### INDIANA UNIVERSITY HEALTH BEDFORD

In Lieu of Form CMS-2552-10

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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1328 Worksheet S Peri od. From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: То 5/29/2024 2:18 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/29/2024 Time: 2:18 pm ] Manually prepared cost report use only 2. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. 3 0 Ē 4 [ 

 [1]Cost Report Status
 6. Date Received:

 [1]As Submitted
 7. Contractor No.

 (2)Settled without Audit
 8. [N]Initial Report for this Provider CCN

 (3)Settled with Audit
 9. [N]Final Report for this Provider CCN

 Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) 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 OF 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 INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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 FINANCIAL OFFICER OR ADMINISTRATOR CHECKBOX ELECTRONI C SIGNATURE STATEMENT 2 I have read and agree with the above certification 1 statement. I certify that I intend my electronic Michael Crain Υ signature on this certification be the legally

		naci craig	binding equivalent of my original signature.	
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				
		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	-782, 379	119, 580	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	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-782, 379	119, 580	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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, Maryl and 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.

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00	City: BEDFORD	State: IN	Zip Cod			nty: LAWRENCE			(D	2.0
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00 01 02 03	Inpati ent PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2015? Enter in c for the portion of the cost reportin 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. Did this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	stment, in accordance r yes or "N" for no. 412.106(c)(2)(Pickle r yes or "N" for no. Ps, including suppler column 1, "Y" for ye g period occurring pr "N" for no for the j r after October 1. (s requires a final UCI ? (see instructions) e portion of the cos column 2, "Y" for yes g period on or after ic reclassification ds for delineating s olumn 1, "Y" for yes g period prior to Oc no for the portion of en October 1. (see in 100 but not more than 2.105)? Enter in colu ic reclassification s delineations for sta column 1, "Y" for yes g period prior to Oc no for the portion of en October 1. (see in 100 but not more than 2.105)? Enter in colu dicaid days on lines of admission, 2 if co of identifying the da method used in the pi	with 42 CFF Is this amendment ental UCPs, s or "N" for ior to Octobe ortion of the ee to be Enter in col reporting or "N" for row urban to the cost structions) 499 beds (a mn 3, "Y" for ober 1. Ente the cost structions) 499 beds (a umn 3, "Y" for ober 1. Ente the cost structions) 499 beds (a umn 3, "Y" for ober 1. Ente the cost structions)	for no per ne umn no, peas no pr ss for s for s for 3 for 3 for 3 for 3 for 3 for 3 for 3 for 3 for 1 for 1 for 1 for 2 for 1 for 2 for 1 for 2 for 1 for for 1 for 1 for 1 for for 1 for for for for for for for for for for	N	2 2.00		3. (		22. 22. 22. 22. 22.

ealth Financial Systems INDIANA UNI OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC			ri od:		Worksh	neet S-2	
				To	om 01/0 12/3	1/2023		[ime Pre 2024 2:1	
	In-State Medicaid paid days	l n-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	St Med el i un	t-of tate i cai d gi bl e pai d	Medica HMO da	ys Me	Other edi cai d days	
4.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00		. 00	5.00	0	6.00	24.00
<ul> <li>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.</li> <li>5.00 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 2, out-of-state Medicaid days in column 3, out-of-state</li> </ul>	0	0			0		0		25. 00
Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
,					Urban/R 1. (			f Geogr 00	
6.00 Enter your standard geographic classification (not wa		at the beg	jinning of t	the	1. 1	2	۷.	00	26.00
<ul> <li>cost reporting period. Enter "1" for urban or "2" for</li> <li>7.00 Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban on enter the effective date of the geographic reclassific.</li> <li>5.00 If this is a sole community hospital (SCH), enter the</li> </ul>	age) status r "2" for r ication in d	ural. If ap column 2.	plicable,			2			27.00
effect in the cost reporting period.		·			Begi ni	ni ng:	End	i ng:	
6.00 Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb	ber	1. (	00	2.	00	36.00
of periods in excess of one and enter subsequent date 7.00 If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	sL		0			37.0
is in effect in the cost reporting period. 7.01 Is this hospital a former MDH that is eligible for the former MDH that is eligible for the former and the former much former and the former much former and the former a									37.0
accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) 8.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	s of MDH st	atus. Ifli	ne 37 is						38.0
enter subsequent dates.					Y/	'N	Y	Z/N	
9.00 Does this facility qualify for the inpatient hospital	navment a	diustment f	for low volu	Ime	1. ( N			00 N	39.0
<pre>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 (ii or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction</pre>	), (İi), or the mileage ii)? Enter n adjustmen	(iii)? Ent requiremer in column 2 t? Enter "Y	er in colur nts in 2 "Y" for ye (" for yes o	nn es or	N	I		N	40. 0
"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.			Ves of in i			V	XVIII	XIX	
Description Description (DDC) Casiltal						1.00	_		1
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payment	nt for disp	roporti onat	e share in	ассо	rdance	N	N	N	45.00
<ul> <li>with 42 CFR Section §412.320? (see instructions)</li> <li>6.00 Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete Wks</li> </ul>			5			N	N	N	46.0
Pt. III. 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS o 8.00 Is the facility electing full federal capital paymen					no.	N	N	N	47.0
Teachi ng Hospi tal s						_			
6.00 Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable ( "Y" for yes; otherwise, enter "N" for no in column 2.	"Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dire	or "N" for under 42 ( "Y", or if prior year	r no in colu CFR 413.78(h this hospit or penultin	umn 1 c)(2) tal w mate	. For , see /as year,	N			56.00
7.00 For cost reporting periods beginning prior to Decembis this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFI	er 27, 2020 residents n column 1. cost report e Worksheet applicable	in approved If column ing period? E-4. If co For cost	d GME progra 1 is "Y", ( P Enter "Y' olumn 2 is ' reporting p	ams t did 'for 'N", perio	yes or ods ess of				57.0
which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not comple 8.00 If line 56 is yes, did this facility elect cost reim	ete column :	2, and comp	olete Worksk	neet	E-4.	N			58.0

	Financial Systems INDIANA UNI AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		HEALTH BEDFOR Provider CO	CN: 15-1328 P	eriod: rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/29/2024 2:1	pared:
					V 1.00	XVIII XIX 0 2.00 3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2	Pt. I.	1.00	5 2.00 5.00	59.00
	Z			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHE	see If column 1	N			60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see				0.00		61. 00
	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or						61. C
1.05	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	Due	News	Durana Carda			61.0
		PT	ogram Name			Direct GME FTE Count	
1 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
1. 20	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name.				0.00		61. 2
	Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					1.00	
	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which	0.00	62.0
o2. 01	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	cti ons) a Teachi	ng Health Cen	ter (THC) into			62. 0
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Setti	i ngs		period? Enter	N	63.00

SPITAL AND HOSPITAL HEALTH CARE COMPLE		VERSITY HEALTH BEDFOI TA Provider C	CN: 15-1328 P	eriod:	u of Form CMS- Worksheet S-2	
				rom 01/01/2023 o 12/31/2023		
		·	Unwei ghted	Unweighted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	libopi tui		
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year			This base year	is your cost r	reporting	
<ul> <li>period that begins on or after Ju</li> <li>OD Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you</li> </ul>	yes, or your facilit er of unweighted non ations occurring in number of unweighted r hospital. Enter in	y trained residents -primary care all nonprovider non-primary care column 3 the ratio	0.00	0. 00	0. 000000	64.(
of (column 1 divided by (column 1	+ column 2)). (see Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
		Fi ograni Code	FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
_	1.00	2.00	3.00	4.00	5.00	-
00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00		0.000000	
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Current Y	oar FTF Posidonto in	Nonnrovidor Sotting	1.00	2.00	3.00	-
beginning on or after July 1, 201		Nonprovider Setting	sEffective T	or cost reporti	ng periods	1
00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	nweighted non-primar curring in all nonpr nweighted non-primar I. Enter in column 3	ovider settings. y care resident the ratio of	0.00	0.00	0. 000000	66.
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
_	1.00	2.00	3.00	4.00	5.00	1
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			0.00	) O. OC	0. 000000	0 67.

Heal th	Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD		In Lieu	」 of For	m CMS-2	2552-10			
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1328	Period: From 01/0 To 12/3	01/2023 1/2023	Workshe Part I Date/Ti 5/29/20	me Pre	pared:			
				1. (	00				
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (Augus For a cost reporting period beginning prior to October 1, 2022, did you obtain permi MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 8 (August 10, 2022)?	ssion from				68.00			
			1.00	2.00	3.00				
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF	subprovi der	? N			70.00			
	<ul> <li>Enter "Y" for yes or "N" for no.</li> <li>1.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)</li> </ul>								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an	RF	N			75.00			
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program recent cost reporting period ending on or before November 15, 2004? Enter "Y" for y no. Column 2: Did this facility train residents in a new teaching program in accord CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instruction	es or "N" fo ince with 42 s Y,	r		0	76.00			
				1. (	00				
80 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	1	80.00			
	Is this a LTCH co-located within another hospital for part or all of the cost repor "Y" for yes and "N" for no. TEFRA Providers	ing period?	Enter	N		81.00			
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for y Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sec §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		or no.	N		85. 00 86. 00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under sect 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	on		Ν	l	87.00			
		Approv Perma Adjus (Y/	nent tment N)	Numbe Appro Perma Adjust	oved nent ments				
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and   89. (see instructions)	i ne		2. (	0	88.00			
	Column 2: Enter the number of approved permanent adjustments.	ine Effecti	ve Date	Appro	oved				
	No.			Perma Adj us Amoun Di sch	nent tment t Per				
89 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	2.	00	3. (		89.00			
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.				J	0,1,00			
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.								
		1.		XI 2. (					
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" fo	or N	1	Y		90.00			
	yes or "N" for no in the applicable column.								
	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see	n   N	I	N		91.00 92.00			
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ente	er N	1	N		93.00			
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	Ν	I	N		94.00			
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. M		0.0 N		95. 00 96. 00			
	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.	0.		0. (		97.00			

105PI	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N: 15-1328	Period: From 01/01/202	Worksheet S- 23 Part I	2
				To 12/31/202	3 Date/Time Pr	
				V	5/29/2024 2: XI X	<u>18 pm</u>
				1.00	2.00	-
8.00	Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	terns and resi	dents post	Ν	Y	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 re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.				Y	98.0
8. 02	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			N	Y	98. 0
3. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye				N	98. 0
3. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in	N	N	98.0		
3. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c		Y	98. 0		
8. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	N	Y	98.0		
15 O/	Rural Providers			Y		105.0
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive meth	od of paymer			105. C
07.00	Column 1: If line 105 is Y, is this facility eligible for co training 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	1. (see inst you train I&Rs	ructions) in an	N		107. C
)7. 0 <sup>^</sup>	approved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instructi If this facility is a REH (line 3, column 4, is "12"), is it reimbursement for I&R training programs? Enter "Y" for yes o	ons) eligible for	cost			107. C
08.00	instructions) Is this a rural hospital qualifying for an exception to the			2 N		108.0
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupationa	al Speech	Respi ratory	
		Physi cal 1.00	Occupationa 2.00	3.00	Respiratory	
09.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
09. 00	) If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1.00	2.00	3.00	4.00 N	
	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3.00 N	4.00 N 1.00	109.0
	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "A"	1.00 N I Demonstratic Y" for yes or	2.00 N on project (§ "N" for no.	3.00 N 8410A If yes,	4.00 N	109.0
	DIF 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. DDid this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter "	1.00 N I Demonstratic Y" for yes or	2.00 N on project (§ "N" for no.	3.00 N N i410A If yes, bugh 215, as	4.00 N 1.00 N	109. C
10. 00	Dif 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. Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	1.00 N I Demonstratic Y" for yes or ksheet E-2, li	2.00 N n project (§ "N" for no. nes 200 thro	3.00 N N 1 f yes, bugh 215, as 1.00	4.00 N 1.00	109. C
10. 00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "A"	1.00 N I Demonstratic Y" for yes or ksheet E-2, li he Frontier Cc st reporting p Jumn 1 is Y, e ticipating in	2.00 N N roproject (§ "N" for no. nes 200 thro mmunity veriod? Enter nter the column 2.	3.00 N N 410A Ifyes, Jugh 215, as 1.00 N	4.00 N 1.00 N	109. C
10. 00	<pre>Dif 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.</pre> Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad	1.00 N I Demonstratic Y" for yes or ksheet E-2, li he Frontier Cc st reporting p Jumn 1 is Y, e ticipating in	2.00 N N roproject (§ "N" for no. nes 200 thro mmunity veriod? Enter nter the column 2.	3.00 N N 410A Ifyes, Jugh 215, as 1.00 N	4.00 N 1.00 N	109. C
0.00	<pre>Dif 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.</pre> Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad	1.00 N N I Demonstratic Y" for yes or ksheet E-2, li he Frontier Cc st reporting p lumn 1 is Y, e ticipating in ditional beds; th Model porting lumn 1 is pating in the	2.00 N N for no. nes 200 thro mmunity period? Enter nter the column 2. and/or "C"	3.00 N N i410A Ifyes, Jugh 215, as 1.00 N	4.00 N 1.00 N 2.00	109. C
10.00	<ul> <li>Plif 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.</li> <li>Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.</li> <li>Plif this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this com "Y" for yes or "N" for no in column 1. If the response to con integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.</li> <li>Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If com "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital caparticipation in the demonstration. If applicable.</li> <li>Miscel Ianeous Cost Reporting Information</li> <li>Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1. If column 2 is "E", enter in column 3 either "9" for yes or provider? Enter "Y" for yes or in column 3 either "9" for yes or the method used (A, B) in column 2. If column 2 is "E", enter in column 3 either "9" for yes provider? Enter "Y" for yes or yes in column 3 either "9" for yes or the method used (A, B) in column 1. If column 2 is "E", enter in column 3 either "9" for yes provider? Enter "Y" for yes or the the provider? Enter "Y" for yes or the the yes or the method used (A, B) in column 2. If column 2 is "E", enter in column 3 either "9" for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider</li> <td>1.00 N N I Demonstratic Y" for yes or ksheet E-2, li he Frontier Cc st reporting p lumn 1 is Y, e ticipating in lditional beds; th Model porting lumn 1 is hating in the sed "N" for no 5, or E only) 3" percent includes</td><td>2.00 N N for no. nes 200 thro peri od? Enter enter the column 2. and/or "C" 1.00</td><td>3.00 N N i410A Ifyes, Jugh 215, as 1.00 N</td><td>4.00 N 1.00 N 2.00</td><td>109. C</td></ul>	1.00 N N I Demonstratic Y" for yes or ksheet E-2, li he Frontier Cc st reporting p lumn 1 is Y, e ticipating in lditional beds; th Model porting lumn 1 is hating in the sed "N" for no 5, or E only) 3" percent includes	2.00 N N for no. nes 200 thro peri od? Enter enter the column 2. and/or "C" 1.00	3.00 N N i410A Ifyes, Jugh 215, as 1.00 N	4.00 N 1.00 N 2.00	109. C
10. 00 11. 00 12. 00	Dif 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. Did this hospital participate in the Rural Community Hospitat Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to cost integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If cost "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital ceat participate in the date the hospital ceat participation in the demonstration. Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	1.00 N N I Demonstratic Y" for yes or ksheet E-2, li he Frontier Cc st reporting p lumn 1 is Y, e ticipating in lditional beds; th Model porting lumn 1 is vating in the used " "N" for no c, or E only) 3" percent includes s) based on	2.00 N N in project (§ "N" for no. nes 200 thro peri od? Enter nter the column 2. and/or "C" <u>1.00</u> N	3.00 N N i410A Ifyes, Jugh 215, as 1.00 N	4.00 N 1.00 N 2.00	109. 0 110. 0 111. 0 111. 0
10. 00 11. 00 12. 00 15. 00 16. 00	<ul> <li>If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.</li> <li>Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.</li> <li>If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is parter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.</li> <li>Did this hospital participate in the date the hospital ceaparticip demonstration. In column 3, enter the date the hospital ceaparticip ate in the demonstration. In column 3, enter the method used (A, B in column 1. If column 1. If column 2. If column 2 is "E", enter in column 3 either "9" for yes or "N" for yes or "N" for yes or in column 1. If column 1. If column 2. If column 3, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9" for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.</li> </ul>	1.00 N N I Demonstratic Y" for yes or ksheet E-2, li he Frontier Cc st reporting p lumn 1 is Y, e ticipating in di ti onal beds; th Model porting lumn 1 is pating in the sed "N" for no c, or E only) '3" percent incl udes 's) based on for yes or	2.00 N N "N" for no. nes 200 thro mmuni ty eri od? Enter enter the col umn 2. and/or "C" <u>1.00</u> N	3.00 N N i410A Ifyes, Jugh 215, as 1.00 N	4.00 N 1.00 N 2.00	109. C

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		riod: om 01/01/2023 12/31/2023		repared
	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	_
8.01 List amounts of malpractice premiums and paid losses:	54, 446	2.00		0 118.
	-	1.00	0.00	
8.02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co		<u>1.00</u> N	2.00	118.
and amounts contained therein. 9.00D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)	' for yes or ne Outpatient	Ν	N	119. 120.
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	s charged to	Y		121.
2.00 Does the cost report contain healthcare related taxes as defined in §1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		Y	5.00	122.
<ol> <li>00 Did the facility and/or its subproviders (if applicable) purchase professi services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.</li> </ol>	and/or	Y	N	123.
If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated orga located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y "N" for no.	ani zati ons			
Certified Transplant Center Information 5.00Does this facility operate a Medicare-certified transplant center? Enter "	'Y" for yes	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare-certified kidney transplant program, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date			126.
7.00 If this is a Medicare-certified heart transplant program, enter the certif in column 1 and termination date, if applicable, in column 2.				127.
8.00 If this is a Medicare-certified liver transplant program, enter the certif in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare-certified lung transplant program, enter the certifi				128. 129.
in column 1 and termination date, if applicable, in column 2. 0.00  f this is a Medicare-certified pancreas transplant program, enter the cer				130.
date in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare-certified intestinal transplant program, enter the c date in column 1 and termination date, if applicable, in column 2.	certi fi cati on			131.
2.00 If this is a Medicare-certified islet transplant program, enter the certif in column 1 and termination date, if applicable, in column 2.	fication date			132.
3. 00 Removed and reserved 4. 00 If this is a hospital based organ procurement organization (0P0), enter the in column 1 and termination date, if applicable, in column 2.	ne OPO number			133. 134.
All Providers 0.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruct	office costs	Y	15H059	140.
1.00         2.00           If this facility is part of a chain organization, enter on lines 141 through the second sec	ugh 143 the nam	3.00 e and address	of the	
home office and enter the home office contractor name and contractor number	er.			
1.00 Name: INDIANA UNIVERSITY HEALTH, INC Contractor's Name: WPS 2.00 Street: 340 WEST 10TH STREET PO Box:	contractor'	s Number: 0810	11	141.
3. OO Ci ty: I NDI ANAPOLI S State: IN	Zip Code:	4620	)2	143.
			1.00	_
4.00 Are provider based physicians' costs included in Worksheet A?			1.00 Y	144.
		4.00	0.00	
5.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs inpatient services only? Enter "Y" for yes or "N" for no in column 1. If o	column 1 is	1.00	2.00	145.
no, does the dialysis facility include Medicare utilization for this cost period? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previously filed cost Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 4	t report?	Ν		146.

