Part II

REDUCTIONS FOR MEDICALD ONLY From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: 5/26/2022 1:16 pm

						5/26/2022 1:1	6 pm
			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	2, 281, 176	198, 943	2, 082, 233	0	0	00.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	453, 114	22, 064	431, 050	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 891, 804	209, 083	2, 682, 721	0	0	54.00
60.00	06000 LABORATORY	2, 811, 107	89, 504	2, 721, 603	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	400, 428	29, 003	371, 425	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	808, 031	33, 469	774, 562	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 212, 360	119, 816	1, 092, 544	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	236, 583	24, 992	211, 591	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	158, 774	16, 761	142, 013	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	208, 578		194, 148	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	79, 408	5, 491	73, 917	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 654, 963	77, 853	3, 577, 110	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	2, 883, 528	179, 285	2, 704, 243	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLI NI C	96, 888	2, 325	94, 563	0	0	90.00
90. 01	09001 VISITING SPECIALTY CLINIC	735, 883	94, 874	641, 009	0	0	90. 01
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90. 02
91.00	09100 EMERGENCY	5, 179, 342	211, 454	4, 967, 888	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 165, 694	81, 941	1, 083, 753	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	25, 257, 661	1, 411, 288	23, 846, 373	0	0	200. 00
201.00		1, 165, 694			0	0	201. 00
202.00	Total (line 200 minus line 201)	24, 091, 967			0	0	202. 00
						•	•

Health Financial Systems

IU HEALTH PAOLI HOSPITAL

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

REDUCTIONS FOR MEDICALD ONLY

In Lieu of Form CMS-2552-10

Provider CCN: 15-1306

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

Date/Time Prepared:

						5/26/2022 1:1	16 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charge	e		
		Operating Cost	Part I, column				
		Reducti on	8)	/ col . 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 281, 176	6, 526, 354	0. 349533	3		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	453, 114	955, 181	0. 474375	5		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 891, 804	15, 478, 149	0. 186831	1		54.00
60.00	06000 LABORATORY	2, 811, 107	8, 048, 836	0. 349256	5		60.00
64.00	06400 I NTRAVENOUS THERAPY	400, 428	2, 445, 450	0. 163744	1		64. 00
65.00	06500 RESPIRATORY THERAPY	808, 031	1, 825, 236	0. 442699	9		65. 00
66.00	06600 PHYSI CAL THERAPY	1, 212, 360	1, 920, 350	0. 631322	2		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	236, 583	371, 185	0. 637372	2		67. 00
68.00	06800 SPEECH PATHOLOGY	158, 774	205, 292	0. 773406	5		68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	208, 578	184, 687	1. 129359	9		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	79, 408	52, 474	1. 513283	3		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 654, 963	14, 120, 064	0. 258849	9		73. 00
74.00	07400 RENAL DIALYSIS	0	0	0. 000000			74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0. 000000			75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0. 000000			76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	2, 883, 528	1, 266, 115	2. 27746	1		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 000000			89. 00
90.00	09000 CLI NI C	96, 888	73, 272	1. 322306	5		90.00
90. 01	09001 VISITING SPECIALTY CLINIC	735, 883	995, 520	0. 739195	5		90. 01
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0	l 0	0. 000000			90. 02
91. 00	09100 EMERGENCY	5, 179, 342	25, 125, 923				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 165, 694					92.00
	OTHER REIMBURSABLE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			-		1
95.00	09500 AMBULANCE SERVICES	0	0	0.000000			95. 00
	10100 HOME HEALTH AGENCY	0	ł				101.00
	SPECIAL PURPOSE COST CENTERS		-		-1		1
113.00	11300 NTEREST EXPENSE						113. 00
200.00	1 1	25, 257, 661	82, 491, 949				200. 00
201.00		1, 165, 694					201. 00
202.00	1 1	24, 091, 967					202. 00
		The state of the s		•	1		

Heal th	Financial Systems	IU HEALTH PAC	DLI HOSPITAL		In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/26/2022 1:1	
			Title	: XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	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 OPERATING ROOM	198, 943	6, 526, 354	0. 03048	3 7, 572	231	50.00
	05200 DELIVERY ROOM & LABOR ROOM	22, 064	955, 181	0. 02309	9 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	209, 083	15, 478, 149	0. 01350	8 201, 182	2, 718	54.00
60.00	06000 LABORATORY	89, 504	8, 048, 836	0. 01112	0 307, 997	3, 425	60.00
64.00	06400 INTRAVENOUS THERAPY	29, 003	2, 445, 450	0. 01186	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	33, 469	1, 825, 236	0. 01833	7 185, 138	3, 395	65. 00
66.00	06600 PHYSI CAL THERAPY	119, 816	1, 920, 350	0. 06239	3 83, 556	5, 213	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	24, 992	371, 185	0.06733	0 38, 021	2, 560	67. 00
68. 00	06800 SPEECH PATHOLOGY	16, 761	205, 292	0. 08164	5 10, 083	823	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 430	184, 687	0. 07813	2 1, 574	123	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 491	52, 474	0. 10464	2 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	77, 853	14, 120, 064	0.00551	4 1, 395, 363	7, 694	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0.00000	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	•					1
88.00	08800 RURAL HEALTH CLINIC	179, 285	1, 266, 115	0. 14160	2 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0	0	89. 00
90.00	09000 CLI NI C	2, 325	73, 272	0. 03173	1 0	0	90.00
90. 01	09001 VISITING SPECIALTY CLINIC	94, 874	995, 520	0. 09530	1 0	0	90. 01
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0		1	0 0	0	90. 02
91. 00	09100 EMERGENCY	211, 454	25, 125, 923	0. 00841	6 9, 221	78	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	81, 941				140	92.00
	OTHER REIMBURSABLE COST CENTERS			•	<u> </u>		1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	1, 411, 288	82, 491, 949		2, 244, 667	26, 400	200. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lieu of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER DASS	Provider CCN: 15-1306	Dari ad:	Workshoot D

Period: From 01/01/2021 To 12/31/2021 Part IV THROUGH COSTS Date/Time Prepared: 5/26/2022 1:16 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Cost Post-Stepdown Adjustments Adjustments 3.00 1.00 2A 2.00 ЗА ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 445, 283 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 06000 LABORATORY 0 0 60.00 60.00 0 0 0 0 0 0 0 0 0 0 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 0 0 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 Λ 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 73.00 0 0 07400 RENAL DIALYSIS 0 74.00 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07697 CARDIAC REHABILITATION 0 0 0 0 0 76. 97 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 0 0 90.00 90.00 09000 CLI NI C 0 0 09001 VISITING SPECIALTY CLINIC 0 0 90. 01 90 01 Ω 09002 PAOLI PRIMARY CARE CLINIC 0 0 90.02 0 0 90.02 09100 EMERGENCY 0 0 91.00 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00

445, 283

0

0

95. 00 0 200. 00

OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

95. 00 09500 AMBULANCE SERVICES

200.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021		
				To 12/31/2021	Date/Time Prep 5/26/2022 1:10	oarea: 6 nm
		Title	e XVIII	Hospi tal	Cost	<u> Бин</u>
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	445, 283	(0 6, 526, 354		50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0)	0 955, 181		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 15, 478, 149		54.00
60. 00 06000 LABORATORY	0	0)	0 8, 048, 836		60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0)	0 2, 445, 450	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 1, 825, 236	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 1, 920, 350	0. 000000	66. 00

Health Financial Systems	IU HEALTH PAOL	_I HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR THROUGH COSTS	Y SERVICE OTHER PASS	Provi der CO	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 1:10	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpati 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)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	7, 572	517	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	(o	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	201, 182		o	0	54.00
60 00 06000 LABORATORY	0 000000	307 997	1	ol ol	0	60 00