JOFTIAL AND HUOFTIAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-1328			Worksheet S-	2
					01/01/2023 2/31/2023		
						1.00	_
47.00 Was there a change in the statist	cal basis? Enter "Y" fo	or yes or "N" for	no.			N	147.0
48.00Was there a change in the order or				_		N	148.0
49.00 Was there a change to the simplifi	ed cost finding method?					N N	149.0
		Part A 1.00	Part 2.00	3 1	<u>Fitle V</u> 3.00	Title XIX 4.00	_
Does this facility contain a prov	der that qualifies for			ication o			
or charges? Enter "Y" for yes or							
55.00Hospi tal		N	N		N	N	155. 0
56.00 Subprovi der – I PF		N	N		N	N	156. C
57.00 Subprovider – IRF		N	N		N	N	157. C
58. 00 SUBPROVI DER							158. C
59. 00 SNF		N	N		N	N	159. C
50.00HOME HEALTH AGENCY 51.00CMHC		N	N		N	N	160.0
			N		N	N	161. C
						1.00	
Multicampus						1	_
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more campu	ises in di	fferent Cl	BSAs?	N	165.0
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
56.00 fline 165 is yes, for each						0.0	0 166. 0
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)							
	I						
· · · · · · · · · · · · · · · · · · ·	· · · · · · ·					1.00	
Heal th Information Technology (HI						N N	-
57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10					a tha	Y	167. 0 168. 0
reasonable cost incurred for the l			10/15	r), enter	the		108.0
58.01 If this provider is a CAH and is i			uualify	For a hard	dshi n		168.0
exception under §413.70(a)(6)(ii)					uom p		
59.00 If this provider is a meaningful u					enter the	0.0	00169. C
transition factor. (see instruction	ons)						
				Be	egi nni ng	Endi ng	_
					1.00	2.00	170.0
70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	beginning date and endir	ng date for the re	eporting				170. C
					1.00	2.00	_
71.00 If line 167 is "Y" does this prov	ider have any days for	individuals enrol	ledin		Y		9171 0
71.00  fline 167 is "Y", does this pro section 1876 Medicare cost plans i				-			9171.0

	Financial         Systems         INDLANA         UNIVERSIT           AL         AND         HOSPITAL         HEALTH         CARE         REIMBURSEMENT         QUESTIONNALRE			In Lie Period: From 01/01/2023 To 12/31/2023		2 epared:
		,		Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	he	_
1.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in a					1.00
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare A	Program? If	1.00 N	2.00	3.00	2.00
3.00	yes, enter in column 2 the date of termination and in colur voluntary or "1" for involuntary. Is the provider involved in business transactions, includin	mn 3, "V" for	Y			3.00
0.00	of the provider find viduals or entities (e.g., chain home or medical supply companies) that are related to the prov officers, medical staff, management personnel, or members of directors through ownership, control, or family and ot relationships? (see instructions)					
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	-
4.00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava	for Compiled,	Y	A	02/22/2024	4.00
5.00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit red		N			5.00
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities				2.00	
6. 00 7. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	3	s the provider	- N N		6.00 7.00
8.00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	ed and/or renew	Ū.	e N		8.00
9.00 10.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	ns.		N		9.00 10.00
11.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I&RinanApp	proved	Ν		11.00
					Y/N 1.00	
12.00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	,	0		N	13.00
	If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement				N	14.00
15.00	Did total beds available change from the prior cost reporti		yes, see inst rt A	ructions.	N t B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
16.00	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 date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2024	Y	04/01/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		Ν		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19.00

Health Financial Systems

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	1	Period: From 01/01/2023 To 12/31/2023	Date/Time Pi	repared:
		Decer	iption	Y/N	5/29/2024 2: Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	N	<u> </u>	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
	Report data for other beserve the other daj distilents.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N	2.00	N		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost		,			
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
	Have changes occurred in the Medicare depreciation expense		als made duri	na the cost	N	23.00
	reporting period? If yes, see instructions.			.g		
24.00	Were new leases and/or amendments to existing leases enter	ed into durina	this cost rep	ortina period?	N	24.00
	If yes, see instructions		51			
25.00	Have there been new capitalized leases entered into during	the cost repor	ting period?	lfyes, see	N	25.00
	instructions.			-		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? If	yes, see	N	26.00
	instructions.		- ·	-		
27.00	Has the provider's capitalization policy changed during th	e cost reportin	ng period? If	yes, submit	N	27.00
	сору.	-				
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost i	reporting	N	28.00
	period? If yes, see instructions.					
29.00	Did the provider have a funded depreciation account and/or		ebt Service Res	serve Fund)	N	29.00
	treated as a funded depreciation account? If yes, see inst					
30.00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt? If yes,	see	N	30.00
	instructions.					
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00
	instructions.					_
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		ed through con	tractual	N	32.00
22.00	arrangements with suppliers of services? If yes, see instr				N	22.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	piled pertainin	ig to competiti	ive blading? IT	N	33.00
	no, see instructions.					_
24 00	Provider-Based Physicians	orrongement wit	h providor bo	and physicians?	Y	24.00
34.00	Were services furnished at the provider facility under an If yes, see instructions.	arrangement wit	.n provider-bas	sed physicians?	ř	34.00
35.00	If line 34 is yes, were there new agreements or amended ex	isting agroomon	te with the p	rovi dor basod	N	35.00
35.00	physicians during the cost reporting period? If yes, see i		its with the pi	ovi del -based	IN IN	35.00
	physicians during the cost reporting period: in yes, see i			Y/N	Date	
				1.00	2.00	
	Home Office Costs			1.00	2.00	
36.00	Were home office costs claimed on the cost report?			Y		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y		37.00
57.00	If yes, see instructions.	repared by the				57.00
38 00	If line 36 is yes, was the fiscal year end of the home of	fice different	from that of	Ν		38.00
00.00	the provider? If yes, enter in column 2 the fiscal year en					00.00
39.00	If line 36 is yes, did the provider render services to oth			Ν		39.00
	see instructions.					
40 00	If line 36 is yes, did the provider render services to the	home office?	lf ves see	Ν		40.00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	RHONDA		UTTER		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	INDIANA UNIVER	SITY HEALTH			42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost	317-556-3910		RUTTER@I UHEALT	H. ORG	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems IND	I ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provider C		Period: From 01/01/2023	Worksheet S-2 Part II	
						Date/Time Pre 5/29/2024 2:1	pared: 8 pm
		-			_		
			3.	00			
	Cost Report Preparer Contact Information						
	Enter the first name, last name and the title		DI RECTOR				41.00
	held by the cost report preparer in columns 1	1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost r	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, respective	vel y.					

	Financial Systems IND AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	IANA UNIVERSITY AI DATA	Provider CC		Period:	u of Form CMS-2 Worksheet S-3	
1105111				N. 13 1320	From 01/01/2023	Part I	
					To 12/31/2023	Date/Time Pre 5/29/2024 2:1	
						I/P Days / 0/P	
						<u>Visits / Trips</u>	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA		2100	0100		0.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	19	6, 93	35 126, 000. 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 I PF Subprovi der						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		19	6, 93	35 126, 000. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	6	2, 19	35, 640. 00	0	8.00
9.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9.00
10.00 11.00	SURGICAL INTENSIVE CARE UNIT						10.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9, 12	161, 640. 00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00							18.00
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY						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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	25			0	26.25
27.00 28.00	Total (sum of lines 14-26) Observation Bed Days		25			0	27.00
29.00	Ambul ance Trips						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	20.00	_		0		33.01 34.00
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	I 0	34.0

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part I Date/Time Pre 5/29/2024 2:1	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E		[
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	PART I – STATI STI CAL DATA	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	2, 162	111	5, 25	0		1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	2, 278	634				2.00
3.00	HMO I PF Subprovi der	2, 2, 0	034				3.00
4.00	HMO I RF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation	2, 162	111	5, 25	0		7.00
	beds) (see instructions)	5 ( 0			-		
8.00		562	37	1, 48	5		8.00
9.00 10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2, 724	148	6, 73	0.00	260. 19	
15.00	CAH visits	0	0		0		15.00
15. 10	REH hours and visits	0	0		0		15.10
16.00	SUBPROVIDER - IPF						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
	HOME HEALTH AGENCY						22.00
23.00 24.00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE						23.00
24.00	HOSPICE HOSPICE (non-distinct part)			11	0		24.00
25.00	CMHC - CMHC				0		25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	o	0		0 0.00	0,00	
27.00	Total (sum of lines 14-26)				0.00	260.19	27.00
28.00	Observation Bed Days		15	1, 37	7		28.00
29.00	Ambul ance Trips	0					29.00
30. 00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	0		0		32.00
32. 01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)						
	LTCH non-covered days	0					33.00
33. 00 33. 01	LTCH site neutral days and discharges	0					33.01

		AL DATA	Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part I Date/Time Pre 5/29/2024 2:13	pared:
		Full Time		Di so	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I – STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	69	0 35	1, 631	1.0
2.00	HMO and other (see instructions)			50	8 159		2.0
3.00	HMO I PF Subprovi der				0		3.0
4.00	HMO I RF Subprovider				0		4.0
5.00	Hospital Adults & Peds. Swing Bed SNF						5.0
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						6.0 7.0
3. 00	beds) (see instructions) INTENSIVE CARE UNIT						8.0
9.00 9.00	CORONARY CARE UNIT						9.0
10.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY						13.0
14.00	Total (see instructions)	0.00	0	69	0 35	1, 631	14.0
5.00	CAH visits						15.0
5.10	REH hours and visits						15.1
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18. 0
9.00	SKILLED NURSING FACILITY						19. (
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23. ( 24. (
4. 10	HOSPICE (non-distinct part)						24.0
5.00	CMHC - CMHC						24.
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
7.00	Total (sum of lines 14-26)	0.00					27.0
8.00	Observation Bed Days						28.0
9.00	Ambul ance Trips						29. (
0. 00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF						31. (
2.00	Labor & delivery days (see instructions)						32. (
2. 01	Total ancillary labor & delivery room						32.
	outpatient days (see instructions)						
3.00	LTCH non-covered days				0		33. (
33.01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care				0		33. ( 34. (

Health Financial Systems HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

I NDI ANA	UNI VERSI TY	HE	EALTH	BEDF	ORD
			Provi	der	CCN:

Provi der CCN: 15-1328

1328	Period: From 01/01/2023 To 12/31/2023	Worksheet Parts I &	S-10 II
	To 12/31/2023	Date/Time 5/29/2024	Prepared: 2:18 pm

				1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			0. 213430	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			13, 591, 119	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Ν	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment		d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicai	d		0	
6.00	Medi cai d charges			60, 778, 798	•
7.00	Medicaid cost (line 1 times line 6)			12, 972, 019	
8.00	Difference between net revenue and costs for Medicaid program (see instru			0	8.00
9.00	Children's Health Insurance Program (CHIP) (see instructions for each lin Net revenue from stand-alone CHIP	e)		0	9.00
9.00 10.00	Stand-al one CHIP charges			0	9.00
10.00	Stand-alone CHIP cost (line 1 times line 10)			0	•
12.00	Difference between net revenue and costs for stand-alone CHIP (see instru	ictions)		0	
12.00	Other state or local government indigent care program (see instructions f			0	12.00
13.00	Net revenue from state or local indigent care program (Not included on li			0	13.00
14.00	Charges for patients covered under state or local indigent care program (		n lines 6 or	0	
				Ũ	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care	program (see i	nstructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and stat instructions for each line)	e/local indiger	nt care program	is (see	
17.00	Private grants, donations, or endowment income restricted to funding char	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital op	2		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent		(sum of lines	0	
	8, 12 and 16)	1 5	•		
		Uni nsured	Insured	Total (col. 1	
		patients	patients	+ col. 2)	
		1.00	2.00	3.00	
~~ ~~	Uncompensated care cost (see instructions for each line)	4 (00 550	000 70/	1 050 000	
20.00	Charity care charges and uninsured discounts (see instructions)	4, 620, 552	338, 786		
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	986, 164	240, 407	1, 226, 571	21.00
22.00	Payments received from patients for amounts previously written off as	3, 520	0	3, 520	22.00
22.00	charity care	5, 520	0	5, 520	22.00
23.00	Cost of charity care (see instructions)	982, 644	240, 407	1, 223, 051	23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	d a length of s	stay limit	Ν	24.00
	imposed on patients covered by Medicaid or other indigent care program?		-		
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program's	s length of	0	25.00
	stay limit				
25.01	Charges for insured patients' liability (see instructions)			125,074	
26.00	Bad debt amount (see instructions)			5, 711, 914	
27.00	Medicare reimbursable bad debts (see instructions)			865, 339	•
	Medicare allowable bad debts (see instructions)			1, 331, 291	•
28.00	Non-Medicare bad debt amount (see instructions)	instruction-)		4, 380, 623	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	Instructions)		1, 400, 908	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2, 623, 959 2, 623, 959	
51.00	Trotal universition seu and uncompensated care cost (TTHE TA PLUS TTHE 30)			2,023,959	1 31.00

Health Financial Systems	INDIANA UNIVERSITY H	EALTH BEDFORD	In Lieu	u of Form CMS-2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-1328	From 01/01/2023	Worksheet S-10 Parts I & II Date/Time Prepared:

	worksneet	
1/01/2023	Parts I &	11

Date/Time 5/29/2024	

PART II HOSPITAL DATA         I.00           Incomponented and Indigent Care Cost-to-Charge Ratio         1.00           Incomponent of and Indigent Care Cost-to-Charge Ratio         1.00           Incomponent of the Set Instructions)         1.00           2.00         Net revenue from Medical         2.00           3.00         Did you receive DBK or supplemental payments from Medical d?         2.00           4.00         If I ine 3 is so, them enter DBK and/or supplemental payments from Medical d?         5.00           0.01         If ine 1 ines ine 6)         0.01         6.00           0.01         Medical cost (line 1 times line 6)         7.00         6.00           0.01         Medical cost (line 1 times line 10)         8.00         7.00           0.01         Medical cost (line 1 times line 10)         8.00         8.00           0.01         Met revenue from stand-alone CHP         1.00         8.00           0.01         Met revenue from stand-alone CHP         9.00         9.00           0.02         DB diducatione CHP insurance Program (CHP) (see instructions)         11.00           12.00         Difference between net revenue and costs for stand-alone CHP (see instructions)         12.00           13.00         Difference between net revenue and costs for state or local indigent care program (s						
Incompensated and indigent Care Cost. to-Charge Ratio         1.00           Ocst to charge ratio (see instructions)         1.00           Modicaid (see instructions for each line)         2.00           ON the revenue from Medicaid 3         2.00           3.00         Did you receive DSH or supplemental payments from Medicaid 7         3.00           5.00         If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid 7         4.00           5.00         If line 4 is no, then entor DSH and/or supplemental payments from Medicaid 3         5.00           6.00         Modicai Charges 5         1.00           7.00         If revenue from Management program (See instructions)         7.00           0.01         Stand-alone CHP proces between net revenue and costs for stand-alone CHP (see instructions)         10.00           0.00         Stand-alone CHP cost (line 1 times line 10)         10.00           1.00         Difference between ent revenue argorgam (See instructions)         11.00           1.00         Difference between ent revenue argorgam (See instructions)         11.00           1.00         Difference between ent revenue argorgam (See instructions)         11.00           1.00         State or local indigent care program cost (line 1 times line 14)         15.00           1.00         Difference between ent revenue argora					1.00	
1.00       Cost to charge ratio (see instructions)       1.00         Medicaid (see instructions for each line)       2.00         2.00       Net revenue from Medicaid d       2.00         3.00       Did you receive DSI or supplemental payments from Medicaid?       2.00         4.00       If line 3 is yes, does line 2 include all DSI and/or supplemental payments from Medicaid?       2.00         6.00       Medicaid cost (line 1 times line 6)       5.00         6.00       Medicaid cost (line 1 times line 6)       6.00         0.01       Difference between net revenue and costs for Medicaid program (see instructions)       6.00         0.01       Net revenue from stand-alone OHP       9.00         1.00       State or local indigent care program (see instructions)       9.00         1.00       Other greas for patients covered under state or local indigent care program (see instructions)       11.00         1.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       11.00         1.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       11.00         1.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       15.00         1.00       Difference between net revenue and costs for state or local indigent care p						-
Medicaid (see Instructions for each line)         2.00           Not revonue from Medicaid         2.00           2.00         Did you receive DSH or supplemental payments from Medicaid?         3.00           3.00         Dif fine 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?         4.00           5.00         If line 4 is no, then enter DSH and/or supplemental payments from Medicaid?         5.00           5.00         Medicaid charges         8.00           7.00         Medicaid charges         8.00           0.01         Difference between net revenue and costs for Medicaid program (see instructions)         0.00           0.00         Stand-alone CHP cost (line 1 times line 10)         10.00           10.00         Stand-alone CHP cost (line 1 times line 10)         11.00           12.00         Difference between net revenue and costs for stand-alone CHP (see instructions)         11.00           12.00         Difference between net revenue and costs for state or local indigent care program (kot included in lines 6 or 10)         11.00           13.00         Charges for patients covered under state or local indigent care program (kot included in lines 6 or 10)         15.00           10.00         Difference between net revenue and costs for state or local indigent care program (see instructions)         16.00           10.00         Difference betwe	1 00					1 1 00
2.00       Net revenue from Medicaid       2.00         3.00       Did you receive USH or supplemental payments from Medicaid?       3.00         4.00       If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?       4.00         5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid?       5.00         6.00       Medicaid cost (line 1 times line 6)       6.00         7.00       Medicaid cost (line 1 times line 6)       7.00         9.00       Nat revenue from stand-al one CHIP (see instructions)       7.00         9.00       Stand-al one CHIP cost (line 1 times line 10)       10.00         11.00       Stand-al one CHIP cost (line 1 times line 10)       10.00         12.00       Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)       10.00         13.00       Nat revenue from state or local indigent care program (Not included in lines 6 or 10)       11.00         14.00       Difference between ent revenue and costs for state or local indigent care program (see instructions)       18.00         10.00       Difference between ent revenue and costs for state or local indigent care programs (sum of lines 8, 12 and 16)       19.00         10.00       Difference between ent revenue and cost for Medical C. CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1.00					1.00
3.00       Did you receive DSH or supplemental payments from Medicaid?       3.00         4.00       If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?       4.00         5.00       Medicaid charges       5.00         6.00       Medicaid charges       7.00         7.00       Medicaid cost (line 1 times line 6)       8.00         0.00       Difference between net revenue and costs for Medicaid program (see instructions)       8.00         0.01.00       Stand-alone CHP charges       11.00         12.00       Difference between net revenue and costs for stand-alone CHP (see instructions)       11.00         12.00       Difference between net revenue and costs for stand-alone CHP (see instructions)       11.00         12.00       Difference between net revenue and costs for state or local indigent care program (Net included in lines 6 or 10)       11.00         13.00       Net revenue from state or local indigent care program (Net included in lines 6 or 10)       14.00         14.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       15.00         16.00       Difference between net revenue and costs for state or local indigent care programs (sum of line)       16.00 </td <td>2 00</td> <td></td> <td></td> <td></td> <td></td> <td>2 00</td>	2 00					2 00
4.00       If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid 7       4.00         5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid       5.00         6.00       Medicaid cost (line 1 times line 6)       5.00         8.00       Difference between net revenue and costs for Medicaid program (see instructions)       7.00         9.00       Net revenue from stand-al one CHIP (see instructions for each line)       9.00         9.00       Stand-al one CHI Ports       1.00         9.00       Stand-al one CHIP cost (line 1 times line 10)       11.00         9.00       Other state or local government indigent care program (See instructions for each line)       12.00         0.01       Obs Tate or local indigent care program (Not included in lines 4.5 or 9)       13.00         14.00       Difference between het revenue and costs for state or local indigent care program (see instructions)       14.00         15.00       Bifference between het revenue and costs for state or local indigent care program (see instructions)       14.00         10.00       Difference between het revenue and costs for state or local indigent care program (see instructions)       14.00         10.00       Difference between het revenue and costs for Medicaid, CHP and state/local indigent care programs (sum of lines 8.12 and 1.00       17.00         10.00       Difference b						
5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicald       5.00         6.00       Medicald coherges       5.00         7.00       Medicaid cost (line 1 times line 6)       6.00         0.00       Difference between net revenue and costs for Medicaid program (see instructions)       8.00         0.01       Difference between net revenue and costs for stand-alone CHIP (see instructions for each line)       9.00         10.00       Stand-alone CHIP cost (line 1 times line 10)       11.00         12.00       Difference between net revenue and costs for stand-alone CHIP (see instructions for each line)       12.00         13.00       Net revenue from state or local indigent care program (Net included on lines 2, 5 or 9)       13.00         14.00       Charges for patients covered under state or local indigent care program (see instructions)       14.00         16.00       Government grants, appropriations or transfers for support of hospital operations       18.00         17.00       Rive grants, conations, or endoment income restricted to funding charity care       17.00         18.00       Cost of patients appropriations or transfers for support of hospital operations       19.00         19.00       Cost of patients appropriations or transfers for patient days beyond a length of stay limit ecol. 21       1.00         20.00       Cost of patients approved for charity care and unins			di cai	d?		
7.00       Medicaid cost (line 1 times line 6)       7.00         00       Difference between net revenue and costs for Medicaid program (see instructions)       8.00         00       Note the evenue from stand-al one CHP (see instructions for each line)       9.00         10.00       Stand-al one CHP cost (line 1 times line 10)       11.00         11.00       Stand-al one CHP cost (line 1 times line 10)       11.00         12.00       Difference between net revenue and costs for stand-al one CHP (see instructions for each line)       12.00         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 100)       15.00         15.00       State or local indigent care program (Not included in lines 6 or 100)       16.00         16.00       Covernment grants, appropriations or transfers for support of hospital operations       17.00         19.00       Forta grants, conations, or endownent income restructions)       18.00         19.00       Covernment grants, appropriations or transfers for support of hospital operations       18.00         19.00       Covernment grants, appropriations or transfers for patient days beyond a length of stay limit       18.00         19.00       Covernment grants, approved for charity care and uninsured disc						5.00
8.00       Difference between net revenue and costs for Medicaid program (see instructions)       8.00         9.00       Net revenue from stand-al one CHIP       (see instructions for each line)       9.00         9.00       Stand-al one CHIP cost (line 1 times line 10)       10.00       10.00       10.00         9.00       Other state or local government indigent care program (see instructions)       11.00       12.00         9.01       Net revenue from stand-al one CHIP (see instructions)       13.00       14.00         10.00       Stand-al one CHIP cost (line 1 times line 10)       13.00       14.00         11.00       Ret revenue from state or local indigent care program (Not included on lines 2.5 or 9)       13.00         11.00       State or local indigent care program cost (line 1 times line 14)       15.00         10.00       Forence between net revenue and costs for state or local indigent care programs (see instructions)       16.00         11.00       Forence achtine)       15.00       16.00         10.00       Forence achtine)       15.00       16.00         10.00       Forence achtine)       15.00       16.00         10.00       Forence achtine)       10.00       10.00         10.00       Covernment grants, appropriations or transfers for support of hospital operations       10.00       18.0	6.00	Medi cai d charges				6.00
Children's Health Insurance Program (CHIP) (see Instructions for each line)         9.00           00         Net revenue from Stand-alone CHIP         9.00           10.00         Stand-alone CHIP charges         10.00           11.00         Stand-alone CHIP cost (line 1 times line 10)         11.00           12.00         Difference between net revenue and costs for stand-alone CHIP (see instructions for each line)         12.00           13.00         Net revenue from State or local indigent care program (Not included on lines 6 or 10.0)         13.00           14.00         Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10.0)         14.00           15.00         State or local indigent care program (Not included on lines 6 or 10.0)         15.00           15.00         Difference between net revenue and costs for state or local indigent care program (see instructions)         15.00           16.00         Difference between net revenue and costs tor stor or local indigent care program (see instructions)         16.00           17.00         Private grants, donations, or endowment income restricted to funding charity care         17.00           18.00         Government grants, appropriations or transfers for support of hospital operations         19.00           19.00         Charity care charges and uninsured discounts (see instructions)         20.00           10.00	7.00	Medicaid cost (line 1 times line 6)				7.00
9.00       Net revenue from stand-alone CHIP       9.00         10.00       Stand-alone CHIP charges       9.00         11.00       Stand-alone CHIP cost (line 1 times line 10)       11.00         12.00       Difference between net revenue and costs for stand-alone CHIP (see instructions)       11.00         12.00       Net revenue from state or local indigent care program (see instructions for each line)       12.00         13.00       Net revenue from state or local indigent care program (see instructions)       11.00         13.00       Net revenue from state or local indigent care program (see instructions)       14.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       16.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       16.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       18.00         19.00       Charity care charges and uninsured discounts (see instructions)       1.00       2.00         10.00       Charity care charges and uninsured discounts (see instructions)       21.00       2.00       2.00       2.00       2.00       2.00       2.00 <t< td=""><td>8.00</td><td>Difference between net revenue and costs for Medicaid program (see instructions)</td><td></td><td></td><td></td><td>8.00</td></t<>	8.00	Difference between net revenue and costs for Medicaid program (see instructions)				8.00
10. 00       Stand-alone CHIP cost (line 1 times line 10)       10. 00         11.00       Stand-alone CHIP cost (line 1 times line 10)       11. 00         12.00       Difference between net revenue and costs for stand-alone CHIP (see instructions)       12. 00         13.00       Het revenue from state or local indigent care program (Not included in lines 2, 5 or 9)       13. 00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 100)       14. 00         15.00       State or local indigent care program cost (line 1 times line 14)       15. 00         16.00       Difference between net revenue and costs for support of hospital operations       16. 00         0       Private grants, donations, or endowment income restricted to funding charity care       17. 00         18.00       Rovernment grants, appropriations or transfers for support of hospital operations       18. 00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care program (sum of lines endowent) income restricted to funding charity care       17. 00         19.00       Rovernment grants, appropriations or transfers for support of hospital operations       18. 00         19.00       Charity care charges and uninsured discounts (see instructions)       18. 00         10.00       Coot of patients approved for charity care and uninsured discounts (see instructions)       20. 00					1	
11.00       Stand-alone CHIP cost (line 1 times line 10)       11.00         12.00       Difference between net revenue and costs for stand-alone CHIP (see instructions)       12.00         13.00       Net revenue from state or local indigent care program (see instructions for each line)       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 2, 5 or 9)       13.00         14.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       15.00         15.00       State or local indigent care program cost (line 1 times line 14)       15.00         16.00       Difference between net revenue add costs for state or local indigent care program (see instructions)       16.00         Grants, donations, or endowment income restricted to funding charity care       17.00       16.00         17.00       Private grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unerimbursed cost for Medicaid, CHIP and state/local indigent care programs (sum of lines       19.00         19.00       Charity care charges and uninsured discounts (see instructions)       1.00       2.00       2.00         19.00       Charity care charges and uninsured discounts (see instructions)       2.00       2.00       2.00       2.00         10.00       Cost of patients cove						
12:00       Difference between net revenue and costs for stand-alone CHIP (see instructions)       12:00         Other state or local government indigent care program (see instructions for each line)       13:00         14:00       Charges for patients covered under state or local indigent care program (Not included in lines 2, 5 or 9)       13:00         15:00       State or local indigent care program cost (line 1 times line 14)       15:00         16:00       Difference between net revenue and costs for state or local indigent care program (see instructions)       16:00         00       Private grants, donations, or endowment income restricted to funding charity care       17:00         17:00       Private grants, donations, or endowment income restricted to funding charity care       18:00         18:00       Coremment grants, appropriations or transfers for support of hospital operations       19:00         19:00       Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines e.tot. 2)       19:00         20:00       Charity care charges and uninsured discounts (see instructions)       1.00       20:00       20:00         21:00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21:00       22:00         22:00       Cost of patients approved for charity care and uninsured discounts (see instructions)       22:00       22:00         23:00		5				
Other state or local government indigent care program (see instructions for each line)         13.00           13.00         Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)         13.00           14.00         Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)         13.00           15.00         State or local indigent care program cost (line 1 times line 14)         15.00           16.00         Difference between net revenue and costs for state or local indigent care program (see instructions)         16.00           Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions)         17.00           17.00         Fivate grants, appropriations or transfers for support of hospital operations         18.00           19.00         Covernment grants, appropriations for each line)         17.00           19.00         Cost of patients approved for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12.00         18.00           19.00         Cost of patients approved for charity care and uninsured discounts (see instructions)         19.00         2.00           20.00         Charity care charges and uninsured discounts (see instructions)         20.00         21.00         21.00           21.00         Cost of patients approved for charity care and uninsured discounts (see instructions)         22.00						
13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       15.00         15.00       State or local indigent care program cost (line 1 times line 14)       16.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       17.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       18.00         18.00       Total unreimbursed cost for Medicaid , CHIP and state/local indigent care programs (sum of lines 8, 12 and 16)       17.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       17.00         20.00       Charity care charges and uninsured discounts (see instructions)       1.00       2.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00         22.00       Cost of charity care (see instructions)       22.00       21.00         22.00       Cost of charity care (see instructions)       22.00       22.00         23.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       22.00       22.00         24.00       Depsents encore de	12.00					12.00
14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       16.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       17.00         17.00       Private grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       18.00         19.00       Charity care charges and uninsured discounts (see instructions)       10.00       20.00       3.00         19.00       Charity care charges and uninsured discounts (see instructions)       21.00       21.00       22.00       3.00         20.00       Cast of charity care (see instructions)       21.00       22.00       3.00       21.00         21.00       Charity care (see instructions)       21.00       22.00       23.00       21.00         22.00       Cost of charity care (see instructions)       22.00       23.00       21	12 00					1 1 2 00
10)       10.0       15.00       State or local indigent care program cost (line 1 times line 14)       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       16.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines)       19.00         10.00       Cost of patients appropriations or transfers for support of hospital operations       19.00         10.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       20.00         20.00       Charity care charges and uninsured discounts (see instructions)       21.00       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00       22.00         22.00       Payments received from patients for amounts previously written off as charity care (see instructions)       22.00       22.00         23.00       Cost of patient accey partient days beyond a length of stay limit imposed on patients covered by Medicaid						
15.00       State or local indigent care program cost (line 1 times line 14)       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       16.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       19.00         19.00       Charity care charges and uninsured discounts (see instructions)       10.00       2.00       3.00         10.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       20.00       21.00         20.00       Cost of patients approved for amounts previously written off as charity care       22.00       21.00         21.00       Des the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit imposed on patients' liability (see instructions)       26.00 <t< td=""><td>14.00</td><td></td><td>ueu i</td><td>IT THES 0 UI</td><td></td><td>14.00</td></t<>	14.00		ueu i	IT THES 0 UI		14.00
16.00       Difference between net revenue and costs for state or local indigent care program (see instructions)       16.00         Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions) for each line)       17.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       17.00         18.00       Covernment grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       18.00         10.00       Covernment grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       10.00         10.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       10.00       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00       22.00         23.00       Cost of charity care (see instructions)       22.00       23.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       25.00         25.00       In insured patients'	15 00					15 00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)       17.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       17.00         19.00       Uncompensated care cost (see instructions for each line)       10.00       2.00       3.00         20.00       Charity care charges and uninsured discounts (see instructions)       20.00       21.00       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00       22.00         22.00       Payments received from patients for amounts previously written off as charity care (see instructions)       22.00       22.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients (see instructions)       25.00         25.01       Charges for insured patients' liability (see instructions)       25.00       25.00         26.02       Cost of charity care (see instructions)       25.00       25.00 <t< td=""><td></td><td>5 1 5 1</td><td>(see</td><td>instructions)</td><td></td><td></td></t<>		5 1 5 1	(see	instructions)		
instructions for each line)       Private grants, donations, or endowment income restricted to funding charity care       17.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       19.00         19.00       Luncompensated care cost (see instructions for each line)       1.00       2.00       3.00         20.00       Charity care charges and uninsured discounts (see instructions)       1.00       2.00       3.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00       22.00         22.00       Payments received from patients for amounts previously written off as charity care       23.00       22.00         23.00       Cost of charity care (see instructions)       1.00       24.00       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit imposed on patients (see instructions)       25.01         26.00       Bad debt amount (see instructions)       25.01       25.01         27.00       Bad debt amount (see instructions)       25.01       25.01					ms (see	
18.00       Government grants, appropriations or transfers for support of hospital operations       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       19.00         19.00       Nui nsured patients       Insured patients       Total (col. 1 + col. 2)         10.00       2.00       3.00       3.00         10.00       Charity care charges and uninsured discounts (see instructions)       1.00       2.00         20.00       Charity care charges and uninsured discounts (see instructions)       20.00       21.00         10.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       22.00         21.00       Payments received from patients for amounts previously written off as charity care       23.00         23.00       Cost of charity care (see instructions)       24.00       Imposed on patients covered by Medicaid or other indigent care program?         25.00       If line 24 is yes, enter the charges for patient days beyond a length of stay limit imposed or insured patients' liability (see instructions)       25.01         26.00       Bad debt amount (see instructions)       25.01         27.01       Medicare allowable bad debts (see instructions)       25.01         28.00       Bad debt amount (see instructions)       27.01         29.00       Cost			5	1 5		
19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       19.00         8, 12 and 16)       Uninsured patients       Insured patients       Total (col. 1 + col. 2)         0.00       Charity care charges and uninsured discounts (see instructions)       1.00       2.00       3.00         20.00       Charity care charges and uninsured discounts (see instructions)       20.00       21.00       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00       21.00         22.00       Payments received from patients for amounts previously written off as charity care       23.00       22.00         23.00       Cost of charity care (see instructions)       23.00       23.00       23.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       24.00         25.01       Charges for insured patients' liability (see instructions)       25.01         26.02       Bad debt amount (see instructions)       25.01         26.00       Bad debt amount (see instructions)       27.00         27.01       Medi care allowable bad debts (see instructions)       27.00         26.00       Bad debt amount (see instructions)       27.00<	17.00	Private grants, donations, or endowment income restricted to funding charity care				17.00
8, 12 and 16)       Uninsured patients       Insured patients       Insured patients       Insured patients       Total (col. 1 patients         20.00       Uncompensated care cost (see instructions for each line)       1.00       2.00       3.00         20.00       Chari ty care charges and uninsured discounts (see instructions)       20.00       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       20.00       21.00         22.00       Payments received from patients for amounts previously written off as charity care       22.00       22.00         23.00       Cost of charity care (see instructions)       23.00       23.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       25.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       25.01         26.00       Bad debt amount (see instructions)       25.01         27.00       Medicare reimbursable bad debts (see instructions)       26.00         27.00       Medicare allowable bad debts (see instructions)       27.01         28.00       Non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       27.01         29.00	18.00	Government grants, appropriations or transfers for support of hospital operations				18.00
Uncompensated care cost (see instructions for each line)         Uninsured patients         Insured patients         Total (col. 1 + col. 2)           20.00         Charity care charges and uninsured discounts (see instructions)         1.00         2.00         3.00           21.00         Cost of patients approved for charity care and uninsured discounts (see instructions)         20.00         21.00         21.00           22.00         Payments received from patients for amounts previously written off as charity care         22.00         21.00           23.00         Cost of charity care (see instructions)         23.00         23.00           24.00         Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?         25.00           25.01         If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit         25.00           26.01         Charges for insured patients' liability (see instructions)         25.01         26.00           27.01         Medi care endownable bad debts (see instructions)         27.00         27.00           27.01         Medi care and non-reimbursable Medicare bad debt amount (see instructions)         27.00           28.00         Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)         28.00	19.00		rams	(sum of lines		19.00
patientspatients+ col. 2)1.002.003.0020.00Charity care cost (see instructions for each line)20.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)20.0022.00Payments received from patients for amounts previously written off as charity care21.0023.00Cost of charity care (see instructions)22.0024.00Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients' liability (see instructions)24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?25.0025.01Charges for insured patients' liability (see instructions)25.0126.00Bad debt amount (see instructions)25.0126.00Bad debt amount (see instructions)27.0027.01Medicare allowable bad debts (see instructions)27.0128.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0029.00<				L man sum and	Tatal (asl 1	
Uncompensated care cost (see instructions for each line)       1.00       2.00       3.00         20.00       Charity care charges and uninsured discounts (see instructions)       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00         22.00       Payments received from patients for amounts previously written off as charity care       21.00         23.00       Cost of charity care (see instructions)       23.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit t       25.01         25.01       Charges for insured patients' liability (see instructions)       25.01         27.00       Medicare allowable bad debts (see instructions)       25.01         27.01       Medicare allowable bad debts (see instructions)       27.01         28.00       Non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       27.01         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       29.00						
Uncompensated care cost (see instructions for each line)       20.00         Charity care charges and uninsured discounts (see instructions)       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00         22.00       Payments received from patients for amounts previously written off as charity care       22.00         23.00       Cost of charity care (see instructions)       23.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       24.00         25.01       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       25.01         26.00       Bad debt amount (see instructions)       25.01         27.00       Medicare reimbursable bad debts (see instructions)       26.00         27.01       Medicare reimbursable bad debts (see instructions)       27.00         27.01       Said debt amount (see instructions)       27.01         28.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       27.01         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       28.00         27.01       Said debt amount (see instructions)       29.00						
20.00       Charity care charges and uninsured discounts (see instructions)       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00         22.00       Payments received from patients for amounts previously written off as charity care       22.00         23.00       Cost of charity care (see instructions)       23.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       25.00         25.01       Charges for insured patients' liability (see instructions)       25.01         26.00       Bad debt amount (see instructions)       25.01         27.00       Medicare reimbursable bad debts (see instructions)       26.00         27.00       Medicare allowable bad debts (see instructions)       27.00         27.01       Medicare allowable bad debts (see instructions)       27.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       29.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       29.00         29.00       Cost of nucompensated care (line 23, c				2.00	5.00	
21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       21.00       21.00         22.00       Payments received from patients for amounts previously written off as charity care       22.00       22.00         23.00       Cost of charity care (see instructions)       23.00       23.00         1.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       25.00         26.00       Bad debt amount (see instructions)       25.01         27.00       Medicare reimbursable bad debts (see instructions)       26.00         27.00       Medicare allowable bad debts (see instructions)       27.00         28.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       27.01         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       28.00         29.00       Cost of nucompensated care (line 23, col. 3, plus line 29)       30.00	20.00					20.00
22. 00       Payments received from patients for amounts previously written off as charity care       22. 00         23. 00       Cost of charity care (see instructions)       23. 00         24. 00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1. 00         25. 00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       25. 01         25. 01       Charges for insured patients' liability (see instructions)       25. 01         26. 00       Bad debt amount (see instructions)       25. 01         26. 00       Bad debt amount (see instructions)       26. 00         27. 00       Medicare reimbursable bad debts (see instructions)       27. 00         28. 00       Non-Medicare bad debt amount (see instructions)       27. 01         29. 00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       29. 00         30. 00       Cost of uncompensated care (line 23, col. 3, plus line 29)       30. 00	21.00					21.00
charity care       23.00       Cost of charity care (see instructions)       23.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       25.00         25.01       Charges for insured patients' liability (see instructions)       25.01         26.00       Bad debt amount (see instructions)       26.00         27.00       Medicare reimbursable bad debts (see instructions)       27.01         28.00       Non-Medicare and non-reimbursable Medicare bad debt amount (see instructions)       27.01         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       28.00         29.00       Cost of uncompensated care (line 23, col. 3, plus line 29)       30.00		instructions)				
23.00       Cost of charity care (see instructions)       23.00         24.00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       25.00         25.01       Charges for insured patients' liability (see instructions)       25.01         26.00       Bad debt amount (see instructions)       25.01         27.01       Medicare reimbursable bad debts (see instructions)       25.01         27.01       Medicare allowable bad debts (see instructions)       27.01         28.00       Non-Medicare and non-reimbursable Medicare bad debt amount (see instructions)       27.01         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       28.00         29.00       Cost of uncompensated care (line 23, col. 3, plus line 29)       30.00	22.00					22.00
24. 00       Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit       1.00         25. 00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       25. 00         25. 01       Charges for insured patients' liability (see instructions)       25. 01         26. 00       Bad debt amount (see instructions)       25. 01         27. 01       Medicare reimbursable bad debts (see instructions)       25. 01         27. 01       Medicare allowable bad debts (see instructions)       27. 01         28. 00       Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)       27. 01         29. 00       Cost of uncompensated care (line 23, col. 3, plus line 29)       30. 00						
24.00Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?25.0025.01Charges for insured patients' liability (see instructions)25.0126.00Bad debt amount (see instructions)25.0127.00Medicare reimbursable bad debts (see instructions)26.0027.01Medicare allowable bad debts (see instructions)27.0128.00Non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00	23.00	Cost of charity care (see instructions)				23.00
24.00Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?25.0025.01Charges for insured patients' liability (see instructions)25.0126.00Bad debt amount (see instructions)25.0127.00Medicare reimbursable bad debts (see instructions)26.0027.01Medicare allowable bad debts (see instructions)27.0128.00Non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00					1.00	
imposed on patients covered by Medicaid or other indigent care program?25.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit25.0025.01Charges for insured patients' liability (see instructions)25.0126.00Bad debt amount (see instructions)26.0027.00Medicare reimbursable bad debts (see instructions)27.0027.01Medicare allowable bad debts (see instructions)27.0128.00Non-Medicare bad debt amount (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00	24.00	Does the amount on Line 20 col 2, include charges for nations days beyond a Long	h of	stav limit	1.00	24.00
25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit25.0025.01Charges for insured patients' liability (see instructions)25.0126.00Bad debt amount (see instructions)26.0027.00Medicare reimbursable bad debts (see instructions)27.0027.01Medicare allowable bad debts (see instructions)27.0128.00Non-Medicare bad debt amount (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00	24.00			stay minit		24.00
stay limit25.0125.01Charges for insured patients' liability (see instructions)25.0126.00Bad debt amount (see instructions)26.0027.00Medicare reimbursable bad debts (see instructions)27.0127.01Medicare allowable bad debts (see instructions)27.0128.00Non-Medicare bad debt amount (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00	25 00		aram'	s length of		25 00
25.01Charges for insured patients' liability (see instructions)25.0126.00Bad debt amount (see instructions)26.0027.00Medicare reimbursable bad debts (see instructions)27.0027.01Medicare allowable bad debts (see instructions)27.0128.00Non-Medicare bad debt amount (see instructions)27.0129.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00	20.00		gram	s rength of		20.00
27.00Medicare reimbursable bad debts (see instructions)27.0027.01Medicare allowable bad debts (see instructions)27.0128.00Non-Medicare bad debt amount (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00	25.01					25.01
27.01Medicare allowable bad debts (see instructions)27.0128.00Non-Medicare bad debt amount (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00	26.00	Bad debt amount (see instructions)				26.00
28.00Non-Medicare bad debt amount (see instructions)28.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00	27.00	Medicare reimbursable bad debts (see instructions)				27.00
29.00Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)29.0030.00Cost of uncompensated care (line 23, col. 3, plus line 29)30.00						
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29) 30.00		, , ,				
			ons)			
31.00   lotal unreimbursed and uncompensated care cost (line 19 plus line 30)   31.00						
	31.00	lotal unreimbursed and uncompensated care cost (line 19 plus line 30)				31.00

LASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider C		Peri od:	Worksheet A	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/29/2024 2:1	
Cost Center Description	Sal ari es	Other	Total (col	1 Recl assi fi cati	Reclassi fi ed	
	Sururres	other	+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS					-	
0 00100 CAP REL COSTS-BLDG & FIXT		0		0 549, 267	549, 267	1.
0 00200 CAP REL COSTS-MVBLE EQUIP		0		0 1, 689, 582	1, 689, 582	2.
0 00400 EMPLOYEE BENEFITS DEPARTMENT	0	8, 008	8, 00	3, 833, 964	3, 841, 972	4.
0 00500 ADMINISTRATIVE & GENERAL	667, 435	19, 139, 409	19, 806, 84	4 -470, 290	19, 336, 554	5.
0 00700 OPERATION OF PLANT	736, 364	4, 286, 498	5, 022, 86	-1, 201, 963	3, 820, 899	7.
0 00800 LAUNDRY & LINEN SERVICE	0	172, 672	172, 67	2 0	172, 672	8.
0 00900 HOUSEKEEPI NG	533, 445	563, 599	1, 097, 04	4 -143, 320	953, 724	9.
00 01000 DI ETARY	430, 792	546, 124	976, 91	6 -447, 396	529, 520	10.
00 01100 CAFETERIA	0	0		0 300, 704	300, 704	11.
00 01300 NURSING ADMINISTRATION	1, 810, 430	855, 412	2, 665, 84	2 -585, 266	2, 080, 576	13.
00 01400 CENTRAL SERVICES & SUPPLY	101, 154	149, 587	250, 74	1 519, 931	770, 672	14.
00 01500 PHARMACY	875, 782	15, 227, 402	16, 103, 18	4 -14, 343, 785	1, 759, 399	15.
00 01700 SOCIAL SERVICE	0	0		0 49, 702	49, 702	17.
INPATIENT ROUTINE SERVICE COST CENTERS						1
00 03000 ADULTS & PEDI ATRI CS	2, 896, 660	3, 853, 753	6, 750, 41	3 -647, 390	6, 103, 023	30.
00 03100 INTENSIVE CARE UNIT	1, 698, 411	1, 229, 132	2, 927, 54	-427, 356	2, 500, 187	31.
ANCILLARY SERVICE COST CENTERS						1
00 05000 OPERATI NG ROOM	995, 994	3, 307, 408	4, 303, 40	2 -1, 130, 777	3, 172, 625	1 50.
00 05100 RECOVERY ROOM	382, 722	121, 589		1 -88,048		51.
00 05400 RADI OLOGY-DI AGNOSTI C	1, 277, 325	764, 358			1, 934, 032	54
00 05600 RADI OI SOTOPE	93, 287	203, 696				56
00 05700 CT SCAN	515, 308	555, 160			562, 397	57.
00 05800 MRI	273, 767	140, 152			380, 728	
00 06000 LABORATORY	322, 883	4, 680, 784				
00 06500 RESPI RATORY THERAPY	947, 227	454, 391	1, 401, 61			65
00 06600 PHYSI CAL THERAPY	766, 975	346, 903			968, 697	66
00 06700 OCCUPATI ONAL THERAPY	311, 963	78, 590			335, 692	67
00 06800 SPEECH PATHOLOGY	180, 191	51,074				68
00 06900 ELECTROCARDI OLOGY	466, 318	839, 493				
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	400, 310	037,473	1, 303, 01	0 368, 358		
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 186, 254		72
00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 14, 742, 704		73
97 07697 CARDI AC REHABI LI TATI ON	0	0		0 85, 185		76
00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0 0	77
00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	/0
00 09000 CLINIC	1, 158, 606	567, 361	1, 725, 96	-342.012	1, 383, 955	90
01 09000 CLINIC - DIABETES	1, 158, 606	583				
00 09100 EMERGENCY	3, 474, 686	4, 108, 345			6, 543, 870	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 474, 000	4, 106, 343	7, 565, 03	-1,039,101	0, 343, 670	91
OTHER REIMBURSABLE COST CENTERS			I		I	92
. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	1102
SPECIAL PURPOSE COST CENTERS	0	0	I	0 0	0	102
	20 017 725	(2.251.402	02 1(0 20	14 (40	02 122 550	1110
. 00 SUBTOTALS (SUM OF LINES 1 through 117)	20, 917, 725	62, 251, 483	83, 169, 20	-46, 649	83, 122, 559	1118
NONREI MBURSABLE COST CENTERS	17 201	17 001	25.40	14 570	10 (00	1100
. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	17, 301	17, 881	35, 18			
. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			3 63, 298		
. 00 07950 OCCUPATI ONAL HEALTH	0	5, 556	5, 55			
. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED	0	0		0 0		194
. 03 07953 HOME CARE	0	0		0 0		194
.00 TOTAL (SUM OF LINES 118 through 199)	20, 935, 026	62, 274, 923	83, 209, 94	9 0	83, 209, 949	1200

Heal th	Financial Systems IND	IANA UNIVERSIT	Y HEALTH BEDFORD	In Lieu of Form CM	MS-2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-1328	Period: Worksheet	A
				From 01/01/2023 To 12/31/2023 Date/Time	Proparod
				5/29/2024	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS	1			
1.00	00100 CAP REL COSTS-BLDG & FIXT	249, 484			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	274, 510			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-164, 422			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-3, 498, 997			5.00
7.00	00700 OPERATION OF PLANT	-13, 434			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-901			8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	-688			9.00
10. 00 11. 00	01100 CAFETERIA	0			10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	156, 035	000,701		13.00
		150, 035			14.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	s s			14.00
17.00	01700 SOCIAL SERVICE	113, 741			17.00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	49,702		17.00
30.00	03000 ADULTS & PEDIATRICS	-1, 652, 009	4, 451, 014		30.00
31.00	03100 I NTENSI VE CARE UNI T	-413, 106			30.00
51.00	ANCI LLARY SERVICE COST CENTERS	-413,100	2,007,001		51.00
50.00	05000 OPERATI NG ROOM	-1, 375, 628	1, 796, 997		50.00
51.00	05100 RECOVERY ROOM	1, 373, 020	416, 263		51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	55, 732			54.00
56.00	05600 RADI OLSOTOPE	00,702	237, 084		56.00
57.00	05700 CT SCAN	0			57.00
58.00	05800 MRI	0			58.00
60.00	06000 LABORATORY	-314, 608			60.00
65.00	06500 RESPI RATORY THERAPY	-59, 410			65.00
66.00	06600 PHYSI CAL THERAPY	118, 692			66.00
67.00	06700 OCCUPATI ONAL THERAPY	-3, 273			67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00	06900 ELECTROCARDI OLOGY	-11, 125	1, 017, 263		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	186, 254		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 742, 704		73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	85, 185		76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	-4, 408	3 1, 379, 547		90.00
90.01	09001 CLINIC - DIABETES	-433	0		90.01
91.00	09100 EMERGENCY	2, 734, 674	9, 278, 544		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102.00
	SPECIAL PURPOSE COST CENTERS				
118.00		-3, 809, 574	79, 312, 985		118.00
	NONREI MBURSABLE COST CENTERS	1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 609		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
	07950 OCCUPATIONAL HEALTH	0	5, 480		194.00
	2 07952 BLOOMNGTN AMBULANCE AND OCC MED	0			194.02
	O7953 HOME CARE	0	0		194.03
200.00	) TOTAL (SUM OF LINES 118 through 199)	-3, 809, 574	79, 400, 375		200.00

# Health Financial Systems RECLASSIFICATIONS

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

RECLAS	SIFICATIONS			Provider CC	CN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet A- Date/Time Pr	
		Increases					5/29/2024 2:	18 pm
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00				
	A - BENEFITS	0.00	1.00					
1.00 2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	0	3, 833, 154 0				1.00 2.00
3.00		0.00	0	0				3.00
4.00 5.00		0.00 0.00	0	0 0				4.00 5.00
6.00		0.00	0	0				6.00
7.00 8.00		0.00 0.00	0	0 0				7.00 8.00
9.00		0.00	0	0				9.00
10. 00 11. 00		0.00 0.00	0	0				10.00 11.00
12. 00 13. 00		0.00 0.00	0	0				12.00 13.00
14.00		0.00	0	0				14.00
15. 00 16. 00		0.00 0.00	0	0				15.00 16.00
17.00		0.00	0	0				17.00
18. 00 19. 00		0.00 0.00	0	0 0				18.00 19.00
20.00		0.00	0	0				20.00
21. 00 22. 00		0.00 0.00	0	0 0				21.00 22.00
23.00		0.00	0	0				23.00
24.00	o	0.00	<u>0</u> 0	3, 833, 154				24.00
1.00	B – DI ETARY/CAFETERI A CAFETERI A	11.00	149, 471	151, 233				1.00
1.00	0		149, 471	151, 233				1.00
1.00	C - CAPITAL LEASE PHYSICIANS' PRIVATE OFFICES	192.00	0	63, 283				1.00
	O CARDI OLOGY		0	63, 283				_
1.00	CARDIAC REHABILITATION		7 <u>5, 0</u> 90	1 <u>0, 0</u> 95				1.00
	0 E - DEPR EXPENSE		75, 090	10, 095				-
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00	0	477, 593 1, 670, 308				1.00 2.00
2.00 3.00	CAP REL COSTS-MUDLE EQUIP	0.00	0 0	1, 070, 308				3.00
4.00 5.00		0.00 0.00	0	0				4.00 5.00
6.00		0.00	0	0				6.00
7.00 8.00		0.00 0.00	0	0				7.00 8.00
9.00		0.00	О	0				9.00
10. 00 11. 00		0.00 0.00	0	0 0				10.00 11.00
12.00		0.00	0	0				12.00
13. 00 14. 00		0.00 0.00	0	0 0				13.00 14.00
15. 00 16. 00		0.00 0.00	0	0 0				15.00 16.00
17.00		0.00	0	0				17.00
18. 00 19. 00		0.00 0.00	0	0				18.00 19.00
20.00		0.00	0	0				20.00
21. 00 22. 00		0.00 0.00	0	0				21.00 22.00
23.00		0.00	<u>0</u>	<u>0</u> 2, 147, 901				23.00
	F - BILLABLE DRUGS							
1.00 2.00	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	14, 742, 704 0				1.00 2.00
3.00		0.00	0	0				3.00
4.00 5.00		0.00 0.00	0	0				4.00 5.00
6.00		0.00	0	0				6.00
7.00 8.00		0.00 0.00	0	0 0				7.00 8.00
9.00		0.00 0.00	0	0				9.00
10. 00 11. 00		0.00	0 0	0				10. 00 11. 00
12. 00 13. 00		0.00 0.00	0 0	0 0				12.00 13.00
		0.00	<u> </u>					