Cost Center Description	Outpatient	inpatient	Inpatient	outpati ent	outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	7, 572	517	0	0	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	201, 182	0	0	0	54. 00
60. 00 06000 LABORATORY	0. 000000	307, 997	0	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	185, 138	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	83, 556	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	38, 021	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	10, 083	0	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 574	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. 000000	1, 395, 363	0	0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	0	0	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	0	75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90.01 09001 VISITING SPECIALTY CLINIC	0. 000000	0	0	0	0	90. 01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000	0	0	0	0	90. 02
91. 00 09100 EMERGENCY	0. 000000	9, 221	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	4, 960	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		2, 244, 667	517	0	0	200. 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1306	Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	narod:
				10 12/31/2021	5/26/2022 1:1	
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
ANOLILARY REDWINE ROOT REVIEWS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.040500		4 404 44			F0 00
50. 00 05000 OPERATING ROOM	0. 349533	0	1, 134, 44	.8	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 474375	0	2 (12 42	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0. 186831	0	3, 612, 43		0	54. 00 60. 00
	0. 349256	0	1, 534, 09		0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 163744	0	753, 34		0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 442699	0	247, 52		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 631322	0	516, 18		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0. 637372 0. 773406	0	68, 87		0	67. 00 68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	11, 98		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1. 129359 1. 513283	0	15, 08		0	71.00
73.00 07300 DRUGS CHARGED TO PATTENTS	0. 258849	0	7, 44 4, 911, 31		0	73.00
74. 00 07400 RENAL DIALYSIS	0. 238849	0	4, 911, 31	0 233	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	0.000000			0	0	70. 77
88. 00 08800 RURAL HEALTH CLINIC						88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLINI C	1. 322306	0	35, 41	5 0	0	
90. 01 09001 VISITING SPECIALTY CLINIC	0. 739195	0	316, 39		ő	90. 01
90. 02 09002 PAOLI PRIMARY CARE CLINIC	0. 000000	0	,	0 0	0	90. 02
91. 00 09100 EMERGENCY	0. 206135	0	5, 481, 41	5 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 402260	0	886, 25		Ō	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0. 000000			0		95. 00
200.00 Subtotal (see instructions)		0	19, 532, 21	8 57, 410	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	19, 532, 21	8 57, 410	0	202. 00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1306	Peri od:	Worksheet D

From 01/01/2021 Part V To 12/31/2021 Date/Time Prepared: 5/26/2022 1:16 pm Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 396, 527 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 674, 915 54.00 0 60.00 06000 LABORATORY 535, 793 0 60.00 64.00 06400 INTRAVENOUS THERAPY 123, 356 2, 341 64.00 65.00 06500 RESPIRATORY THERAPY 109.577 65.00 0 06600 PHYSI CAL THERAPY 325, 876 66.00 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 43, 901 67.00 06800 SPEECH PATHOLOGY 9, 269 0 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 17,035 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 269 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 271, 290 60 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 75.00 76.97 07697 CARDIAC REHABILITATION 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88. 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 46, 829 90.00 09001 VISITING SPECIALTY CLINIC 233, 880 0 90.01 90.01 09002 PAOLI PRIMARY CARE CLINIC 90.02 0 90.02 09100 EMERGENCY 1, 129, 911 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 356, 503 17, 250 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 5, 285, 931 200.00 Subtotal (see instructions) 19,651 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 5, 285, 931 202.00 19, 651

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2021	Worksheet D Part I	
				Го 12/31/2021		pared: 6 pm
		Ti tI	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	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)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30.00 ADULTS & PEDIATRICS	356, 059	12, 217	343, 84	1, 989		•
31.00 INTENSIVE CARE UNIT	0			0	0.00	1
43. 00 NURSERY	10, 793	l e	10, 79			1
200.00 Total (lines 30 through 199)	366, 852		354, 63	5 2, 145		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	36	6, 223				30.00
31. 00 INTENSIVE CARE UNIT	0	0	1			31.00
43. 00 NURSERY	12	ł	1		ļ	43.00
200.00 Total (lines 30 through 199)	48	7, 053	il .			200. 00

Health Financial Systems		IU HEALTH PAOLI	HOSPI TAL		In Lieu of Form CMS-2552-10
ADDODELONMENT OF LADATICAL	ANGLILADY CEDVICE CADITA	U COCTC	D: -I CON 1E 120/	D!I	Wasalaalaa B

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/26/2022 1:1	pared:
		Ti tl	e XIX	Hospi tal	PPS	о рііі
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, 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 OPERATING ROOM	198, 943					
52.00 O5200 DELIVERY ROOM & LABOR ROOM	22, 064		1		371	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	209, 083		1		l	54. 00
60. 00 06000 LABORATORY	89, 504		1		l	
64. 00 06400 I NTRAVENOUS THERAPY	29, 003				0	64. 00
65. 00 06500 RESPI RATORY THERAPY	33, 469					
66. 00 06600 PHYSI CAL THERAPY	119, 816					
67. 00 06700 OCCUPATI ONAL THERAPY	24, 992					
68. 00 06800 SPEECH PATHOLOGY	16, 761		1		l e	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 430				0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 491		1		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	77, 853	14, 120, 064			l .	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000		0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	179, 285	1, 266, 115	1		"	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000		0	89. 00
90. 00 09000 CLI NI C	2, 325				0	90. 00
90.01 09001 VISITING SPECIALTY CLINIC	94, 874	995, 520			0	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC	0		0.0000		0	90. 02
91. 00 09100 EMERGENCY	211, 454					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	81, 941	2, 897, 861	0. 02827	6 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	1, 411, 288	82, 491, 949	1	180, 600	3, 071	200. 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST			Period: From 01/01/2021 Fo 12/31/2021	Worksheet D Part III Date/Time Pre 5/26/2022 1:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
· ·	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	J	Adjustments		Education Cost	
	Adjustments		1			
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	Ó		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
,	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				1	9. 99	
30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 98	9 0.00	36	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1	0.00	0	31.00
43. 00 04300 NURSERY		0	15			
200.00 Total (lines 30 through 199)		0	•		•	200.00
Cost Center Description	I npati ent	-	_,,	-1		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T	0					31.00
43. 00 04300 NURSERY						43.00
200.00 Total (lines 30 through 199)	0					200.00
200.00 10tal (11163 30 till dugil 177)	1					1200.00

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1306	Peri od:	Worksheet D

From 01/01/2021 Part IV
To 12/31/2021 Date/Time Prepared: THROUGH COSTS 5/26/2022 1:16 pm Title XIX Hospi tal Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Post-Stepdown Cost Adjustments Adjustments 1.00 ЗА 3.00 2A 2.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 445, 283 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0 0 60.00 0 06400 I NTRAVENOUS THERAPY 0 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 Λ 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 73.00 0 07400 RENAL DIALYSIS 74.00 74.00 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07697 CARDIAC REHABILITATION 0 0 0 0 0 76. 97 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 0 09000 CLI NI C 0 90.00 90.00 0 0 09001 VISITING SPECIALTY CLINIC 0 0 90. 01 90 01 Ω 09002 PAOLI PRIMARY CARE CLINIC 0 0 90.02 0 0 90.02 09100 EMERGENCY 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

445, 283

0

0

0 200.00

Total (lines 50 through 199)

200.00

Health Financial Systems	IU HEALTH PAO	II HOSPITAI		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS				Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV	pared:
		Ti tl	e XIX	Hospi tal	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,	(from Wkst. C,	(col. 5 ÷ col. 7)	
	4.00	5. 00	and 4)	7. 00	(see instructions) 8.00	

	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			·			
	05000 OPERATING ROOM	0	445, 283	0	6, 526, 354		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	955, 181		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	15, 478, 149		
60.00	06000 LABORATORY	0	0	0	8, 048, 836		
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	2, 445, 450		
65.00	06500 RESPI RATORY THERAPY	0	0	0	1, 825, 236	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	1, 920, 350		
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	371, 185	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	205, 292	0.000000	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	184, 687	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	52, 474	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	14, 120, 064	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0.000000	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0	0	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	1, 266, 115	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89. 00
90.00	09000 CLI NI C	0	0	0	73, 272	0.000000	90.00
90. 01	09001 VISITING SPECIALTY CLINIC	0	0	0	995, 520	0.000000	90. 01
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90. 02
91.00	09100 EMERGENCY	0	0	0	25, 125, 923	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2, 897, 861	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	445, 283	0	82, 491, 949	,	200. 00
		•	•	•	•		•

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1306	Peri od: Worksheet D Part IV To 12/31/2021 Date/Time Prepared: 5/26/2022 1:16 pm