Heal th	Fi nanci al	Systems							
RECLASSIFICATIONS									

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

Inc.         Dest. Center         Line Jack         Starty / Inc. Prepared           14, 00         2, 00         5, 00         4, 00         7, 00         14, 00	RECLAS	SIFICATIONS			Provider CC	CN: 15-1328	Peri od:	Worksheet	A-6
Image: constraints         Uncertaints         Other           14         0.001         0.001         0.001         0.001         0.001         15.00							From 01/01/2023 To 12/31/2023		
2.00         3.00         4.00         5.00         4.00 <th< th=""><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th>0/29/2024</th><th>2. 16 pili</th></th<>								0/29/2024	2. 16 pili
10.00         0.00         0         0         14.00         15.00         10.00         15.00         10.00 <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>									
0         0         14         14         14         14         14         14         14         12         100           0.00         0         0         160         25         0         160         26         160         26         160         26         160         260         160         260	15. 00 16. 00	2.00	0.00 0.00 0.00	0 0 0	0				15.00 16.00
1.00         IPPL TRY GARGED TO         72.00         0         186.254         1.00           2.00         0.00         0.00         0         2.00         2.00         2.00           2.00         0.00         0.00         0         0         2.00 <td< td=""><td>17.00</td><td>0</td><td>0</td><td></td><td>14, 742, 704</td><td></td><td></td><td></td><td>17.00</td></td<>	17.00	0	0		14, 742, 704				17.00
2.00         MITRIS         0.00         0         0.00         0         3.0	1 00		72.00	0	186 254				1.00
3.00         0.00         0         0         3.00         0         4.00         5.00         4.00         5.00 <td></td> <td></td> <td></td> <td>0</td> <td>100, 234</td> <td></td> <td></td> <td></td> <td></td>				0	100, 234				
4.00         0.00         0         0         4.00           0.00         0.00         0         0         0         0         0           0.00         0.00         0         0         0         0         0         0           1.00         0 </td <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>					0				
0.00         0.00         0 </td <td></td> <td></td> <td>0.00</td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0.00		0				
7.00         0.00         0 </td <td></td> <td></td> <td></td> <td>-</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>				-	0				
0				-	0				
I         BILLABLE MEDICAL SUPPLIES           1.00         MEDICAL SUPPLIES CHARGE TO         71.00         0         366.358           2.00         RESPERTORY THERAPY         65.00         0         3.00           3.00         0.00         0         0         3.00           3.00         0.00         0         0         3.00           3.00         0.00         0         0         3.00           3.00         0.00         0         0         0         0.00           4.00         0.00         0         0         0.00         0           6.00         0.00         0         0         0         0.00         0           7.00         0.00         0         0         0         0         0.00         0           10.00         0.00         0         0         0         0         0         10.00         11.00           12.00         0.00         0         0         0         0         0         11.00         11.00         11.00         12.00         13.00         13.00         13.00         13.00         14.00         12.00         14.00         12.00         14.00         12.00	8.00		0.00	0	0				8.00
PATT ENT         PATT ENT		I - BILLABLE MEDICAL SUPPLIES	;	0	100, 234				
2.00         RESPIRATORY THERAPY         65.00         0         51         2.00           4.00         0.00         0         0         0         3.00           4.00         0.00         0         0         0         3.00           4.00         0.00         0         0         0         3.00           6.00         0.00         0         0         0         0         4.00           6.00         0.00         0	1.00		71.00	0	368, 358				1.00
4.00         0.00         0 </td <td>2.00</td> <td></td> <td>65.00</td> <td>О</td> <td>51</td> <td></td> <td></td> <td></td> <td>2.00</td>	2.00		65.00	О	51				2.00
5.00         0.00         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
7.00         0.00         0         0.00         0         8.00         9.00<					-				
8.00         0.00         0         0         0         9.00           10.00         0.00         0         0         0         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         10.00         10.00         11.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         12.00         13.00         10.00         12.00         13.00         10.00 <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>				0	0				
10.00         0.00         0         0         0         0         10.00         11.00           12.00         0.00         0         0         0         12.00         12.00         12.00         13.00         13.00         13.00         12.00         13.00         10.00         13.00         13.00         10.00         13.00         10.00         13.00         10.00         13.00         10.00				0	0				
11,00         0.00         0         0         11,00           12,00         0.00         0         0         11,00           13,00         0.00         0         0         13,00           14,00         0         0         0         0         368,409           1,00         CAP REL COSTS-BUG & FIXT         1.00         0         71,908         1.00           2,00         0         91,182         1.00         0         91,182         1.00           1,00         SOCIAL WORKER         1.00         0         71,908         1.00         1.00           1,00         SOCIAL SERVICE         0         234         1.00         1.00         1.00           1,00         SOCIAL SERVICE         17,00         49,702         0         1.00         1.00           0,00         0         0         0         0         3.00         1.00         3.00           1,00         0.00         0         0         0         0         1.00         3.00           1,00         0.00         0         0         0         0         0         0           1,00         0.00         0         0				-	0				9.00
12.00         0.00         0         0         12.00         12.00         12.00         13.00           14.00         0         0.00         0         368.409         14.00         10.00				0	0				
14.00	12.00		0.00		0				12.00
0         -         -         0         368.409           J.         POPCPETY INSURANCE         -         -         0         1.00         CAP REL COSTS-BLDG & FINT         1.00         0         71.908         2.00         2.00         0         -         19.274         0         2.00         0         91.182         1.00         2.00         0         -         2.00         0         -         2.00         0         2.00         0         2.00         0         2.00         0         2.00         0         2.00         0         2.00         0         2.00         0         2.00         0         2.00         0         0         2.00         0         0         2.00         0         0         2.00         0         0         0         2.00         0				-	0				
1.00         CAP REL COSTS-MUDE & FIXT         1.00         0         71,908         1.00           2.00         CAP REL COSTS-MUDE EQUIP         2.00         0         19,274         0         234           1.00         0         71,908         1.80         234         1.00         1.00           2.00         0         234         0         234         1.00         1.00           2.01         0         234         0         234         1.00         1.00           2.00         0         49,702         0         0         234         1.00           1.00         0         17,00         49,702         0         0         308,252         1.00           1.00         0         0.00         0         0         3.00         3.00         3.00           1.00         0.00         0         0         0         3.00         3.00           1.00         0.00         0         0         0         3.00         3.00           1.00         0.00         0         0         0         3.00         3.00           1.00         0.00         0         0         0         3.00         3.00<		0			368, 409				
O         PROPERTY TAXES           1.00         ADMI NI STRATI VE & GENERAL	1.00		1.00	0	71, 908				1.00
k         PROPERTY TAXES         1         1         0         1         0         2         1         0         1         0         1         0         2         1         0         2         1         0         2         1         0         2         1         0         2         1         0         2         1         0         2         1         0         2         1         0         2         1         0         2         1         0         2         0         1         0         2         0         1         0         2         0         1         0         2         0         1         0         2         0         1         0         2         0         1         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2         2         1         0         2         2         2         2	2.00	CAP REL COSTS-MVBLE EQUIP	2.00						2.00
0		K - PROPERTY TAXES		U	91, 182				
L         SOCI AL WORKER	1.00	ADMI NI STRATI VE_& GENERAL	5.00						1.00
0         -         -         -         49, 702         - </td <td></td> <td>L - SOCIAL WORKER</td> <td></td> <td><u> </u></td> <td>234</td> <td></td> <td></td> <td></td> <td>_</td>		L - SOCIAL WORKER		<u> </u>	234				_
M         - NONBILLABLE DRUGS         -           1.00         PHARMACY         15.00         0         308,252         1.00           3.00         0.00         0         0         0         3.00         3.00           4.00         0.00         0         0         0         3.00         3.00         3.00           5.00         0.00         0         0         0         3.00         4.00           6.00         0.00         0         0         0         6.00         6.00         6.00         7.00         6.00         8.00         8.00         8.00         8.00         9.00         0         0.00         0         9.00         10.00         10.00         10.00         10.00         12.00         13.00         12.00         12.00         13.00         12.00         13.00         12.00         13.00         10.00         14.00         14.00	1.00	<u>SOCI AL_SERVI</u> CE			0				1.00
2.00         0.00         0         0         0         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         4.00         5.00         0.00         0         0         0         3.00         4.00         5.00         5.00         6.00         7.00         5.00         6.00         7.00         8.00         9.00         0         0         9.00         7.00         8.00         9.00         0         0         9.00         10.00         11.00         12.00         12.00         12.00         12.00         12.00         13.00         12.00         13.00         12.00         3.08, 252         1.00         2.00         3.00         4.00         5.382         2.00         3.00         4.00         3.00         4.00         5.00         2.205         3.00         2.00         3.00         4.00         5.00         2.205         3.00         4.00         5.00         2.00         3.00         4.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00		U M - NONBILLABLE DRUGS		49, 702	0				
3.00         0.00         0         0         3.00           4.00         0.00         0         0         0         4.00           5.00         0.00         0         0         0         5.00           6.00         0.00         0         0         0         6.00           7.00         0.00         0         0         6.00         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         10.00         11.00           12.00         0.00         0         0         12.00         12.00           13.00         0         0.00         0         2.205         2.00           3.00         0         0.223.382         1.00         3.30           2.00         ADMINISTRATIVE & GENERAL         5.00         0         2.205         2.00           3.00         0         0.00         0         5.30         5.00         5.00           6.00         0         1.942         6.00         6.00         6.00         6.00<		PHARMACY							
5.00         0.00         0         0         0         6.00         6.00         6.00         6.00         6.00         6.00         6.00         7.00         8.00         0.00         0         0         6.00         7.00         8.00         9.00         0.00         0         0         9.00         9.00         0.00         0         0         9.00         10.00         9.00         10.00         10.00         10.00         10.00         11.00         12.00         13.00         0         0         0         12.00         13.00         12.00         13.00         13.00         0         0         12.00         13.00         12.00         13.00         13.00         14.00         0         623.382         2.00         2.00         3.00         2.205         3.00         2.00         3.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         5.00         5.00         5.00         5.00         5.00         6.00         7.00         6.00         7.00         6.00         7.00         6.00         7.00         0.00         7.00         0.00         9.00         10.00         10.00         <				0	0				
6.00         0.00         0         0         0         7.00         7.00         7.00         7.00         7.00         7.00         7.00         8.00         7.00         8.00         7.00         8.00         9.00         0.00         0         8.00         9.00         9.00         9.00         9.00         0.00         0         9.00         10.00         10.00         10.00         10.00         11.00         12.00         12.00         12.00         12.00         12.00         13.00         0         0         0         13.00         13.00         13.00         13.00         13.00         13.00         13.00         1.00         13.00         1.00         13.00         1.00         14.00         0         623,382         1.00         1.00         13.00         1.00         13.00         1.00									
8.00         0.00         0.00         0         0         8.00         9.00<					-				
9.00         0.00         0.00         0         0         9.00           10.00         0.00         0         0         10.00         10.00           11.00         0.00         0         0         11.00         11.00           12.00         0.00         0         0         11.00         12.00         12.00           0         0.00         0         0         0         13.00         13.00           0         0.00         0         0         308,252         1.00         13.00           1.00         CENTRAL SERVICES & SUPPLY         14.00         0         623,382         1.00           2.00         ADMINISTRATIVE & GENERAL         5.00         0         2,205         2.00           3.00         OPERATION OF PLANT         7.00         0         12,251         3.00           4.00         HOUSEKEEPING         9.00         0         1,942         6.00           5.00         DI ETARY         10.00         53         5.00         5.00           6.00         RADI OI SOTOPE         56.00         0         1,942         6.00           7.00         CT SCAN         57.00         0         6,272				0	0				
11.00       0.00       0       0       0       11.00         12.00       0.00       0       0       0       12.00         13.00       0       0.00       0       0       12.00         0       0.00       0       0       0       12.00         13.00       0       0       0       0       12.00         1       0       0.00       0       0       12.00         1.00       CENTRAL SERVICES & SUPPLY       14.00       0       623,382       1.00         2.00       ADMI NI STRATI VE & GENERAL       5.00       0       2,205       2.00         3.00       0PERATION OF PLANT       7.00       0       12,251       3.00         4.00       HOUSEKEEPI NG       9.00       0       204       4.00         5.00       DI ETARY       10.00       53       5.00       6.00         6.00       RADI OI SOTOPE       56.00       0       1,942       6.00         7.00       CT SCAN       57.00       0       6,272       7.00       8.00         9.00       PHYSI CAL THERAPY       66.00       0       7.88       9.00       9.00				0	0				
12.00         0.00         0         0         0         12.00           13.00         0         0         0         0         0         13.00           0         0         0         0         0         0         0         13.00           0         0         0         0         308,252         1.00         13.00         13.00           1.00         CENTRAL SERVICES & SUPPLY         14.00         0         623,382         1.00         2.00           3.00         OPERATI ON OF PLANT         7.00         0         12,251         3.00           4.00         HOUSEKEEPI NG         9.00         0         2.04         4.00           5.00         DI ETARY         10.00         0         53         5.00           6.00         RADI OI SOTOPE         56.00         0         1,942         6.00           7.00         CT SCAN         57.00         0         6,272         7.00         9.00           8.00         PHYSI CAL THERAPY         66.00         0         788         8.00         9.00           9.00         0.00         0         0         0         0         10.00         11.00 <t< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<>				0	0				
13.00				0	0				
N         - NONBI LLABLE MEDI CAL SUPPLIES           1.00         CENTRAL SERVICES & SUPPLY         14.00         0         623, 382         1.00           2.00         ADMI NI STRATI VE & GENERAL         5.00         0         2, 205         2.00           3.00         OPERATION OF PLANT         7.00         0         12, 251         3.00           4.00         HOUSEKEEPI NG         9.00         0         204         4.00           5.00         DI ETARY         10.00         0         53         5.00           6.00         RADI OI SOTOPE         56.00         0         1, 942         6.00           7.00         CT SCAN         57.00         0         6, 272         7.00           8.00         PHYSI CAL THERAPY         66.00         0         788         8.00           9.00         PHYSI CI ANS' PRI VATE OFFICES         192.00         0         15         9.00           10.00         0.00         0         0         10.00         10.00         11.00           12.00         0.00         0         0         0         12.00         11.00           12.00         0.00         0         0         0         12.00         13.					0				
1.00       CENTRAL SERVICES & SUPPLY       14.00       0       623,382       1.00         2.00       ADMI NI STRATI VE & GENERAL       5.00       0       2,205       2.00         3.00       OPERATI ON OF PLANT       7.00       0       12,251       3.00         4.00       HOUSEKEEPI NG       9.00       0       204       4.00         5.00       DI ETARY       10.00       53       5.00         6.00       RADI OI SOTOPE       56.00       0       1,942       60.00         7.00       CT SCAN       57.00       0       6,272       7.00         8.00       PHYSI CAL THERAPY       66.00       0       788       8.00         9.00       PHYSI CI ANS' PRI VATE OFFICES       192.00       0       15       9.00         10.00       0.00       0       0       10.00       10.00       10.00         11.00       0.00       0       0       12.00       11.00       12.00       11.00         12.00       0.00       0       0       0       0       12.00       13.00		U N - NONBILLABLE MEDICAL SUPPL	IES	0	308, 252				_
3.00         0PERATI ON OF PLANT         7.00         0         12,251         3.00           4.00         HOUSEKEEPI NG         9.00         0         204         4.00           5.00         DI ETARY         10.00         0         53         5.00           6.00         RADI OI SOTOPE         56.00         0         1,942         6.00           7.00         CT SCAN         57.00         0         6,272         7.00           8.00         PHYSI CAL THERAPY         66.00         788         8.00           9.00         PHYSI CI ANS' PRI VATE OFFICES         192.00         0         15         9.00           10.00         0.00         0         0         10.00         10.00         10.00           11.00         0.00         0         0         0         11.00         12.00         13.00		CENTRAL SERVICES & SUPPLY	14.00						
4.00       HOUSEKEEPING       9.00       0       204       4.00         5.00       DI ETARY       10.00       0       53       5.00         6.00       RADI OI SOTOPE       56.00       0       1,942       6.00         7.00       CT SCAN       57.00       0       6,272       7.00         8.00       PHYSI CAL THERAPY       66.00       0       788       8.00         9.00       PHYSI CI ANS' PRI VATE OFFICES       192.00       0       15       9.00       10.00         10.00       0.00       0       0       10.00       10.00       10.00       10.00         11.00       0.00       0       0       0       11.00       12.00       13.00       13.00									
6.00         RADI 0I SOTOPE         56.00         0         1,942         6.00           7.00         CT SCAN         57.00         0         6,272         7.00           8.00         PHYSI CAL THERAPY         66.00         0         788         8.00           9.00         PHYSI CI ANS' PRI VATE OFFICES         192.00         0         15         9.00           10.00         0.00         0         0         10.00         10.00           11.00         0.00         0         0         11.00         12.00         12.00         13.00	4.00	HOUSEKEEPI NG	9.00	0	204				4.00
7.00         CT SCAN         57.00         0         6,272         7.00           8.00         PHYSI CAL THERAPY         66.00         0         788         8.00           9.00         PHYSI CI ANS' PRI VATE OFFICES         192.00         0         15         9.00           10.00         0.00         0         0         10.00         10.00           11.00         0.00         0         0         11.00         12.00         12.00         13.00				-					
9.00         PHYSICIANS' PRIVATE OFFICES         192.00         0         15         9.00           10.00         0.00         0         0         10.00         10.00         10.00           11.00         0.00         0         0         0         11.00         11.00         11.00         11.00         12.00         13.00	7.00	CT SCAN	57.00	0	6, 272				7.00
10.00         0.00         0         10.00           11.00         0.00         0         0         11.00           12.00         0.00         0         0         12.00           13.00         0.00         0         0         13.00				0					
12.00         0.00         0         0         12.00           13.00         0.00         0         0         13.00	10.00		0.00						10.00
13.00 0.00 0 0 13.00					0				
0 0 647, 112				0	0				
		0		0	647, 112				I

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

						From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 2:18	
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	P - COMMUNITY BENEFIT							
1.00	OCCUPATI ONAL HEALTH	194.00	0	1, 092				1.00
	0		0	1, 092				
	R – TRIMEDX							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	836				1.00
2.00	OPERATION OF PLANT	7.00	0	1, 868				2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	46, 238				3.00
4.00	PHARMACY	15.00	0	1, 742				4.00
5.00	ADULTS & PEDIATRICS	30.00	0	60, 764				5.00
6.00	INTENSIVE CARE UNIT	31.00	0	14, 024				6.00
7.00	OPERATING ROOM	50.00	0	68, 289				7.00
8.00	RECOVERY ROOM	51.00	0	685				8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	442, 042				9.00
10.00	RADI OI SOTOPE	56.00	0	310				10.00
11.00	MRI	58.00	0	81, 564				11.00
12.00	LABORATORY	60.00	0	583				12.00
13.00	RESPI RATORY THERAPY	65.00	0	14, 285				13.00
14.00	PHYSI CAL THERAPY	66.00	0	3, 468				14.00
15.00	ELECTROCARDI OLOGY	69.00	0	30, 233				15.00
16.00	CLINIC	90.00	0	2, 486				16.00
17.00	EMERGENCY	91.00	0	14, 306				17.OC
18.00	OCCUPATI ONAL HEALTH	194.00	0	4, 386				18. OC
	TOTALS	— — — †	— — — d	788, 109				
500.00	Grand Total: Increases		274, 263	23, 339, 014	1		5	500.00

## INDIANA UNIVERSITY HEALTH BEDFORD

Provider CCN: 15-1328 P

Perio	bd:	Worksheet	A-6
	01/01/2023		
То	12/31/2023	Date/Time	Prepared:
		5/20/2024	2.19 nm