THROUG	H COSTS				o 12/31/2021	Date/Time Pre	
				VI V		5/26/2022 1:1	6 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges (col. 6 ÷ col.	Charges	Pass-Through Costs (col. 8	Charges	Pass-Through Costs (col. 9	
		,		,		,	
		7)	10.00	x col. 10) 11.00	12.00	x col. 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
	05000 OPERATING ROOM	0, 000000	26, 770	1, 826	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	16, 067	1,020		0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	16, 214			0	54.00
	06000 LABORATORY	0. 000000	23, 769			0	60.00
	06400 I NTRAVENOUS THERAPY	0.000000	23, 70 9			0	64.00
	06500 RESPIRATORY THERAPY	0. 000000	18, 118			0	65.00
	06600 PHYSI CAL THERAPY	0. 000000	4, 123			0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	3, 042			0	67.00
	06800 SPEECH PATHOLOGY	0. 000000	1, 895			0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 0,5			0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0			0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	48, 840	ì		,	73.00
	07400 RENAL DIALYSIS	0. 000000	0,010	ì		o o	74.00
	07500 ASC (NON-DISTINCT PART)	0. 000000	0			0	75. 00
	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	ì		o o	76. 97
	OUTPATIENT SERVICE COST CENTERS	0.00000			,		70.77
	08800 RURAL HEALTH CLINIC	0. 000000	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	(0	0	89. 00
90.00	09000 CLI NI C	0. 000000	0	(0	0	90.00
90. 01	09001 VISITING SPECIALTY CLINIC	0. 000000	0	(0	0	90. 01
90. 02	09002 PAOLI PRIMARY CARE CLINIC	0. 000000	0	(0	0	90. 02
91.00	09100 EMERGENCY	0. 000000	21, 762	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	(0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50 through 199)		180, 600	1, 826	0	0	200. 00

Health Financial Systems	IU HEALTH PAOLI F	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1306	Peri od: From 01/01/2021	Worksheet D-1
			To 12/31/2021	Date/Time Prepared: 5/26/2022 1:16 pm
		Title XVIII	Hospi tal	Cost

			10 12,01,2021	5/26/2022 1: 1	6 pm
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 124	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			1, 989	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			1, 515	
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	64	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
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	71	7. 00
0.00	reporting period	D 2	1 -6 -1	,	0 00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after becember 3	or the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (eveluding	cwing had and	614	9. 00
9.00	newborn days) (see instructions)	The Program (excruding	Swifig-bed and	014	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	oly (including private r	nom days)	64	10. 00
10.00	through December 31 of the cost reporting period (see instruct		Join days)	1	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er		dayo, areo.	1	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
	through December 31 of the cost reporting period	3 (
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e) ,		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16.00	Nursery days (title V or XIX only)			0	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		17. 00
	reporting period			,	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	231. 10	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 21 of t	ho cost	0.00	20. 00
20.00	reporting period	sarter becember 51 of t	ile cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		5, 065, 284	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ina period (line	0	1
	5 x line 17)		3 1		
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	16, 408	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
27 00	x line 20)			172 001	2/ 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (Tipo 21 minus Lipo 24)		173, 801 4, 891, 483	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Title 21 illitius Title 20)		4, 071, 403	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	l and observation hed ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a did observation bed en	ar gos)	Ö	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			Ö	
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	33. 00	
34.00	Average per diem private room charge differential (line 32 mir	0.00	34. 00		
35.00	Average per diem private room cost differential (line 34 x lin	0.00	35. 00		
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	4, 891, 483	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 459. 27	•
39. 00	Program general inpatient routine service cost (line 9 x line	,		1, 509, 992	•
40.00	Medically necessary private room cost applicable to the Progra	•		0	
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)	l	1, 509, 992	41.00

<u>Heal</u> th	Financial Systems	IU HEALTH PAO	_I_HOSPITAL		In Lie	eu of Form CMS-	<u> 2552-1</u> 0
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-1306	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre 5/26/2022 1:1	epared:
	Cost Center Description	Total Inpatient Cost	Total	e XVIII Average Pes Diem (col. col. 2)	3	Cost Program Cost (col. 3 x col. 4)	
10.00	In the second se	1.00	2. 00	3.00	4.00	5. 00	10.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0	. 00		42. 00
43. 00	INTENSIVE CARE UNIT	0		0 0	. 00	О	43. 00
44.00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					681, 409	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	y , ,		,		2, 191, 401	
50. 00	Pass through costs applicable to Program inp.	atient routine	services (Tro	m WKST. D, S	um or Parts I and	C	50.00
51. 00	Pass through costs applicable to Program inpland IV)		y services (f	rom Wkst. D,	sum of Parts II	C	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-ph	ysician anes	thetist, and	0000	
54. 00	Program di scharges					С	54. 00
55. 00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (line 56 minu	s line 53)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	rger amount (Time oo iiii na	3 11110 00)	Ö	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and	compounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market baske	t	0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% o	f the amount by	0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62. 00	Relief payment (see instructions)	,				o	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost repor	ting period (See	157, 393	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the	cost reporti	ng period (See	C	65. 00
// 00	instructions)(title XVIII only)					457.000	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (Tine	64 prus rine	65)(title XV	iii oniy). For	157, 393	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost	reporting period	C	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost re	porting period	d	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					C	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				7)		70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (I			•		71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv		•				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)				Part II, column		75. 00
76.00	Per diem capital related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79. 00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		ost limitatio	n (line 78 m	inus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per dreim frim)				82. 00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	•	•				86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					47.4	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			4 / 4 2, 459. 27	87. 00 88. 00
00. UU	, , , , , , , , , , , , , , , , , , , ,						

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 1:10	
		Title	XVIII	Hospi tal	Cost	
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 O	COST					
90.00 Capital -related cost	356, 059	5, 065, 284	0. 07029	4 1, 165, 694	81, 941	90.00
91.00 Nursing Program cost	0	5, 065, 284	0.00000	0 1, 165, 694	0	91.00
92.00 Allied health cost	0	5, 065, 284	0.00000	0 1, 165, 694	0	92.00
93.00 All other Medical Education	О	5, 065, 284	0. 00000	0 1, 165, 694	0	93. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15	5-1306 Peri od: From 01/01/2021	Worksheet D-1
		To 12/31/2021	Date/Time Prepared: 5/26/2022 1:16 pm
	Title XIX	(Hospi tal	PPS

Description				10 12/31/2021	5/26/2022 1:10	
DART I ALL PROVIDER COMPOWENTS AND PRACTICAL DAY PARTICIPATION AND PRACTICAL DAY AND			Title XIX	Hospi tal		
Next FALL PROVICES COMPONENTS		Cost Center Description				
Part					1. 00	
1.00 Inpatient days (including private room days, excluding newborn) 2,124 1.00 Inpatient days (including private room days, excluding swing-bed an excluding the private room days) 1,999 2.0 1,990 2.0 2						ļ
1,989 2.0 1 impatient days (including private room days, excluding swing-bed and newborn days) 2,00 Private room days (excluding swing-bed and observation bed days) 3,00 Semi-private room days (excluding swing-bed and observation bed days) 4,00 Semi-private room days (excluding swing-bed and observation bed days) 5,00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 6,00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 6,00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 6,00 Total inpatient days including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 6,00 Swing-bed SNF type inpatient days applicable to the WNII only (including private room days) 6,00 Swing-bed SNF type inpatient days applicable to the WNII only (including private room days) 6,00 Swing-bed SNF type inpatient days applicable to the WNII only (including private room days) 7,00 Swing-bed SNF type inpatient days applicable to the WNII only (including private room days) 8,00 Swing-bed SNF type inpatient days applicable to the WNII only (including private room days) 9,00 Swing-bed SNF type inpatient days applicable to services with the swing of the work of the cost reporting period (if callendar year, enter 0 on this line) 9,00 Swing-bed SNF type inpatient days applicable to services with the swing-bed days) 10,00 Swing-bed NF type inpatient days applicable to services with the swing of the cost reporting period (including private room days) 11,00 Modical of Anter for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 8 to 10 swing-bed cost applicable to SNF type services after December 31 of the cost reporting peri						
1.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. Incomplete the line of the cost of the c						1.00
on not complete this line. Semi-private room days (excluding swing-bed and observation bed days) 7. Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. Total swing-bed Kippe inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. Total inpatient days lind uding private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) 10. Weld call ynecessary private room days applicable to title XWIII only (including private room days) 10. Swing-bed SWF type inpatient days applic						2.00
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General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) The program inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) Odo Average per diem private room cost applicable to the Program (line 14 x line 35) Odo Average per diem private room cost differential (line 4, 891, 483) Average per diem private room cost differential (line 4, 891, 483) Odo Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Odo Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Odo Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Odo Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Odo Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Odo Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Odo Average per diem private room cost net of swing	27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 891, 483	27.00
Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) The program inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) O documents (line 30, 20, 00, 00) Description (line 27 ÷ line 28) O documents (line 27 ÷ line 28) O documents (line 30, 00, 00) O documents (line 27 · line 28) O documents (line 31, 00, 00) O documents (line 27 · line		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) 37. 02 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)		28.00
31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.0000000000000000000000000000000000	29. 00					29.00
Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00	Semi-private room charges (excluding swing-bed charges)				30.00
Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 00					31.00
Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Biological Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Biological Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost adjferential (line 32 minus line 33) (see instructions) 0.00 44.00	32. 00					32.00
Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Brivate room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) The program inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 00					
Ref. 00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 891, 483 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 36. 00 48, 891, 483 48, 891, 483 57. 00 48, 891, 483 58. 00 88, 534 88, 534 90. 00	34.00					34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 891, 483 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 48, 534 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	35. 00	9	ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 88.00 Adjusted general inpatient routine service cost per diem (see instructions) 99.00 Program general inpatient routine service cost (line 9 x line 38) 10.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2, 459.27 88, 534 90.00 O delically necessary private room cost applicable to the Program (line 14 x line 35)		· · · · · · · · · · · · · · · · · · ·				36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 88.00 Adjusted general inpatient routine service cost per diem (see instructions) 99.00 Program general inpatient routine service cost (line 9 x line 38) 10.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2, 459.27 88, 534 90.00 Outlier of the program (line 14 x line 35) 30.00 Adjusted general inpatient routine service cost (line 9 x line 38) 80.00 Outlier of the program (line 14 x line 35)	37.00					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 88.00 Adjusted general inpatient routine service cost per diem (see instructions) 99.00 Program general inpatient routine service cost (line 9 x line 38) 10.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2, 459.27 88, 534 90.00 O delically necessary private room cost applicable to the Program (line 14 x line 35) 20.00 O delically necessary private room cost applicable to the Program (line 14 x line 35)						
Adjusted general inpatient routine service cost per diem (see instructions) 2, 459. 27 38. 00 Program general inpatient routine service cost (line 9 x line 38) 88, 534 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00			ICTMENTS			-
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 88,534 39.00 40.00	20.00				2 452 25	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
		, , ,	-			
+1.00 Total Program general impatient routine service cost (Tine 39 + Tine 40)		, , , , , , , , , , , , , , , , , , , ,				
	41.00	Tiotal Program general impatrent routine service cost (line 39	+ ITTIE 40)	l	88, 534	41.UC

	ATION OF INPATIENT OPERATING COST		HOSPITAL Provider CO	°N: 15_1204	Peri od:	Worksheet D-1	2552-10
COMITOT	ALLON OF INFALLENT OPERALLING COST		Frovider CC	ы. 10-13U0	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:1	pared:
			Ti tl	e XIX	Hospi tal	PPS	o piii
	Cost Center Description	Total Inpatient Costlr	Total patient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
10.00	NUDGEDY (1) II V o V(V I I)	1.00	2. 00	3. 00	4. 00	5. 00	10.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	137, 593	156	882.	01 12	10, 584	42.00
43. 00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1. 00 59, 466	48. 00
49. 00	Total Program inpatient costs (sum of lines			ns)		158, 584	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine se	ervices (from	Wkst. D, su	m of Parts I and	7, 053	50.00
E1 00	III)	ationt andillary	complete (fr	om Wko+ D	oum of Donto II	4 007	F1 00
51. 00	Pass through costs applicable to Program inp and IV)	atrent ancillary	services (fr	om wkst. D,	Suill OT Parts II	4, 897	51.00
52. 00	Total Program excludable cost (sum of lines					11, 950	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ited, non-phy	sician anest	hetist, and	146, 634	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					1
	Program di scharges					0	
56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (I	ine 56 minus	line 53)	0	1
58.00	Bonus payment (see instructions)						
59. 00	market basket	porting period er	naing 1996, u	paatea ana c	ompounded 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		(TITIES ST X	00), 01 1% 0	the target		
62.00	Relief payment (see instructions)	ont (oog i notrugi	· i ana)			0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstruc	.1 0115)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the	cost report	ing period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reportin	g period (See	0	65. 00
	instructions)(title XVIII only)			•			
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	I plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through [December 31 o	f the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Dec	cember 31 of	the cost rep	ortina period	0	68. 00
	(line 13 x line 20)				3		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID routi	ne service c	ost (line 37)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		[line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine serv			,			74. 00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service o	costs (from W	orksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77.00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider record	s)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the cos			nus 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 (* .					82. 00 83. 00
84. 00	Program inpatient ancillary services (see in						84. 00
85.00	Utilization review - physician compensation	(see instructions	•				85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 85)				86. 00
							1
87. 00	Total observation bed days (see instructions)				474	87. 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 1:10	
		Titl	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 O	COST					
90.00 Capital -related cost	356, 059	5, 065, 284	0. 07029	4 1, 165, 694	81, 941	90.00
91.00 Nursing Program cost	0	5, 065, 284	0.00000	0 1, 165, 694	0	91.00
92.00 Allied health cost	0	5, 065, 284	0.00000	0 1, 165, 694	0	92.00
93.00 All other Medical Education	О	5, 065, 284	0. 00000	0 1, 165, 694	0	93. 00

INPATIENT ROUTINE SERVICE COST CENTERS	Ti tl (Ratio of Cost	Hospi tal	Cost	6 pm
INPATI ENT ROUTI NE SERVI CE COST CENTERS				LUST	
30. 00				I npati ent	
30. 00		To Charges		Program Costs (col. 1 x col. 2)	
30. 00		1. 00	2. 00	3. 00	
31. 00					
43. 00			1, 335, 839		30.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC			0		31.00
50. 00					43.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC					
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 34953			
		0. 47437		ı .	52. 0
60. 00 06000 LAB0RAT0RY		0. 18683		37, 587	
		0. 34925		107, 570	
54. 00 06400 I NTRAVENOUS THERAPY		0. 16374		0	
55. 00 06500 RESPI RATORY THERAPY		0. 44269		·	
66. 00 06600 PHYSI CAL THERAPY		0. 63132			
57. 00 06700 OCCUPATIONAL THERAPY		0. 63737		24, 234	
98. 00 06800 SPEECH PATHOLOGY		0. 77340		·	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 12935			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 51328		0	72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 25884			
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STINCT PART)		0.00000		0	74. 0 75. 0
75. 00 07500 ASC (NON-DISTINCT PART) 76. 97 07697 CARDIAC REHABILITATION		0. 00000 0. 00000		ŭ	76. 9
OUTPATIENT SERVICE COST CENTERS		0.00000	O O	U	70.9
38. 00 08800 RURAL HEALTH CLINIC		0.00000	10	0	88. 0
38. 00 08800 RURAL HEALTH CLINIC 39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 0
90. 00 09000 FEDERALLY QUALIFIED HEALTH CENTER		1. 32230		Ŭ	1
90.01 09000 CETNIC 90.01 09001 VISITING SPECIALTY CLINIC		0. 73919		0	90.0
00.02 09002 PAOLI PRIMARY CARE CLINIC		0. 73919		0	90.0
01. 00 09100 EMERGENCY		0. 20613		1, 901	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				1, 7011	
OTHER REIMBURSABLE COST CENTERS			0 4 960	1 995	1 92 n
P5. 00 09500 AMBULANCE SERVICES		0. 40226	4, 960	1, 995	92. 0
Total (sum of lines 50 through 94 and 96 through 98)		0. 40226	4, 960	1, 995	92. 0 95. 0

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)