					1	o 12/31/2023 Date/Time 5/29/2024	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9.00	10.00		
1.00	A – BENEFITS ADMINISTRATIVE & GENERAL	5.00	0	91, 967	0		1.00
2.00	OPERATION OF PLANT	7.00	Ő	189, 885			2.00
3.00	HOUSEKEEPI NG	9.00	0	121, 213			3.00
4.00	DI ETARY	10.00	0	129, 978			4.00
5.00	NURSING ADMINISTRATION	13.00	0	289, 977			5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	55, 756			6.00
7.00 8.00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	157, 292 470, 747			7.00 8.00
9.00	I NTENSI VE CARE UNI T	31.00	0	317, 483			9.00
10.00	OPERATING ROOM	50.00	0	202, 864			10.00
11.00	RECOVERY ROOM	51.00	0	72, 084	0		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	212, 803			12.00
13.00	RADI OI SOTOPE	56.00	0	31,605	0		13.00
14.00 15.00	CT SCAN MRI	57.00 58.00	0	76, 011 56, 027	-		14.00 15.00
16.00	LABORATORY	60.00	0	28, 572			16.00
17.00	RESPI RATORY THERAPY	65.00	0	158, 559			17.00
18.00	PHYSI CAL THERAPY	66.00	О	143, 969	0		18.00
19.00	OCCUPATI ONAL THERAPY	67.00	0	54, 861	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	36, 681	0		20.00
21.00	ELECTROCARDI OLOGY	69.00 90.00	0	50, 493			21.00
22.00 23.00	CLINIC EMERGENCY	90.00	0	239, 251 628, 503	0		22.00 23.00
23.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	16, 573			23.00
24.00	CANTEEN	170.00	0	10, 575	0		24.00
	0		0	3, 833, 154			
1 00	B - DI ETARY/CAFETERI A	10.00	4.40, 474	454 000			
1.00	DI ETARY	<u>10.00</u>	<u> </u>	<u>151, 233</u> 151, 233			1.00
	C - CAPITAL LEASE		147, 471	151, 255			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	63, 283	0		1.00
	0			63, 283			
	D - CARDI OLOGY						
1.00	ELECTROCARDIOLOGY		75, 090 75, 090	<u>10, 095</u> 10, 095			1.00
	E - DEPR EXPENSE		75,090	10, 095			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26	9		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	О	220, 316	9		2.00
3.00	OPERATION OF PLANT	7.00	0	238, 088			3.00
4.00	HOUSEKEEPING	9.00	0	22, 299			4.00
5.00 6.00	DI ETARY NURSI NG ADMI NI STRATI ON	10.00 13.00	0	16, 761 243, 192	0		5.00 6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	72, 355			7.00
8.00	PHARMACY	15.00	o	69, 399			8.00
9.00	ADULTS & PEDIATRICS	30.00	0	58, 365			9.00
10.00	INTENSIVE CARE UNIT	31.00	0	58, 244			10.00
11.00	OPERATING ROOM	50.00	0	282, 195			11.00
12.00	RECOVERY ROOM	51.00	0	14, 678			12.00
13.00 14.00	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54.00 56.00	0	272, 202 29, 477			13.00 14.00
15.00	CT SCAN	57.00	0	29, 477			15.00
16.00	MRI	58.00	Ő	35, 850			16.00
17.00	RESPI RATORY THERAPY	65.00	0	44, 515			17.00
18.00	PHYSICAL THERAPY	66.00	0	3, 994	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	584			19.00
20.00	ELECTROCARDI OLOGY	69.00	0	96, 322			20.00
21.00 22.00		90.00 90.01	0	6, 414 150			21.00 22.00
22.00	CLINIC - DIABETES EMERGENCY	90.01	0	70, 334			22.00
20.00			— — — <sub>ö</sub>	2,147,901			20.00
	F - BILLABLE DRUGS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	4, 889			1.00
2.00	NURSING ADMINISTRATION	13.00	0	560			2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,658			3.00
4.00 5.00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	14, 416, 047			4.00 5.00
5.00 6.00	INTENSIVE CARE UNIT	30.00	0	21, 050 7, 783			5.00 6.00
7.00	OPERATING ROOM	50.00	0	19, 615			7.00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	13, 198			8.00
9.00	RADI OI SOTOPE	56.00	0	381	0		9.00
10.00	CT SCAN	57.00	0	142, 934			10.00
11.00	MRI	58.00	0	22, 134			11.00
12.00	RESPI RATORY THERAPY	65.00	U	1, 080	U		12.00

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

 Provider CCN: 15-1328
 Period: From 01/01/2023
 Worksheet A-6

(LOLAS)					NV. 13 1320	From 01/01/2023 To 12/31/2023	Date/Time Pi 5/29/2024 2:	repared:
	Cost Center	Decreases Line #	Salary	Other W	/kst. A-7 Ref	1		
	6. 00	7.00	Salary 8.00	9.00	10.00	<u>.</u>		
13.00	PHYSI CAL THERAPY	66.00	0	62		0		13.0
14.00	ELECTROCARDI OLOGY	69.00	0	53, 459		o		14.0
15.00	CLINIC	90.00	0	2, 563		0		15.0
16.00		91.00	0	28, 737		0		16.0
17.00	OCCUPATIONAL HEALTH	194.00	0	<u>5, 5</u> 54 14, 742, 704				17.0
	G - IMPLANT SUPPLIES	I I	<u>Ч</u>	14, 742, 704				_
1.00	NURSING ADMINISTRATION	13.00	0	26		0		1.0
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 355		0		2.0
3.00	PHARMACY	15.00	0	174		0		3.0
1.00 5.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	419 170		0		4.0 5.0
5.00 5.00	OPERATING ROOM	50.00	0	145, 985				6.0
7.00 .00	CLINIC	90.00	0	34, 453		0		7.0
3.00	EMERGENCY	91.00	0	2, 672		0		8.0
	0 — — — — — —		0	186, 254		<u> </u>		
	I - BILLABLE MEDICAL SUPPLIES							
1.00 2.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	12 6		0		1.0
2.00 3.00	CENTRAL SERVICES & SUPPLY	14.00	0	14, 796				3.0
4.00	ADULTS & PEDIATRICS	30.00	0	17, 596		ŏ		4.0
. 00	INTENSIVE CARE UNIT	31.00	õ	7, 792		0		5.0
5.00	OPERATING ROOM	50.00	0	272, 468		o		6.0
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 864		0		7.0
3.00	RADI OI SOTOPE	56.00	0	73		0		8.0
0.00	CT SCAN	57.00	0	32		0		9.0
0.00 1.00	MRI PHYSI CAL THERAPY	58.00 66.00	0	10 1, 412				10.0
2.00	ELECTROCARDI OLOGY	69.00	0	207				12.0
3.00	CLINIC	90.00	0	13, 307		o		13.0
4.00	EMERGENCY	91.00	0	37, 834		0		14.0
	0		0	368, 409				_
1.00	J - PROPERTY INSURANCE ADMINISTRATIVE & GENERAL	5.00	0	91, 182	1	า		1.0
2.00	ADMINISTRATIVE & GENERAL	0.00	0	91, 162	1			2.0
2.00	0		— — — <u>o</u>	91, 182	'			2.0
	K – PROPERTY TAXES							
1.00	CAP REL_COSTS_BLDG_&_FIXT	1.00	0	234	1	3		1.0
	U L - SOCIAL WORKER		0	234				_
. 00	NURSI NG ADMI NI STRATI ON	13.00	49, 702	0		0		1.0
	0		49, 702	o		7		
	M - NONBILLABLE DRUGS							
. 00	NURSING ADMINISTRATION	13.00	0	1, 206		0		1.0
2.00	CENTRAL SERVICES & SUPPLY	14.00 30.00	0	1, 312		0		2.0
. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00	0 0	39, 461 19, 529				3. C 4. C
. 00 . 00	OPERATI NG ROOM	50.00	0	35, 188		0		5.0
. 00	RECOVERY ROOM	51.00	0	601		0		6.0
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	14, 448		0		7.0
. 00	RADI OI SOTOPE	56.00	0	615		0		8.0
. 00	CT SCAN	57.00	0	3, 225		0		9. (
0.00	MRI	58.00	0	312		0		10.0
1.00 2.00	ELECTROCARDI OLOGY	69.00 90.00	0	2, 101 35, 374		0		11. (
2.00 3.00	CLINIC EMERGENCY	90.00	0	35, 374 154, 880				12.0
5.00	0		— — <u> </u>	308, 252				10.0
	N - NONBILLABLE MEDICAL SUPPI			· · ·				
. 00	NURSING ADMINISTRATION	13.00	0	603		0		1.0
. 00	CENTRAL SERVICES & SUPPLY	14.00	0	457		0		2.0
00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	10, 867 100, 516				3.0
. 00	INTENSIVE CARE UNIT	31.00		30, 379		0		5.0
. 00	OPERATING ROOM	50.00	ŏ	240, 751		o		6.0
00	RECOVERY ROOM	51.00	Ö	1, 370		0		7.0
. 00	RADI OLOGY-DI AGNOSTI C	54.00	О	34, 178		0		8. (
00	MRI	58.00	О	422		0		9. (
0. OO	RESPI RATORY THERAPY	65.00	0	64, 037		0		10. (
				10 000		0		11.0
1. 00	ELECTROCARDI OLOGY	69.00	0	19, 889		-		
1.00 2.00 3.00	ELECTROCARDI OLOGY CLINIC EMERGENCY	69.00 90.00 91.00	0	19, 889 13, 136 130, 507		0		12.0

Heal th	Financial Systems	IND	IANA UNIVERSITY	HEALTH BEDFO	)RD	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider CCN: 15-1328		Peri od:	Worksheet A-	.6
						From 01/01/2023 To 12/31/2023	Date/Time Pr 5/29/2024 2:	epared: 18 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	,		
	6. 00	7.00	8.00	9.00	10.00			
	P - COMMUNITY BENEFIT		I					
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>1, 0</u> 92		Q		1.00
	0		0	1, 092				
	R – TRIMEDX	1 1			1	-		
1.00	OPERATION OF PLANT	7.00	0	788, 109		0		1.00
2.00		0.00	0	C		0		2.00
3.00		0.00	0	C		0		3.00
4.00		0.00	0	C		0		4.00
5.00		0.00	0	C		0		5.00
6.00		0.00	0	C		0		6.00
7.00		0.00	0	C		0		7.00
8.00		0.00	0	C		0		8.00
9.00		0.00	0	C		0		9.00
10.00		0.00	0	C		0		10.00
11.00		0.00	0	C		0		11.00
12.00		0.00	0	C		0		12.00
13.00		0.00	0	C		0		13.00
14.00		0.00	0	C		0		14.00
15.00		0.00	0	C		0		15.00
16.00		0.00	0	C		0		16.00
17.00		0.00	0	C		0		17.00
18.00	L	0.00	0	0	)	Ō		18.00
	TOTALS		0	788, 109				
500.00	Grand Total: Decreases		274, 263	23, 339, 014				500.00

Heal th Financia	al Systems		
RECONCI LI ATI ON	OF CAPI TAL	COSTS	CENTERS

### I NDI ANA UNI VERSI TY HEALTH BEDFORD Provi der CCN: 15-1328 Peri od: From 01/0

					From 01/01/2023 To 12/31/2023		
				Acqui si ti on	S		
		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				T		
1.00	Land	1,034,321	0		0 0	0	1.00
2.00	Land Improvements	1, 093, 347			0 0	0	2.00
3.00	Buildings and Fixtures	13, 907, 417			0 0	0	3.00
4.00	Building Improvements	6, 211, 197	546, 183		0 546, 183	3, 932	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	19, 388, 690	2, 510, 844		0 2, 510, 844	638, 041	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41, 634, 972	3, 057, 027		0 3, 057, 027	641, 973	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	41, 634, 972			0 3, 057, 027	641, 973	10.00
		Endi ng Bal ance					
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1,034,321	0				1.00
2.00	Land Improvements	1, 093, 347					2.00
3.00	Buildings and Fixtures	13, 907, 417	0				3.00
4.00	Building Improvements	6, 753, 448	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	21, 261, 493	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	44, 050, 026	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	44, 050, 026	0				10.00

Heal th	Financial Systems INC	DIANA UNIVERSITY HEALTH BEDFORD			In Lieu of Form CMS-2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1328	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		nared
					10 12/01/2020	5/29/2024 2:1	8 pm
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	)	0 0	0	3.00
		SUMMARY O	OF CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)		1			
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

ECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2023 To 12/31/2023		pared
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COS						
.00 CAP REL COSTS-BLDG & FIXT .00 CAP REL COSTS-MVBLE EQUIP .00 Total (sum of lines 1-2)	22, 788, 532 21, 261, 493 44, 050, 025	0	22, 788, 532 21, 261, 493 44, 050, 025	0. 482667	0 0 0	1. ( 2. ( 3. (
		TION OF OTHER (		SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COS	TS CENTERS					
.00 CAP REL COSTS-BLDG & FIXT .00 CAP REL COSTS-MVBLE EQUIP .00 Total (sum of lines 1-2)	0	0		477, 593 1, 944, 818 2, 422, 411	0 0	1. 2. 3.
		SL	JMMARY OF CAPIT			0.
Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COS						
. OO CAP REL COSTS-BLDG & FLXT	249, 484	71, 908	-234	1 O	798, 751	1.

## INDIANA UNIVERSITY HEALTH BEDEORD

Heal th	Financial Systems	I NDI	ANA UNIVERSIT	Y HEALTH BEDFORD	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2023	Worksheet A-8	
					To 12/31/2023	Date/Time Pre	pared:
				Expense Classification o	n Worksheet A	5/29/2024 2:1	8 pm
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
1.00	COSTS-BLDG & FIXT (chapter 2)	D	0, 474, 701		1.00		1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
	discounts (chapter 8)		0				
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
9.00 10.00	Provi der-based physician	A-8-2	-3, 801, 544		0.00	0	
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
	(chapter 23)		-		0.00		
12.00	Related organization transactions (chapter 10)	A-8-1	16, 470, 136			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0	CAFETERI A	11.00		
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
	abstracts		0				
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.)						
20.00	Vending machines		0		0.00		
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
	charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of						
25.00	limitation (chapter 14) Utilization review –		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation		-				
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
	COSTS-BLDG & FIXT						
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.00
29.00 30.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00		29.00 30.00
50.00	therapy costs in excess of	A 0-5	0	OUT ATTUNAL THEMALT	07.00		30.00
20.00	limitation (chapter 14)		~		20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for	А	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	Depreciation and Interest MISCELLANEOUS INCOME	В	-74,406	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
			, , , , , 00	real a cherche	1 5.00		00.00

Health Financial Systems	I NDI	ANA UNIVERSIT	Y HEALTH BEDFORD	In Lie	eu of Form CMS-:	2552-10
ADJUSTMENTS TO EXPENSES				Period:	Worksheet A-8	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/29/2024 2:1	
			Expense Classification or	Worksheet A	372772024 2.1	
			To/From Which the Amount is			
				· · · · · · · · · · · · · · · · · · ·		
Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.00 MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7.00		
35.00 MI SCELLANEOUS I NCOME	В		LAUNDRY & LINEN SERVICE	8.00		00.00
36.00 MI SCELLANEOUS I NCOME	В		HOUSEKEEPI NG	9.00		36.00
37.00 MI SCELLANEOUS I NCOME	В		PHARMACY	15.00		37.00
38.00 MI SCELLANEOUS I NCOME	В		ADULTS & PEDIATRICS	30.00		00.00
39.00 MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00		07.00
45.00 MI SCELLANEOUS I NCOME	В		RESPI RATORY THERAPY	65.00		101.00
45.01 MI SCELLANEOUS I NCOME	В		OCCUPATI ONAL THERAPY	67.00		1 101 01
45.02 MI SCELLANEOUS I NCOME	В	-11, 125	ELECTROCARDI OLOGY	69.00	9	45.02
45.03 UNWONTED SITUATIONS	A	-250	ADULTS & PEDIATRICS	30.00	0	45.03
45.04 INVESTMENT FEES	В	6, 914	ADMI NI STRATI VE & GENERAL	5.00	0	45.04
45.05 PHONES	A	-2, 690	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.05
45.06 HAF	A	-5, 844, 285	ADMI NI STRATI VE & GENERAL	5.00	0	45.06
45.07 MARKETI NG	A		ADMINISTRATIVE & GENERAL	5.00		1 101 07
45.08 MARKETING	A	-57	CLINIC	90.00	0	45.08
45. 09 BENEFITS	A	-3, 833, 154	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	45.09
45.10 CONTRIBUTION EXPENSE	A	-7,880	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11 CONTRIBUTION EXPENSE	A	-128	RADI OLOGY-DI AGNOSTI C	54.00	0	45.11
45.12 DIABETES CLINIC	A	-433	CLINIC – DIABETES	90.01	0	45.12
50.00 TOTAL (sum of lines 1 thru 49)		-3, 809, 574				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

 column 6, line 200.)

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

 (2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

Heal th	Financial Systems	I NDI ANA UNI VERSI	TY HEALTH BEDFORD	In Lie	eu of Form CMS-	2552-10
STATEME OFFICE				Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 2:1	pared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:			RGANIZATIONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	6, 744, 465	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	277, 200	0	2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT		3, 654, 009		3.00
4.00			HOME OFFICE	11, 609, 329		4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT		14, 723	0	4.01
4.02			RELATED PARTY	2, 386, 885	1, 072, 405	4.02
4.03			RELATED PARTY	100, 237		4.03
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	226, 256	70, 221	4.05
4.06			RELATED PARTY	562, 192	448, 383	
4.07			RELATED PARTY	103, 183		4.07
4.08			RELATED PARTY	22, 880		4.08
4.09			RELATED PARTY	229, 460		4.09
4.10			EMERGENCY ROOM	3, 545, 523		
4.11		EMPLOYEE BENEFITS DEPARTMENT		1, 790		
4.12			SHARED EMPLOYEES	7,680		
4.13			SHARED EMPLOYEES	36, 178		
4.14			SHARED EMPLOYEES	1, 745, 246		
4.15			SHARED EMPLOYEES	413, 106		4.15
4.16			SHARED EMPLOYEES	8, 909		4.16
4.17			SHARED EMPLOYEES	4, 245, 987	4, 245, 987	4.17
4.18		RESPI RATORY THERAPY		213	213	4. 18
4.20			SHARED EMPLOYEES	496, 009		4.20
4.21		CLINIC	SHARED EMPLOYEES	58, 372		4.21
5.00	TOTALS (sum of lines 1-4).			36, 489, 832	20, 019, 696	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.

				Related Organization(s) and	'or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
	-		Ownership		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.

i ci indui			
6.00	В	0.00 I U HEALTH, I NC. 50.00	6.00
7.00	F	0.00 I UH BLOOMI NGTO 50.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		1

(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.

	Financial Syste				EALTH BEDFOR			u of Form CMS-	
		SERVICES FROM	I RELATED ORGANIZATIONS	AND HOME	Provider CC	N: 15-1328	Peri od:	Worksheet A-8	8-1
OFFICE	COSTS						From 01/01/2023 To 12/31/2023	Date/Time Pre	anarad
							10 12/31/2023	5/29/2024 2:	
	Net	Wkst. A-7 Ref.						0/2//2021 2.	
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6.00	7.00	-						
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RE	SULT OF TRA	ANSACTIONS WI	TH RELATED	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO								
1.00	6, 744, 465	11	1						1.00
2.00	277, 200	9	9						2.00
3.00	3, 654, 009	0	0						3.00
4.00	1, 115, 749	0	0						4.00
4.01	14, 723	0	0						4.01
4.02	1, 314, 480	0	0						4.02
4.03	100, 237	0	0						4.03
4.05	156, 035	0	0						4.05
4.06	113, 809	0	0						4.06
4.07	103, 183	0	0						4.07
4.08	22, 880	0	0						4.08
4.09	118, 692	0	0						4.09
4.10	2, 734, 674	0	0						4.10
4.11	0	0	0						4.11
4.12	0	0	0						4.12
4.13	0	0	0						4.13
4.14	0	0	0						4.14
4.15	0	0	0						4.15
4.16	0	0	0						4. 16
4.17	0	0	0						4. 17

0 0 4.18 4.18 0 4.20 0 4.20 0 0 4.21 4.21 5.00 16, 470<u>, 136</u> 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		
	51		
	6, 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
	D. THTERREPARTONOMIT TO REER		

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.

i ci indui			
6.00	HOME OFFICE	6.00	
7.00	HEALTHCARE	7.00	
8.00		8.00	
9.00		9.00	
9. 00 10. 00		10.00	
100.00		100.00	

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

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.