681, 409 200. 00 201. 00 202. 00

2, 244, 667

2, 244, 667

200. 00 201. 00

202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1306	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z306	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:1	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
10. 00 03000 ADULTS & PEDIATRICS					30.0
81. 00 03100 NTENSI VE CARE UNI T					31.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					1
0.00 05000 OPERATING ROOM		0. 3495	33 0	0	50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4743	75 0	0	52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1868	31 4, 982	931	54.0
D. 00 06000 LABORATORY		0. 3492		3, 360	60.
4.00 06400 INTRAVENOUS THERAPY		0. 1637	44 0	0	64. (
5. 00 06500 RESPIRATORY THERAPY		0. 4426			
6. 00 06600 PHYSI CAL THERAPY		0. 6313			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 6373	· ·		
B. 00 06800 SPEECH PATHOLOGY		0. 7734			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1293		0	1
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 5132		0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2588	· ·		1
4. 00 07400 RENAL DI ALYSI S		0.0000		0	
5. 00 07500 ASC (NON-DISTINCT PART) 6. 97 07697 CARDIAC REHABILITATION		0.0000		-	
OUTPATIENT SERVICE COST CENTERS		0.0000	0	0	/6. `
B. 00 08800 RURAL HEALTH CLINIC		0.0000	20	0	88. (
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	1
0. 00 09000 CLINI C		1. 3223		0	
D. 01 09001 VISITING SPECIALTY CLINIC		0. 7391		0	
D. 02 09002 PAOLI PRIMARY CARE CLINIC		0.0000		Ö	
1. 00 09100 EMERGENCY		0. 2061		Ö	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4022		1	1
OTHER REIMBURSABLE COST CENTERS			•		1
5. 00 09500 AMBULANCE SERVICES					95.
OO OO Total (sum of lines 50 through 04 and 06 through 09)		1	70 260	22 066	200

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)

32, 066 200. 00 201. 00 202. 00

78, 268 0

78, 268

200. 00 201. 00

202.00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 1:10	
	Ti tl	e XIX	Hospi tal	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	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			78, 124		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31. 00
43. 00 04300 NURSERY			18, 668		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 34953			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 47437			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 18683			1
60. 00 06000 LABORATORY		0. 34925		1	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 16374		ı "	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 44269			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 63132			
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0. 63737			67.00
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 77340 1. 12935		1, 466 0	68. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS		1. 51328		0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 25884			
74. 00 07400 RENAL DI ALYSI S		0. 00000		12, 042	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000			75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 00000			76. 97
OUTPATIENT SERVICE COST CENTERS		0.0000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	J	70.77
88. 00 08800 RURAL HEALTH CLINIC		2, 27746	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	00	0	89. 00
90. 00 09000 CLI NI C		1. 32230		0	90.00
90.01 09001 VISITING SPECIALTY CLINIC		0. 73919	0 0	0	90. 01
90.02 09002 PAOLI PRIMARY CARE CLINIC		0.00000	00 0	0	90. 02
01 00 00100 EMEDGENCY		0 20/12	21 7/2	4 40/	01 00

0. 206135

0. 402260

21, 762

180, 600

180, 600

4, 486

0

59, 466 200. 00 201. 00 202. 00

91.00

92. 00

95.00

91.00

92.00

200. 00 201. 00

202.00

09100 EMERGENCY

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

Date/Time Prepared: 12/31/2021 5/26/2022 1:16 pm Title XVIII Hospi tal Cost 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 5, 305, 582 Medical and other services reimbursed under OPPS (see instructions) 2.00 0 2.00 OPPS payments 3.00 0 3 00 4.00 Outlier payment (see instructions) 0 4.00 4.01 Outlier reconciliation amount (see instructions) 0 4.01 Enter the hospital specific payment to cost ratio (see instructions) 5.00 0.000 5.00 6.00 Line 2 times line 5 Λ 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 Transitional corridor payment (see instructions) 8.00 0 8.00 9 00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 0 10.00 Organ acquisitions Λ 10.00 5, 305, 582 Total cost (sum of lines 1 and 10) (see instructions) 11.00 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 12.00 Ancillary service charges 0 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 0 13.00 14.00 Total reasonable charges (sum of lines 12 and 13) 0 14.00 Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 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) 0 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 instructions) 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20 00 0 instructions) 21 00 Lesser of cost or charges (see instructions) 5, 358, 638 21 00 Interns and residents (see instructions) 22.00 22.00 0 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 0 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 64, 902 Deductibles and coinsurance amounts (for CAH, see instructions) 25, 00 25, 00 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 3, 346, 827 26.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 1, 946, 909 27.00 27.00 instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.00 0 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 0 30 00 1, 946, 909 30 00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 3, 918 31.00 32.00 Subtotal (line 30 minus line 31) 1, 942, 991 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33 00 33 00 0 34.00 Allowable bad debts (see instructions) 926, 323 34.00 Adjusted reimbursable bad debts (see instructions) 602, 110 35.00 781, 745 36, 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 36, 00 2, 545, 101 37.00 Subtotal (see instructions) 37.00 38.00 MSP-LCC reconciliation amount from PS&R 38.00 0 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.00 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 39.99 0 Subtotal (see instructions) 2, 545, 101 40.00 40.00 40.01 Sequestration adjustment (see instructions) 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 3, 834, 987 41.00 Interim payments 41.00 Interim payments-PARHM 41.01 41.01 42.00 Tentative settlement (for contractors use only) 42.00 Tentative settlement-PARHM (for contractor use only) 42.01 42.01 43.00 Balance due provider/program (see instructions) -1, 289, 886 43.00 Balance due provider/program-PARHM (see instructions) 43.01 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 146, 348 44.00 §115 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 0 0 00 92.00 92 00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 94.00 Total (sum of lines 91 and 93) 0 94.00

Health Financial Systems IU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1306

					5/26/2022 1:10	6 pm
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 097, 112		3, 834, 987	1. 00
2. 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,		О		0	2. 00
3. 00	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)					3. 00
	Program to Provider	10/00/0001				
3. 01	ADJUSTMENTS TO PROVIDER	10/28/2021	314, 600		0	3. 01
3. 02 3. 03			0		0	3. 02 3. 03
3. 03			0		0	3. 03
3. 04						3. 04
3.03	Provider to Program		0		0	3.03
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	A DOGGETHIE TO THOUSE HIS		0		0	3. 51
3. 52			0		o	3. 52
3.53			0		o	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		314, 600		0	3. 99
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		2, 411, 712		3, 834, 987	4. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
	Provi der to Program		_			
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51 5. 52			0		0	5. 51 5. 52
5. 52 5. 99			0		0	5. 99
5. 77	5. 50-5. 98)		0		U	3. 77
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		386, 908		1, 289, 886	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 024, 804		2, 545, 101	7. 00
			_,,,	Contractor Number	NPR Date (Mo/Day/Yr)	30
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		•	. '	

Health Financial Systems IU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 IU HEALTH PAOLI HOSPITAL Peri od: Worksheet E-1
From 01/01/2021 Part | Date/Time Prepared: 5/26/2022 1:16 pm Provider CCN: 15-1306 Component CCN: 15-Z306 Swing Beds - SNF Part B 022 .. Cost Title XVIII Inpatient Part A

		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	1.00	208, 640	3.00	4.00	1. 00
2.00	Interim payments payable on individual bills, either		200, 040			2. 00
2.00	submitted or to be submitted to the contractor for		0		U	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	<u> </u>				
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		l ol	3. 02
3. 03			0		l ol	3. 03
3. 04			Ö		Ö	3. 04
3. 05			0		0	3. 05
0.00	Provider to Program				, and the second	0.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		l ol	3. 51
3. 52			0		l ol	3. 52
3. 53			0		l ol	3. 53
3.54			0		l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines	•	0		l ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		208, 640		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5.03			0		0	5. 03
F F0	Provi der to Program					F F0
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			ľ			5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					6. 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					0. 00
6. 01	SETTLEMENT TO PROVIDER		_		o	6. 01
6. 02	SETTLEMENT TO PROGRAM		17, 286			6. 02
7. 00	Total Medicare program liability (see instructions)		191, 354			7. 00
7.00	Trotal medicale program travitity (see Instructions)		171, 334	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
		1			'	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1306 Period: From 01/01/2021 Part II Part II Provider CCN: 15-1306 Period: From 01/01/2021 Part II Part II	Heal th	Financial Systems IU HEALTH PA	OLI HOSPITAL	In Lie	u of Form CMS-	2552-10		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost 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 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) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial / interim HIT payment adjustment (see instructions) 30.00 Initial / interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify)	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1306 Period: Workshe From 01/01/2021 Part II To 12/31/2021 Date/Ti							
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost 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 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) 5.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify)			Title XVIII	Hospi tal	Cost			
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9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify) 9.00 10.00 30.00 31.00	8.00	1	5)			8.00		
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INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00			on (see instructions)			10.00		
30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00			(1		
31.00 Other Adjustment (specify) 31.00	30.00		30.00					
						1		

1.00			Component CCN: 15-Z306	To 12/31/2021	Date/Time Pre 5/26/2022 1:1	
1.00 2.00			Title XVIII	Swing Beds - SNF		<u>o p</u>
COMPUTATION OF INT COST OF COUNTED SINVICES 10.00 1.						
1.00 Inpatient routine services - saing bed-NFF (see instructions) 188,967 0 1.00		COMPUTATION OF MET COOT OF COMPTED CERTIFICATION		1. 00	2. 00	
1.	1 00			150.047	0	1 00
Ancil Harry services (from West, 0-3, col. 3, line 200, for Part A, and sum of West. 0.		, ,		158, 967	U	
Part V, Cols 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions) 3.01 Nursing and Iled health payment-PARRM (see instructions) 3.01 Nursing and Iled health payment-PARRM (see instructions) 6.00 4.00 Per diem cost for interns and residents not in approved teaching program (see 0.00 4.00 4.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.00 1.00 6.			· A and sum of Wkst D	32 387	0	1
Instructions	0.00		· · ·		Ŭ	0.00
Per diem cost for Interns and residents not in approved teaching program (see instructions) 6.4			3 [
Instructions	3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
Program days	4.00		ng program (see		0. 00	4. 00
Interns and residents not in approved teaching program (see instructions)	г оо				0	F 00
Utilization review - physician compensation - SNF optional method only 0 7.00			04			
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205. 00 Medicare swing-bed SNF target amount 206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 206. 00 Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207. 00 Program reimbursement under the §410A Demonstration (see instructions) 208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209. 00 Reserved for future use 209. 00 Reserved for future use 209. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00		Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	ration	1
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Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209.00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00						
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209.00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00	206.00					206. 00
208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209.00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00	207.00					207 00
and 3) 209. 00 Adj ustment to Medicare swing-bed SNF PPS payments (see instructions) 210. 00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00		· · · · · · · · · · · · · · · · · · ·				1
209. 00 Adj ustment to Medicare swing-bed SNF PPS payments (see instructions) 209. 00 210. 00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00	208.00					208.00
210.00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00	209 00					209 00
Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00						
215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00	2. 30					1
instructions)	215.00		209 plus line 210) (see			215. 00
		instructions)				

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL			In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN:	15-1306	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 1:16 pm

				5/26/2022 1:10	6 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			2, 191, 401	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructio	ns)		0	2. 00
3.00	Organ acquisition			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)		2, 191, 401	4. 00	
5.00	Primary payer payments		0	5. 00	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 213, 315	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for p	3	9	0	11. 00
12.00	Amounts that would have been realized from patients liable for		n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13.00
14. 00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete onl	y if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)			_	
16. 00	Excess of reasonable cost over customary charges (complete onl	y if line 6 exceeds line	e 14) (see	0	16. 00
	instructions)			_	
17. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	17. 00
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				40.00
18.00	Direct graduate medical education payments (from Worksheet E-4	, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 213, 315	
20.00	Deductibles (exclude professional component)			198, 096	
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 015, 219	
23. 00	Coinsurance			742	23. 00
24. 00	Subtotal (line 22 minus line 23)	> (!+		2, 014, 477	
25. 00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		15, 888	
26. 00	Adjusted reimbursable bad debts (see instructions)			10, 327	26. 00
27. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		11, 796	
28. 00 29. 00	Subtotal (sum of lines 24 and 25, or line 26) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2, 024, 804 0	29. 00
	, , , , ,	`		0	29. 50
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29. 50 29. 98
29. 98	Recovery of accelerated depreciation.			-	
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			2, 024, 804	
30. 01	Sequestration adjustment (see instructions)			0	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			U	30. 02
30. 03	Sequestration adjustment-PARHM			0 411 710	30. 03
31.00	Interim payments			2, 411, 712	
31. 01	Interim payments-PARHM				31. 01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)	21 and 22)		20/ 000	32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02		22 01)	-386, 908	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, mi		,	F7 004	33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2, (cnapter I,	57, 301	34. 00
	§115. 2				l

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

Provider CCN: 15-1306

Peri od: Worksheet G From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 1:16 pm

General Fund Specific Endowment Fund Purpose Fund	Plant Fund	
	4 00	
	4. 00	
CURRENT ASSETS 20, 329, 784 0 0	0	1. 00
2.00 Temporary investments	0	2. 00
3. 00 Notes recei vable 51, 168 0 0	0	3. 00
4. 00 Accounts receivable 4, 089, 520 0 0	o o	4. 00
5. 00 Other recei vable 294, 383 0	0	5. 00
6.00 Allowances for uncollectible notes and accounts receivable 0 0	0	6. 00
7. 00 Inventory 749, 099 0	0	7. 00
	0	8. 00
	0	9. 00
	-	
	0	10.00
11. 00 Total current assets (sum of lines 1-10) 25, 621, 766 0 0	0	11. 00
FI XED ASSETS 12.00 Land 183.505 0 0	0	10.00
1	0	12.00
13.00 Land improvements 625,604 0 0 14.00 Accumulated depreciation -414.802 0 0	0	13.00
		14. 00
15. 00 Bui I di ngs 9, 679, 689 0 0	0	15.00
16. 00 Accumulated depreciation -3, 979, 336 0 0 0	0	16.00
17. 00 Leasehold improvements 791, 602 0	0	17. 00
18.00 Accumulated depreciation -791,602 0 0	0	18.00
19.00 Fixed equipment 0 0 0	0	19. 00
20.00 Accumulated depreciation 0 0	0	20. 00
21.00 Automobiles and trucks 39,582 0 0	0	21. 00
22.00 Accumulated depreciation 0 0	0	22. 00
23.00 Maj or movable equipment 12,126,092 0 0	0	23. 00
24. 00 Accumul ated depreciation -8, 314, 475 0 0	0	24.00
25.00 Minor equipment depreciable 0 0 0	0	25.00
26.00 Accumulated depreciation 0 0	0	26.00
27.00 HIT designated Assets 0 0 0	0	27.00
28.00 Accumulated depreciation 0 0	0	28.00
29.00 Minor equipment-nondepreciable 0 0 0	0	29.00
30.00 Total fixed assets (sum of lines 12-29) 9,945,859 0 0	0	30.00
OTHER ASSETS		
31.00 Investments 2,116,806 0 0	0	31.00
32.00 Deposits on Leases 0 0 0	0	32.00
33.00 Due from owners/officers 0 0	0	33.00
34.00 Other assets 10,851,002 0	0	34.00
35.00 Total other assets (sum of lines 31-34) 12,967,808 0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35) 48,535,433 0	0	36.00
CURRENT LI ABI LI TI ES		
37. 00 Accounts payable 1, 919, 841 0 0	0	37.00
38.00 Salaries, wages, and fees payable 695,250 0	0	38.00
39.00 Payrol I taxes payable 0 0	ol	39. 00
40.00 Notes and Loans payable (short term) 0 0	0	40.00
41.00 Deferred income 0 0	ol	41. 00
42. 00 Accel erated payments 1,660,519	- 1	42. 00
43. 00 Due to other funds 0 0	О	43. 00
44.00 Other current liabilities 5,584,633 0	o	44. 00
45 00 7 1 1 1 1 1 1 1 1 1	ő	45. 00
LONG TERM LIABILITIES (sum of lines 37 thru 44) 9,860,243 0 0		45.00
46. 00 Mortgage payable 0 0 0	0	46. 00
47. 00 Notes payable	o	47. 00
48. 00 Unsecured Loans 0 0 0	ő	48. 00
49.00 Other long term liabilities 29,249 0	o	49. 00
50.00 Total long term liabilities (sum of lines 46 thru 49) 29,249 0	0	50.00
, , , , , , , , , , , , , , , , , , ,	0	51. 00
		51.00
CAPI TAL ACCOUNTS 52, 00 General fund balance 38, 645, 941		E2 00
		52. 00
53. 00 Specific purpose fund 0		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	_ [56.00
57.00 Plant fund balance - invested in plant	0	57. 00
58.00 Plant fund balance - reserve for plant improvement,	0	58. 00
replacement, and expansion	[]	FO 00
	0	59.00
59.00 Total fund balances (sum of lines 52 thru 58) 38,645,941 0	•	
59.00 Total Fund balances (sum of lines 52 thru 58) 38,645,941 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	60.00