Heal th	Fi nar	nci al	Syste	ms	
		SED DI	17 1274	ΛN	

## INDIANA UNIVERSITY HEALTH BEDFORD

	Financial Syste		NDIANA UNIVERSI				eu or Form CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (		Period:	Worksheet A-8	3-2
						From 01/01/2023 To 12/31/2023		parod
						10 12/31/2023	5/29/2024 2:1	
	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	
			itomarior a cross		oomponone		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1, 651, 528	1, 651, 528	(	0 0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	413, 106	413, 106		ol o	0	2.00
3.00		OPERATING ROOM	1, 375, 628			0	0	
4.00		RADI OLOGY-DI AGNOSTI C	42, 323			0	0	4.00
5.00		LABORATORY	314, 608				0	5.00
6.00			4, 351			-	0	6.00
7.00		EMERGENCY	730, 854			~ ~ ~	0	7.00
8.00	0.00		, 30, 034				0	8.00
9.00	0.00						0	9.00
10.00	0.00						0	
200.00	0.00		4, 532, 398	3, 801, 544	730, 854		0	1
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WKSL. A LINE #	I denti fi er		Unadjusted RCE			of Malpractice	
		ruentirrei			Continuing	Share of col.		1
					Educati on	12	Thisurance	1
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0.00					1.00
2.00		INTENSIVE CARE UNIT					-	
2.00 3.00		OPERATI NG ROOM					0	
3.00 4.00		RADI OLOGY-DI AGNOSTI C				-	0	4.00
4.00 5.00		LABORATORY					0	5.00
		CLINIC					0	6.00
6.00							0	
7.00		EMERGENCY	0				0	7.00
8.00	0.00		0	0			0	0.00
9.00	0.00		0	0		0	0	9.00
10.00	0.00		0	0		°	0	
200.00			0	0		, , , , , , , , , , , , , , , , , , , ,	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	15.00					1.00
2.00		INTENSIVE CARE UNIT						2.00
2.00		OPERATING ROOM						2.00
3.00 4.00		RADI OLOGY-DI AGNOSTI C						
		LABORATORY				12,020		4.00
5.00					· · · · · · · · · · · · · · · · · · ·			5.00
6.00				í v		1,001		6.00
7.00		EMERGENCY		0	· · · · · · · · · · · · · · · · · · ·	0		7.00
8.00	0.00		0	0		-		8.00
9.00	0.00		0	0		-		9.00
10.00	0.00		0	0				10.00
200.00	1		0	0	0	3, 801, 544		200.00

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

5/29/2024 2           Cost Center Description         Net Expenses for Cost Al location (from Wkst A col. 7)         CAPITAL RELATED COSTS           BLDG & FIXT         MVBLE EQUIP         EMPLOYEE BENEFITS DEPARTMENT         Subtotal           6         0         1.00         2.00         4.00         4A           0         1.00         2.00         4.00         4A           0         1.964,092         1,964,092         1,964,092         1,964,092           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         3,677,550         2,196         7,390         3,687,136           5.00         00500 ADMINISTRATIVE & GENERAL         15,837,557         109,410         368,183         117,551         16,432,7           7.00         000700 [OPERATIION OF PLANT         3,807,465         88,151         296,643         129,691         4,321,557	
Cost Center Description         Net Expenses for Cost Al location (from Wkst A col. 7)         BLDG & FIXT         MVBLE EQUIP         EMPLOYEE BENEFITS DEPARTMENT         Subtotal           0         1.00         2.00         4.00         4A           0         1.00         2.00         4.00         4A           0         1.00         2.00         4.00         4A           0         00100         CAP REL COSTS-BLDG & FIXT         798,751         798,751         1,964,092 <td></td>	
O         1.00         2.00         4.00         4A           GENERAL SERVICE COST CENTERS         00100         CAP REL COSTS-BLDG & FIXT         798,751         798,751         1,964,092	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         CAP         REL         COSTS-BLDG & FIXT         798, 751         798, 751           2.00         00200         CAP         REL         COSTS-MVBLE         EQUI P         1, 964, 092         1, 964, 092           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT         3, 677, 550         2, 196         7, 390         3, 687, 136           5.00         00500         ADMINISTRATIVE & GENERAL         15, 837, 557         109, 410         368, 183         117, 551         16, 432, 7	
1.00         00100         CAP         REL         COSTS-BLDG         & FIXT         798, 751         798, 751           2.00         00200         CAP         REL         COSTS-MVBLE         EQUI P         1, 964, 092         1, 964, 092           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT         3, 677, 550         2, 196         7, 390         3, 687, 136           5.00         00500         ADMINISTRATIVE         & GENERAL         15, 837, 557         109, 410         368, 183         117, 551         16, 432, 7	
2.00         00200         CAP_REL_COSTS-MVBLE_EQUIP         1,964,092         1,964,092           4.00         00400         EMPLOYEE_BENEFITS_DEPARTMENT         3,677,550         2,196         7,390         3,687,136           5.00         00500         ADMINISTRATIVE & GENERAL         15,837,557         109,410         368,183         117,551         16,432,7	1.00
4. 00         00400         EMPLOYEE         BENEFITS         DEPARTMENT         3, 677, 550         2, 196         7, 390         3, 687, 136           5. 00         00500         ADMINISTRATIVE & GENERAL         15, 837, 557         109, 410         368, 183         117, 551         16, 432, 7	2.00
5. 00 00500 ADMINISTRATIVE & GENERAL 15, 837, 557 109, 410 368, 183 117, 551 16, 432, 7	4.00
7 00 00700 OPERATION OF PLANT 3 807 465 88 151 296 643 129 691 4 321 0	01 5.00
8. 00 00800 LAUNDRY & LINEN SERVICE 171, 771 3, 315 11, 155 0 186, 2	241 8.00
9. 00 00900 HOUSEKEEPI NG 953, 036 7, 586 25, 528 93, 952 1, 080, 1	02 9.00
10. 00 01000 DI ETARY 529, 520 16, 015 53, 894 49, 547 648, 9	76 10.00
11. 00 01100 CAFETERIA 300, 704 9, 765 32, 862 26, 325 369, 6	56 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 2, 236, 611 26, 816 90, 241 310, 105 2, 663, 7	73 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 770, 672 18, 646 62, 746 17, 816 869, 8	380 14.00
15. 00 01500 PHARMACY 1, 873, 140 8, 930 30, 052 154, 245 2, 066, 3	867 15.00
17. 00         01700         SOCI AL         SERVICE         49, 702         731         2, 459         8, 754         61, 6	46 17.00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS 4, 451, 014 48, 897 164, 549 510, 168 5, 174, 6	
31. 00 03100 I NTENSI VE_CARE_UNI T 2,087,081 13,180 44,355 299,129 2,443,7	45 31.00
ANCI LLARY SERVICE COST CENTERS	(1) 50.00
50. 00         05000         OPERATI NG ROOM         1, 796, 997         51, 945         174, 805         175, 417         2, 199, 1	
51.00 05100 RECOVERY ROOM 416, 263 0 0 67, 406 483, 6	
54. 00         05400         RADI OLOGY - DI AGNOSTI C         1, 989, 764         26, 837         90, 311         224, 966         2, 331, 8           54. 00         05400         RADI OLOGY - DI AGNOSTI C         1, 989, 764         26, 837         90, 311         214, 430         253, 535	
56. 00         05600         RADI 0I SOTOPE         237, 084         0         0         16, 430         253, 5           57. 00         05700         CT         SCAN         562, 397         4, 672         15, 722         90, 758         673, 5	
58. 00  05800  MRI 380, 728 4, 480 15, 075 48, 217 448, 5	
60. 00 06000 LABORATORY 4, 661, 070 19, 560 65, 822 56, 867 4, 803, 3	
65. 00 06500 RESPI RATORY THERAPY 1, 088, 353 9, 051 30, 460 166, 828 1, 294, 6	
66. 00 06600 PHYSI CAL THERAPY 1, 087, 389 9, 962 33, 522 135, 082 1, 265, 9	
67.00 06700 0CCUPATIONAL THERAPY 332,419 5,294 17,815 54,944 410,4	
68.00 06800 SPEECH PATHOLOGY 194,000 1,816 6,112 31,736 233,6	
69. 00 06900 ELECTROCARDI 0LOGY 1, 017, 263 23, 426 78, 832 68, 904 1, 188, 4	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 368,358 0 0 0 368,3	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 186, 254 0 0 0 186, 2	
73. 00 07300 DRUGS CHARGED TO PATIENTS 14, 742, 704 0 0 0 14, 742, 7	/04 73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 85, 185 1, 578 5, 311 13, 225 105, 2	99 76.97
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0	0 77.00
78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0	0 78.00
OUTPATI ENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 1, 379, 547 31, 772 106, 917 204, 057 1, 722, 2	
90. 01 09001 CLINIC - DIABETES 0 0 0 0	0 90.01
91. 00 09100 EMERGENCY 9, 278, 544 24, 641 82, 921 611, 969 9, 998, 0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0 92.00
OTHER REIMBURSABLE COST CENTERS	0 102.00
102.00         OPI OI D         TREATMENT         PROGRAM         O<	0102.00
	49 118. 00
	52 190. 00
	25 192.00
	74 194.00
	75 194. 02
194. 03 07953 HOME CARE 0 0 0 0	0 194.03
200.00 Cross Foot Adjustments	0 200. 00
201.00 Negative Cost Centers 0 0 0	0 201.00
	375 202. 00

Health Financial Systems         INDI           COST ALLOCATION - GENERAL SERVICE COSTS         INDI			Provider C	CN: 15-1328	Peri od:	Worksheet B	
					From 01/01/2023	Part I	
					To 12/31/2023	Date/Time Pre 5/29/2024 2:1	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVIC	E		
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS			1			
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	44 400 704					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 432, 701					5.00
7.00	00700 OPERATION OF PLANT	1, 127, 899					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	48, 603	30, 160				8.00
9.00	00900 HOUSEKEEPI NG	281, 874			0 1, 430, 996		9.00
10.00		169, 363	145, 712		0 61, 443	1, 025, 494	
11.00		96, 469			0 37, 465		
13.00		695, 165			0 102, 880		
14.00		227,013			0 71, 534	0	
15.00		539, 260			0 34, 261	0	
17.00		16, 088	6, 647		0 2,803	0	17.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 050 400	444.00/	00/ 57	407.50/	700.000	1
30.00		1, 350, 423					
31.00		637, 744	119, 920	58, 43	50, 567	226, 111	31.00
	ANCI LLARY SERVI CE COST CENTERS	570.04/	470 (45		400.005		1 50 00
50.00		573, 916			0 199, 285	0	
51.00		126, 223	0		0 0	0	
54.00		608, 550	244, 170	)	0 102, 960		
56.00		66, 160	10 50		0 0	0	
57.00		175, 776	42, 506		0 17, 923	0	
58.00		117,045			0 17, 187	0	
60.00		1, 253, 522	177, 962		0 75,042	0	
65.00		337, 876			0 34, 726	0	
66.00		330, 376	90, 633		0 38, 218	0	
67.00		107, 121	48, 166		0 20, 310	0	
68.00		60, 979	16, 524		0 6, 968	0	
69.00		310, 143	213, 136		0 89, 874	0	
71.00		96, 130	0	)	0 0	0	
72.00		48, 607	0	)	0 0	0	
73.00		3, 847, 431	11.050		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	27, 480	14, 359		0 6, 055	0	
77.00		0	0		0 0	0	
78.00		0	C	)	0 0	0	78.00
~ ~	OUTPATIENT SERVICE COST CENTERS	440 4/7	200.0/0	J	0 101 000	0	00.00
90.00		449, 467	289, 069		0 121, 893	0	
90.01	09001 CLINIC - DIABETES	0	004 100		0 04 525	0	
91.00		2, 609, 198	224, 190		0 94, 535	0	
92.00							92.00
102 0	OTHER REIMBURSABLE COST CENTERS 0 10200 OPI 0I D TREATMENT PROGRAM	0	C	1	0 0	0	1102 00
102.0	SPECIAL PURPOSE COST CENTERS	0		/	0 0	0	102.00
110 0		16 225 001	2 254 500	245.00	1 272 525	1 005 404	1110 00
118.0		16, 335, 901	3, 356, 508	265, 00	1, 373, 525	1, 025, 494	118.00
	NONREI MBURSABLE COST CENTERS	10 017	36, 466	I	0 15 377		100 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 217			0 15, 377		190.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	65, 588					192.00
	007950 OCCUPATIONAL HEALTH	13, 929			0 42,094		194.00
	2 07952 BLOOMNGTN AMBULANCE AND OCC MED	7,066	246, 336		0 0		194.02
	3 07953 HOME CARE	0			0	0	194.03
200.0		_			0	_	200.00
201.0 202.0		0					201.00
	UN TOTAL (SUM LINES LIX INFOURD 201)	16, 432, 701	5, 449, 849	265,00	1, 430, 996	1, 025, 494	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CC	Provider CCN: 15-1328		Worksheet B Part I Date/Time Prepa 5/29/2024 2:18	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	SOCIAL SERVICE	
		11.00	13.00	14.00	15.00	17.00	
	GENERAL SERVICE COST CENTERS		1				
	DO100 CAP REL COSTS-BLDG & FIXT						1
	DO200 CAP REL COSTS-MVBLE EQUIP						2
	00400 EMPLOYEE BENEFITS DEPARTMENT						4
	DO500 ADMINISTRATIVE & GENERAL						5
	00700 OPERATION OF PLANT						7
	DO800 LAUNDRY & LINEN SERVICE						8
	DO900 HOUSEKEEPI NG						9
	D1000 DI ETARY						10
	D1100 CAFETERI A	592, 438	1				11
	D1300 NURSI NG ADMI NI STRATI ON	40, 504					13
	01400 CENTRAL SERVICES & SUPPLY	5, 903		1, 343, 97	'3		14
	D1500 PHARMACY	21, 610		21, 62	2, 764, 372		15
-	D1700 SOCIAL SERVICE	1, 581	0		0 0	88, 765	17
	NPATIENT ROUTINE SERVICE COST CENTERS		1 1			1	-
	D3000 ADULTS & PEDI ATRI CS	93, 825		110, 38			
	D3100 I NTENSI VE CARE UNI T	45, 863	543, 345	39, 68	37 3, 587	19, 572	31
	ANCILLARY SERVICE COST CENTERS		,		- 1		
	D5000 OPERATI NG ROOM	29, 908		287, 07			
	D5100 RECOVERY ROOM	9, 533	153, 088	1, 51	2 110	0	51
	05400 RADI OLOGY-DI AGNOSTI C	35, 712	397	38, 44	4 2, 654	0	54
o. 00  0	D5600 RADI OI SOTOPE	2, 692	0	53	39 113	0	56
7.00	D5700 CT SCAN	16, 448	0	4, 36	592	0	57
3.00	05800 MRI	9, 138	0	51	9 57	0	58
0.00	D6000 LABORATORY	52, 111	0		0 0	0	60
5.00 0	06500 RESPI RATORY THERAPY	30, 822	0	70, 61	4 0	0	65
5.00 0	D6600 PHYSI CAL THERAPY	24, 623	0	12	29 0	0	66
7.00	06700 OCCUPATI ONAL THERAPY	9, 089	0		0 0	0	67
3.00	D6800 SPEECH PATHOLOGY	4, 569	0		0 0	0	68
9.00	06900 ELECTROCARDI OLOGY	11, 015	93, 995	25, 85	51 386	0	69
. 00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	388, 08	32 0	0	71
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	196, 22	27 0	0	72
. oo	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 708, 211	0	73
. 97 0	07697 CARDI AC REHABI LI TATI ON	2,643	0		0 0	0	76
	D7700 ALLOGENEIC HSCT ACQUISITION	0	1		0 0	0	77
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78
C	DUTPATIENT SERVICE COST CENTERS				L		
. 00	09000 CLINIC	35, 366	354, 959	14, 43	6, 498	0	90
. 01 0	D9001 CLINIC - DIABETES	0	0		0 0	0	90
	09100 EMERGENCY	108, 396	1, 102, 950	144, 45	28, 451	0	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	OTHER REIMBURSABLE COST CENTERS		1 1		1		
	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102
	SPECIAL PURPOSE COST CENTERS		· ·		- <u>-</u>		
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	591, 351	3, 746, 303	1, 343, 93	2, 764, 372	88, 765	1118
	NONREI MBURSABLE COST CENTERS			.,	_/		1
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 087	0		0 0	0	190
2.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	., 507	0	3	34 0		192
	07950 OCCUPATI ONAL HEALTH	0			0 0		194
	07952 BLOOMNGTN AMBULANCE AND OCC MED	0			0 0		194
	07953 HOME CARE	0					194
4.03 0.00	Cross Foot Adjustments	0			0		200
1.00	Negative Cost Centers	^	_		0	_	200
	TOTAL (sum lines 118 through 201)	592, 438	3, 746, 303	1, 343, 97	0 73 2, 764, 372		
2.00		597 438	u .5 /40 .5().51	1. 343. 97	a z. 704. 372	i 88./65	120.