Provider CCN: 15-1306

					To 12/	/31/2021	Date/Time Prep 5/26/2022 1:10	
		General	Fund	Speci al	Purpose F	und	Endowment Fund	
		1.00	2. 00	3.00	4.	00	5. 00	
1.00	Fund balances at beginning of period		27, 662, 104			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10, 889, 334			0		2.00
3. 00 4. 00	Total (sum of line 1 and line 2) DONATED PPE	94, 500	38, 551, 438		0	0	0	3. 00 4. 00
5.00	ROUNDING	3			0		Ö	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8.00		0			0		0	8. 00
9. 00 10. 00	Total additions (sum of line 4-9)		94, 503		U	0	0	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		38, 645, 941			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	00,010,711		0	Ü	0	12. 00
13.00		O			0		0	13.00
14. 00		0			0		0	14. 00
15.00		0			0		0	15. 00
16. 00 17. 00		0			0		0	16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)		o		o	0		18. 00
19. 00	Fund balance at end of period per balance		38, 645, 941			0		19. 00
	sheet (line 11 minus line 18)	Frankrich Frank	DIt	Fried				
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) DONATED PPE	0	0		0			3. 00 4. 00
5.00	ROUNDING		0					5. 00
6. 00			Ō					6. 00
7.00			0					7. 00
8.00			0					8. 00
9. 00 10. 00	Total additions (sum of line 4-9)		۷		0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12.00	Deductions (debit adjustments) (specify)		О					12. 00
13. 00			0					13. 00
14.00			0					14. 00
15. 00 16. 00			0					15. 00 16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)	0	Ĭ		0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)		l					

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1306

			To 12/31/2021	Date/Time Pre 5/26/2022 1:1	
	Cost Center Description	I npati ent	Outpati ent	Total	O pili
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>		•	
	General Inpatient Routine Services]
1.00	Hospi tal	3, 742, 5	551	3, 742, 551	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	124, 8	38	124, 838	5. 00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	3, 867, 3	89	3, 867, 389	10.00
	Intensive Care Type Inpatient Hospital Services		*		
11.00	INTENSIVE CARE UNIT		0	0	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines		0	0	16. 00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3, 867, 3	89	3, 867, 389	17. 00
18.00	Ancillary services	7, 448, 2	94 44, 684, 966	52, 133, 260	18. 00
19.00	Outpatient services	397, 9	28, 694, 598	29, 092, 575	19. 00
20.00	RURAL HEALTH CLINIC		0 1, 266, 115	1, 266, 115	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23.00	AMBULANCE SERVICES		0 0	0	23. 00
24.00	CMHC				24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	OTHER NRCC		0 31, 264	31, 264	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 11, 713, 6	60 74, 676, 943	86, 390, 603	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		29, 695, 090		29. 00
30. 00	ADD (SPECIFY)		0		30. 00
31. 00			0		31. 00
32. 00			0		32. 00
33. 00			0		33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			U		39. 00
40. 00			0		40. 00
41. 00			0		41.00
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)(trans	ster	29, 695, 090		43. 00
	to Wkst. G-3, line 4)	I	I	I	I

	Financial Systems	IU HEALTH PAOLI			eu of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-1306	Peri od:	Worksheet G-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 1:1	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, lin	e 28)		86, 390, 603	1. 00
2.00	Less contractual allowances and discounts on	patients' accoun	ts		52, 808, 389	2. 00
3.00	Net patient revenues (line 1 minus line 2)				33, 582, 214	3. 00
4.00	Less total operating expenses (from Wkst. G-2	2, Part II, line	43)		29, 695, 090	4. 00
5.00	Net income from service to patients (line 3 m	minus line 4)			3, 887, 124	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 miscellaneo	ous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11. 00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gues	sts			0	14.00
15.00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical sur	oplies to other t	han patients		0	16. 00
17.00	Revenue from sale of drugs to other than pati	ents	•		0	17. 00
18.00	Revenue from sale of medical records and abst	tracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, ar	nd canteen			0	20. 00
21.00	Rental of vending machines				0	21. 00
22. 00	Rental of hospital space				0	22. 00
23. 00	Governmental appropriations				0	23. 00
24. 00	MI SCELLANEOUS I NCOME				1, 444, 618	24. 00
	COVI D-19 PHE Funding				5, 557, 592	
	Total other income (sum of lines 6-24)				7, 002, 210	
	Total (line 5 plus line 25)				10 000 224	

10, 889, 334

26.00 27. 00 0 0 28.00 10, 889, 334 29.00

24.00 MISCELLANEOUS INCOME
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Heal th	Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Li€	eu of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO		Peri od:	Worksheet M-1	
			Component (From 01/01/2021 To 12/31/2021		aanad.
			Component	JUN: 15-8557	10 12/31/2021	Date/Time Prep 5/26/2022 1:10	
					RHC I	Cost	
		Compensation	Other Costs	Total (col. 1	Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	455, 433	64, 196	519, 62	9 -8, 412	511, 217	1.00
2.00	Physician Assistant	0	0		0	0	2.00
	las a series	000 000				054 004	0 00

		Compensation	Other Costs	Total (col. 1	Recl assi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	455, 433	64, 196	519, 629	-8, 412	511, 217	1. 00
2.00	Physician Assistant	0	0	0	0	0	2. 00
3. 00	Nurse Practitioner	329, 003	59, 543	388, 546	-36, 622	351, 924	3. 00
4. 00	Visiting Nurse	0	0	0	0	0	4. 00
5.00	Other Nurse	0	0	0	0	0	5. 00
6. 00	Clinical Psychologist	0	0	0	0	0	6. 00
7.00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	395, 609		395, 609			9. 00
	Subtotal (sum of lines 1 through 9)	1, 180, 045	123, 739	1, 303, 784	-43, 519	1, 260, 265	10.00
11. 00	Physician Services Under Agreement	0	0	0	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15. 00	Medical Supplies	0	22, 437	22, 437	-846	21, 591	15. 00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22, 437	22, 437	-846	21, 591	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 180, 045	146, 176	1, 326, 221	-44, 365	1, 281, 856	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
	Pharmacy	0	0	0	0	0	23. 00
24.00	Dental	0	0	0	0	0	24.00
25. 00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	216, 078	216, 078	-203, 579	12, 499	29. 00
30.00	Administrative Costs	0	277, 489	277, 489	-166, 670	110, 819	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	493, 567	493, 567	-370, 249	123, 318	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 180, 045	639, 743	1, 819, 788	-414, 614	1, 405, 174	32.00
	and 31)						

Health Financial Systems	IU HEALTH PAOLI	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1306		Worksheet M-1
		Component CCN: 15-8557	From 01/01/2021 To 12/31/2021	Date/Time Prepared:

			Component	CCN: 15-8557	То	12/31/2021	Date/Time Pr 5/26/2022 1:	
						RHC I	Cost	1.5
		Adjustments	Net Expenses					
			for Allocation					
		((col. 5 + col.					
			6)					
		6. 00	7. 00					
4 00	FACILITY HEALTH CARE STAFF COSTS	ما	F44 047					4
1.00	Physi ci an	0	511, 217	1				1.00
2.00	Physician Assistant	0	0	1				2.00
3.00	Nurse Practitioner	0	351, 924					3.00
4.00	Visiting Nurse	O O	0					4.00
5. 00 6. 00	Other Nurse	0	0	1				5. 00 6. 00
7. 00	Clinical Psychologist Clinical Social Worker	0	0					7.00
7. 00 8. 00	Laboratory Techni ci an	0	0	1				8.00
9.00	Other Facility Health Care Staff Costs	0	397, 124	1				9.00
10. 00	Subtotal (sum of lines 1 through 9)	0	1, 260, 265					10.00
	Physician Services Under Agreement	0	1, 200, 203	i				11.00
	Physician Supervision Under Agreement	0	0					12.00
	Other Costs Under Agreement	0	0	1				13. 00
	Subtotal (sum of lines 11 through 13)	0	0	1				14. 00
15. 00	Medical Supplies	0	21, 591					15. 00
	Transportation (Health Care Staff)	0	21, 371					16.00
	Depreciation-Medical Equipment	0	0					17. 00
	Professional Liability Insurance	0	0					18. 00
	Other Health Care Costs	0	0					19. 00
	Allowable GME Costs	ا ا	· ·					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	21, 591					21. 00
22. 00		o	1, 281, 856					22. 00
22.00	lines 10, 14, and 21)	Ĭ	1,201,000					1 22. 00
	COSTS OTHER THAN RHC/FQHC SERVICES	,						
23.00	Pharmacy	0	0)				23. 00
24.00	Dental	0	0					24. 00
25.00	Optometry	0	0					25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	Chronic Care Management	0	0					25. 02
26.00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)							
	FACILITY OVERHEAD	,						
	Facility Costs	36, 909	49, 408	1				29. 00
30. 00	Administrative Costs	-64, 189	46, 630					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-27, 280	96, 038					31. 00
22.00	30)	07 000	4 077 001					22.00
32. 00	Total facility costs (sum of lines 22, 28	-27, 280	1, 377, 894					32. 00
	and 31)	I		I				1

Heal th	Financial Systems	IU HEALTH PAC	OLI HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2021 To 12/31/2021	Date/Time Pre	narad:
			Component	JCN. 13-6557	10 12/31/2021	5/26/2022 1:10	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00			3)	4	
	VICITO AND PROPUSTIVITY	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	1 70	2.7//	4 20	7 140		1 00
1.00	Physi ci an	1. 70					1.00
2.00	Physician Assistant	0.00			0 0		2.00
3.00	Nurse Practitioner	1. 80			0 3, 780 10, 920		3. 00 4. 00
4. 00 5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	3. 50 0. 00			10, 920	10, 920 0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.00
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
7.02	only)	0.00					7.02
8. 00	Total FTEs and Visits (sum of lines 4	3. 50	7, 150			10, 920	8.00
	through 7)	-					
9.00	Physician Services Under Agreements		0			0	9. 00
	<u> </u>						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			VI CES			
10.00	Total costs of health care services (from W					1, 281, 856	
11. 00						0	
12.00	Cost of all services (excluding overhead) (s					1, 281, 856	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		96, 038	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			1, 505, 634	
16.00	Total overhead (sum of lines 14 and 15)					1, 601, 672	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	NIC comi cos (1:	no 10 v lic- 1	0)		1, 601, 672	
	Overhead applicable to hospital based RHC/FC					1, 601, 672	
∠∪. ∪∪	Total allowable cost of hospital-based RHC/F	runc services (s	sum of fines to	and 19)		2, 883, 528	₁ 20.00

		U00D1 T41		6.5. 0110.6	
	Financial Systems IU HEALTH PAOLI ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1306	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (Component CCN: 15-8557	From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 1:10	pared:
		Title XVIII	RHC I	Cost	<u> </u>
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2, line 20)		2, 883, 528	1. 00
2.00	Cost of injections/infusions and their administration (from Wk			6, 813	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		2, 876, 715	•
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	ine 9)		10, 920 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	THE 7)		10, 920	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			263. 44	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through	through	
			03/31/2021)	12/31/2021) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or vour contractor)	263. 44	263.44	8. 00
9.00	Rate for Program covered visits (see instructions)		263. 44		•
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		117	534	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contra		30, 822	140, 677 0	
13. 00	Program covered cost from mental health services (line 9 x lin	•	0	0	
14. 00	Limit adjustment for mental health services (see instructions)		0	0	
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	171, 499	•
16. 01	Total program charges (see instructions) (from contractor's rec			114, 121	
16. 02 16. 03	Total program preventive charges (see instructions)(from provi Total program preventive costs ((line 16.02/line 16.01) times			11, 498 17, 279	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03			117, 835	
	(Titles V and XIX see instructions.)	,		·	
16. 05	Total program cost (see instructions)		0	135, 114	•
17. 00	Primary payer amounts	(from contractor		0	
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		6, 926	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	s) (from contractor		19, 139	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			135, 114	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		1, 778	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			136, 892	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	uctions)		0	
25. 00	,			0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration				25. 99
26. 00	Net reimbursable amount (see instructions)			136, 892	
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	
27. 00	Interim payments			105, 666	
28. 00	1			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	•		31, 226	
30. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-II,		699	30. 00
	chapter I, §115.2		I I		I

	Financial Systems IU HEALTH PAG				eu of Form CMS-2	2552-10
COMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO		Peri od:	Worksheet M-4	
		Component (CCN: 15-8557	From 01/01/2021	Doto/Time Dro	norod.
		Component	JUN: 15-8557	To 12/31/2021	Date/Time Pre 5/26/2022 1:1	pareu: 6 nm
		Title	XVIII	RHC I	Cost	Орш
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCINES	ANTI BODY	
					PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 260, 265	1, 260, 26	5 1, 260, 265	1, 260, 265	1. 00
2.00	Ratio of injection/infusion staff time to total health	0. 000117	0.00096	0. 000000	0. 000000	2.00
	care staff time					
3.00	Injection/infusion health care staff cost (line 1 x line	147	1, 21	0	0	3.00
	2)					
4.00	Injections/infusions and related medical supplies costs	355	1, 31	6 0	0	4.00
	(from your records)					
5.00	Direct cost of injections/infusions (line 3 plus line 4)	502	2, 52	26 0	0	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	1, 281, 856	1, 281, 85	1, 281, 856	1, 281, 856	6.00
	Worksheet M-1, col. 7, line 22)					
7.00	Total overhead (from Wkst. M-2, line 19)	1, 601, 672				7. 00
8.00	Ratio of injection/infusion direct cost to total direct	0. 000392	0. 00197	0. 000000	0.000000	8. 00
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	628			0	9. 00
10.00	Total injection/infusion costs and their administration	1, 130	5, 68	33 0	0	10.00
	costs (sum of lines 5 and 9)					
11. 00	Total number of injections/infusions (from your records)	25		32 0	0	11. 00
12. 00	Cost per injection/infusion (line 10/line 11)	45. 20				
13.00	Number of injection/infusion administered to Program	1	2	25 0	0	13. 00
	benefi ci ari es			_	_	
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
	administered to MA enrollees					
14. 00	Program cost of injections/infusions and their	45	1, 73	33 0	0	14. 00
	administration costs (line 12 times the sum of lines 13					
15 00			, 01			15. 00
15.00			6, 81	3		15.00
16 00			1 77	10		16. 00
10.00			', ' '	0		10.00
15. 00 16. 00	and 13.01, as applicable) Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		6, 81 1, 77			

Health Financial Systems	IU HEALTH PAOLI H	HOSPI TAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHOSERVICES RENDERED TO PROGRAM BENEFICIARIES		Provi der C	CN: 15-1306	Peri od: From 01/01/2021	Worksheet M-5
SERVI SES REMBERED TO TROSIGNIM BENEFI STAMLES		Component	CCN: 15-8557	To 12/31/2021	Date/Time Prepared:

		Component CCN: 15-8557	To 12/31/2021	Date/Time Prep 5/26/2022 1:16	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			105, 666	1.00
2.00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	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. 01				0	
3. 02			0	3. 02	
3. 03				0	3. 03
3. 04				0	3. 04
3. 05				0	3.05
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 5
3. 52				0	3. 5
3. 53				0	3. 5
3.54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		105, 666	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				ļ
	Program to Provider				
5. 01				0	5. 0°
5.02				0	5.02
5. 03				0	5.03
	Provider to Program				
5. 50				0	5. 50
5. 51				0	5. 5
5. 52				0	5. 52
5. 99				0	5. 9
6. 00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.00
6. 01	SETTLEMENT TO PROVIDER			31, 226	6. 0°
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			136, 892	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor				8.00