ST ALLOCATION	- GENERAL SERVICE COSTS		Provider CC	N: 15-1328	Period:	Worksheet B
					From 01/01/2023 To 12/31/2023	Part I Date/Time Prepared 5/29/2024 2:18 pm
Cost	Center Description	Subtotal	Intern &	Total		<u>372772024 2.10 pm</u>
		F	Residents Cost			
			& Post			
			Stepdown			
		24.00	Adjustments 25.00	26.00		
GENERAL SI	ERVICE COST CENTERS	24.00	23.00	20.00		
	REL COSTS-BLDG & FIXT					1. (
	REL COSTS-MVBLE EQUI P					2.0
	OYEE BENEFITS DEPARTMENT					4. (
	NI STRATI VE & GENERAL					5. (
	ATION OF PLANT					7. (
00 00800 LAUN	IDRY & LINEN SERVICE					8. (
оо 00900 ноиз						9. (
. 00 01000 DI ET	ARY					10. (
. 00 01100 CAFE	TERIA					11. (
. 00 01300 NURS	SENG ADMENISTRATION					13. (
. 00 01400 CENT	RAL SERVICES & SUPPLY					14. (
. 00 01500 PHAF	MACY					15. (
. 00 01700 SOCI	AL SERVICE					17. (
I NPATI ENT	ROUTINE SERVICE COST CENTERS					
. 00 03000 ADUL	TS & PEDIATRICS	9, 750, 147	0	9, 750, 1	47	30. 0
	INSIVE CARE UNIT	4, 188, 572	0	4, 188, 5	72	31. (
	SERVICE COST CENTERS					
	ATING ROOM	3, 959, 984	0	3, 959, 9		50.0
. 00 05100 RECO		774, 135	0	774, 1		51.0
	OLOGY-DI AGNOSTI C	3, 364, 765	0	3, 364, 7		54.0
. 00 05600 RADI		323, 018	0	323, 0		56.0
.00 05700 CT S	SCAN	931, 161	0	931, 1		57.0
. 00 05800 MRI		633, 204	0	633, 2		58.0
. 00 06000 LABO		6, 361, 956	0	6, 361, 9		60.0
	PIRATORY THERAPY	1, 851, 082	0	1, 851, 0		65. (
	SICAL THERAPY	1, 749, 934	0	1, 749, 9		66. (
	IPATI ONAL THERAPY	595, 158	0	595, 1		67.0
	CH PATHOLOGY	322, 704	0	322, 7		68.0
		1, 932, 825	0	1, 932, 8		69.0
	CAL SUPPLIES CHARGED TO PATIENT	852, 570	0	852, 5		71. (
	DEV. CHARGED TO PATIENTS	431,088	0	431,0		72.0
	S CHARGED TO PATIENTS DIAC REHABILITATION	21, 298, 346 155, 836	0	21, 298, 3 155, 8		73. (
	DENELC HSCT ACQUISITION	155, 850	0	100, 0	0	70.
	T-CELL IMMUNOTHERAPY	0	0		0	78.0
	SERVICE COST CENTERS		<u> </u>		0	70.0
. 00 09000 CLIN		2, 993, 980	0	2, 993, 9	80	90.0
	II C – DI ABETES	2, 770, 700	0	2, 770, 7	0	90.0
00 09100 EMER		14, 310, 251	0	14, 310, 2	-	91. 0
	RVATION BEDS (NON-DISTINCT PART	11,010,201	0	11,010,2		92.0
	IBURSABLE COST CENTERS					72.0
	DID TREATMENT PROGRAM	0	0		0	102.0
	JRPOSE COST CENTERS		-1			
	OTALS (SUM OF LINES 1 through 117)	76, 780, 716	0	76, 780, 7	16	118. (
	RSABLE COST CENTERS		-1			
	, FLOWER, COFFEE SHOP & CANTEEN	102, 299	0	102, 2	99	190. (
	SICIANS' PRIVATE OFFICES	2,027,660	0	2,027,6		192. (
	IPATI ONAL HEALTH	209, 223	0	209, 2		194. (
	MNGTN AMBULANCE AND OCC MED	280, 477	0	280, 4		194. (
4. 03 07953 HOME		0	0		0	194. (
	s Foot Adjustments	0	0		0	200. (
	tive Cost Centers	0	0		0	201. (
	L (sum lines 118 through 201)	79, 400, 375	0	79, 400, 3	75	202. (

		DIANA UNIVERSITY				u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2023 o 12/31/2023	Worksheet B Part II Date/Time Pre	epared:
				LATED COSTS		5/29/2024 2:1	8 pm
			CAFITAL KLI	LATED COSTS			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
	OFNERAL CERVICOE ODOT OFNITERO	0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 196	7, 390	9, 586	9, 586	
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	0	109, 410		477, 593	306	
7.00	00700 OPERATI ON OF PLANT	0	88, 151		384, 794	337	
8.00	00800 LAUNDRY & LINEN SERVICE	0	3, 315		14, 470	0	
9.00	00900 HOUSEKEEPING	0	7, 586		33, 114	244	
10.00	01000 DI ETARY	0	16, 015		69, 909	129	
11.00	01100 CAFETERI A	0	9, 765		42, 627	68	
13.00	01300 NURSING ADMINISTRATION	0	26, 816	90, 241	117, 057	806	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	18, 646	62, 746	81, 392	46	14.00
15.00	01500 PHARMACY	0	8, 930	30, 052	38, 982	401	15.00
17.00	01700 SOCIAL SERVICE	0	731	2, 459	3, 190	23	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	0	48, 897		213, 446		
31.00	03100 I NTENSI VE CARE UNI T	0	13, 180	44, 355	57, 535	778	31.00
50.00	ANCI LLARY SERVICE COST CENTERS		54.045	474.005	00/ 750	454	1 50 00
50.00	05000 OPERATING ROOM	0	51, 945		226, 750	456	
51.00	05100 RECOVERY ROOM	0	0	0 00 011	117 140	175	
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	0	26, 837	90, 311	117, 148	585	
57.00	05700 CT SCAN	0	4, 672	-	20, 394	43 236	
58.00	05800 MRI	0	4, 672		19, 555	125	
60.00	06000 LABORATORY	0	19, 560		85, 382	148	
65.00	06500 RESPIRATORY THERAPY	0	9, 051		39, 511	434	
66.00	06600 PHYSI CAL THERAPY	0	9, 962		43, 484	351	
67.00	06700 OCCUPATI ONAL THERAPY	0	5, 294		23, 109	143	
68.00	06800 SPEECH PATHOLOGY	0	1, 816	6, 112	7, 928	83	68.00
69.00	06900 ELECTROCARDI OLOGY	0	23, 426	78, 832	102, 258	179	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0	1, 578	5, 311	6, 889	34	
77.00	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0	0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
00.00			21 772	10/ 017	120 (00	E 2 1	
90. 00 90. 01		0	31, 772	106, 917	138, 689	531	
90.01 91.00	09001 CLINIC - DIABETES 09100 EMERGENCY	0	24, 641	82, 921	107, 562	1, 590	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	24, 041	02, 921	107, 582	1, 590	91.00
92.00	OTHER REIMBURSABLE COST CENTERS				U		92.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS				0		102.00
118.00		0	568, 672	1, 913, 682	2, 482, 354	9, 578	118.00
	NONREI MBURSABLE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,008	13, 488	17, 496	8	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	188, 024	0	188, 024		192.00
	07950 OCCUPATI ONAL HEALTH	0	10, 972	36, 922	47, 894	0	194.00
	07952 BLOOMNGTN AMBULANCE AND OCC MED	0	27, 075	0	27, 075		194. 02
194.03	07953 HOME CARE	0	0	0	0	0	194.03
200.00					0		200.00
201.00			0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	798, 751	1, 964, 092	2, 762, 843	9, 586	202.00

Heal th	Fina	nci	al S	yste	ems		
	TLON	OF	CADI	TAI	DEL	ATED	

	Financial Systems INL NTION OF CAPITAL RELATED COSTS	DIANA UNIVERSITY	Provider C		eriod:	Worksheet B	2552-10
ALLOUP	TION OF CALLINE RELATED COSTS				rom 01/01/2023	Part II	epared:
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LI NEN SERVI CE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	477, 899					5.00
7.00	00700 OPERATION OF PLANT	32, 804	417, 935				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 414	2, 313				8.00
9.00	00900 HOUSEKEEPING	8, 198	5, 293		46, 849		9.00
10.00	01000 DI ETARY	4, 926	11, 174		2, 012	88, 150	
11.00	01100 CAFETERIA	2, 806	6, 814		1, 227	00, 150	
13.00	01300 NURSI NG ADMI NI STRATI ON	20, 218	18, 710		3, 368	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	6,602	13,009		2, 342	0	
15.00	01500 PHARMACY	15, 684	6, 231		1, 122	0	
17.00	01700 SOCIAL SERVICE	468	510	0	92	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	39, 275	34, 117		6, 142	68, 714	
31.00	03100 I NTENSI VE CARE UNI T	18, 548	9, 196	4, 012	1, 655	19, 436	31.00
	ANCI LLARY SERVI CE COST CENTERS	1					-
50.00	05000 OPERATI NG ROOM	16, 692	36, 244		6, 523	0	
51.00	05100 RECOVERY ROOM	3, 671	0	-	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 699	18, 725	0	3, 371	0	
56.00	05600 RADI OI SOTOPE	1, 924	0	0	0	0	56.00
57.00	05700 CT SCAN	5, 112	3, 260	0	587	0	57.00
58.00	05800 MRI	3, 404	3, 126	0	563	0	58.00
60.00	06000 LABORATORY	36, 457	13, 647	0	2, 457	0	60.00
65.00	06500 RESPI RATORY THERAPY	9, 827	6, 315	0	1, 137	0	65.00
66.00	06600 PHYSI CAL THERAPY	9, 609	6, 950	0	1, 251	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 115	3, 694	0	665	0	67.00
68.00	06800 SPEECH PATHOLOGY	1, 774	1, 267	0	228	0	68.00
69.00	06900 ELECTROCARDI OLOGY	9,020	16, 345	0	2, 942	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 796	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 414	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	111, 871	0	0	0	0	73.00
76.97	07697 CARDI AC REHABI LI TATI ON	799	1, 101	0	198	0	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	
	OUTPATIENT SERVICE COST CENTERS	-		-	-	-	
90.00	09000 CLINIC	13,072	22, 168	0	3, 991	0	90.00
90.01	09001 CLINIC - DIABETES	0	0		0, 7, 7	0	
91.00	09100 EMERGENCY	75, 885	17, 193		3, 095	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	75,005	17,175	0	3, 073	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
118.00		475,084	257, 402	18, 197	44, 968	00 150	118.00
116.00	NONREIMBURSABLE COST CENTERS	475,064	237, 402	10, 197	44, 900	66, 150	118.00
100.00		207	2 704	0	FOO	0	1100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	297	2, 796		503		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 908	131, 191		1 070		192.00
	07950 OCCUPATI ONAL HEALTH	405	7, 655		1, 378		194.00
	207952 BLOOMNGTN AMBULANCE AND OCC MED	205	18, 891		0		194.02
	07953 HOME CARE	0	0	0	0	0	194.03
200.00							200.00
201.00	U U U U U U U U U U U U U U U U U U U	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	477, 899	417, 935	18, 197	46, 849	88, 150	202.00

ALLOCATION	I OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/29/2024 2:1	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
		11.00	13.00	14.00	15.00	17.00	
	ERAL SERVICE COST CENTERS						
	00 CAP REL COSTS-BLDG & FIXT						1.0
	00 CAP REL COSTS-MVBLE EQUIP						2.0
	00 EMPLOYEE BENEFITS DEPARTMENT						4. C
	00 ADMINISTRATIVE & GENERAL						5.0
	OO OPERATION OF PLANT						7.C
	00 LAUNDRY & LINEN SERVICE						8.0
	00 HOUSEKEEPI NG						9.0
	00 DI ETARY						10. C
	00 CAFETERI A	53, 542					11. C
	00 NURSING ADMINISTRATION	3, 661					13.0
	00 CENTRAL SERVICES & SUPPLY	533		103, 92			14.0
	00 PHARMACY	1, 953		1, 67			15.0
	00 SOCI AL SERVI CE	143	0		0 0	4, 426	17. C
	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	8, 479		8, 53		3, 450	
	DO INTENSIVE CARE UNIT	4, 145	23, 760	3, 06	9 86	976	31.0
	I LLARY SERVICE COST CENTERS					-	1
	OO OPERATING ROOM	2, 703		22, 19		0	
	DO RECOVERY ROOM	862		11		0	
	00 RADI OLOGY-DI AGNOSTI C	3, 228		2, 97		0	
	00 RADI OI SOTOPE	243		4		0	
	DO CT SCAN	1, 487		33		0	
	DO MRI	826		4		0	
	00 LABORATORY	4, 710			0 0	0	
	00 RESPI RATORY THERAPY	2, 786		5, 46		0	
	00 PHYSI CAL THERAPY	2, 225		1		0	
	00 OCCUPATIONAL THERAPY	821			0 0	0	
	00 SPEECH PATHOLOGY	413			0 0	0	
	00 ELECTROCARDI OLOGY	995		1, 99		0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0		30, 00		0	
	00 IMPL. DEV. CHARGED TO PATIENTS	0		15, 17		0	
	00 DRUGS CHARGED TO PATIENTS	0			0 64, 704	0	
	97 CARDI AC REHABI LI TATI ON	239			0 0	0	
	DO ALLOGENEIC HSCT ACQUISITION	0			0 0	0	
	DO CAR T-CELL I MMUNOTHERAPY	0	0		0 0	0	78.
	PATIENT SERVICE COST CENTERS	2.10/	15 500	1 11	155	0	
		3, 196	15, 522	1, 11		0	
1	01 CLINIC - DIABETES	0	10, 220	11 17	0 0	0	
		9, 796	48, 230	11, 17	0 680	0	
	00 OBSERVATI ON BEDS (NON-DI STI NCT PART						92. (
	ER REIMBURSABLE COST CENTERS	0	0		0 0	0	100 /
	00 OPI OI D TREATMENT PROGRAM	U	U U		0 0	0	102. (
	CLAL PURPOSE COST CENTERS	E2 444	1/2 020	103, 92	1 (( 045	4 424	1110 /
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	53, 444	163, 820	103, 92	1 66, 045	4, 426	1110. (
	REIMBURSABLE COST CENTERS DO GIFT, FLOWER, COFFEE SHOP & CANTEEN						100 /
70.001900	00 PHYSICIANS' PRIVATE OFFICES	98					190. ( 192. (
72. UU 1920	DUPPHISICIANS PRIVATE UPPICES	0			3 0		
	50 OCCUPATIONAL HEALTH	0			0 0		194.
	52 BLOOMNGTN AMBULANCE AND OCC MED	0	0		0 0		194.
	53 HOME CARE	0	0		0 0	0	194.
00.00	Cross Foot Adjustments	~			0	_	200.
01.00 02.00	Negative Cost Centers		0	100.00			201.
	TOTAL (sum lines 118 through 201)	53, 542	163, 820	103, 92	4 66, 045	4, 426	1202.

Heal th	Fi nanci	ial Syst	ems
ALL 00A		OADL TAL	

	TION OF CAPITAL RELATED COSTS	TANA UNIVERSIT	Provi der CC		Peri od: From 01/01/2023 To 12/31/2023	
	Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
1.00 2.00 4.00 5.00 7.00 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 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					1.00 2.00 4.00 5.00 7.00 8.00 9.00
10. 00 11. 00 13. 00 14. 00 15. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01700 SOCI AL SERVI CE					10.00 11.00 13.00 14.00 15.00 17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	454.052	0	45.4.0	50	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	454, 953 143, 196	0	454, 9 143, 1		30.00 31.00
51.00	ANCI LLARY SERVICE COST CENTERS	143, 190	0	143, 1	70	31.00
50.00	05000 OPERATING ROOM	320, 097	0	320, 0	97	50.00
51.00	05100 RECOVERY ROOM	11, 522	0 0	11, 5		51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	163, 809	0	163, 8		54.00
56.00	05600 RADI OI SOTOPE	2, 255	0	2, 2		56.00
57.00	05700 CT SCAN	31, 428	0	31, 4		57.00
58.00	05800 MRI	27, 640	0	27, 6		58.00
60.00	06000 LABORATORY	142, 801	0	142, 8		60.00
65.00	06500 RESPI RATORY THERAPY	65, 470	0	65, 4		65.00
66.00	06600 PHYSI CAL THERAPY	63, 880	0	63, 8		66.00
67.00	06700 OCCUPATI ONAL THERAPY	31, 547	0	31, 5		67.00
68.00	06800 SPEECH PATHOLOGY	11, 693	0	11, 6		68.00
69.00	06900 ELECTROCARDI OLOGY	137, 857	0	137, 8		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32, 805	0	32, 8		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 587	0	16, 5		72.00
	07300 DRUGS CHARGED TO PATIENTS	176, 575	0	176, 5		73.00
	07697 CARDI AC REHABI LI TATI ON	9, 260	0	9, 2		76.97
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	772	0	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	78.00
	OUTPATIENT SERVICE COST CENTERS	ı				
90.00	09000 CLINIC	198, 440	0	198, 4	40	90.00
90.01	09001 CLINIC - DIABETES	0	0		0	90.01
91.00	09100 EMERGENCY	275, 201	0	275, 2	01	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0	102.00
	SPECIAL PURPOSE COST CENTERS					
118.00		2, 317, 016	0	2, 317, 0	16	118.00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 198	0	21, 1		190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	321, 126	0	321, 1	26	192.00
194.00	07950 OCCUPATI ONAL HEALTH	57, 332	0	57, 3	32	194.00
194.02	07952 BLOOMNGTN AMBULANCE AND OCC MED	46, 171	0	46, 1	71	194.02
101 00	07953 HOME CARE	0	0		0	194.03
194.03						
200.00		0	0		0	200.00
	Cross Foot Adjustments	0 0	0 0		0	200. 00 201. 00

	LOCATI ON - STATI STI CAL BASI S	TANA UNIVERSIT	Provider C	CN: 15-1328 P F	reniod: rom 01/01/2023 o 12/31/2023		 epared
		CAPI TAL REL	LATED COSTS			J72772024 2: 1	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	ENERAL SERVICE COST CENTERS		1			1	
	0100 CAP REL COSTS-BLDG & FIXT	191, 318					1.(
	0200 CAP REL COSTS-MVBLE EQUIP	50/	139, 797				2.0
	0400 EMPLOYEE BENEFITS DEPARTMENT	526				(2.0/7./74	4.0
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT	26, 206 21, 114				62, 967, 674 4, 321, 950	
1	0800 LAUNDRY & LINEN SERVICE	794				186, 241	1
	0900 HOUSEKEEPING	1, 817			-	1, 080, 102	
	1000 DI ETARY	3, 836				648, 976	
	1100 CAFETERIA	2, 339				369, 656	
	1300 NURSI NG ADMI NI STRATI ON	6, 423				2, 663, 773	
	1400 CENTRAL SERVICES & SUPPLY	4, 466				869, 880	
5.00 0	1500 PHARMACY	2, 139			0	2, 066, 367	15. (
7.00 0	1700 SOCIAL SERVICE	175	175	49, 702	0	61, 646	17.
	NPATIENT ROUTINE SERVICE COST CENTERS		1		-	1	
	3000 ADULTS & PEDIATRICS	11, 712					30.0
	3100 INTENSIVE CARE UNIT	3, 157	3, 157	1, 698, 411	0	2, 443, 745	31.0
	NCI LLARY SERVI CE COST CENTERS						
	5000 OPERATING ROOM	12, 442	12, 442			_, ,	
	5100 RECOVERY ROOM	0	0	382, 722		483, 669	
	5400 RADI OLOGY-DI AGNOSTI C	6, 428				2, 331, 878	
	5600 RADI OI SOTOPE	0	-	93, 287		253, 514	
	5700 CT SCAN	1, 119				673, 549	
		1,073				448, 500	
	6000 LABORATORY 6500 RESPI RATORY THERAPY	4, 685 2, 168				4, 803, 319 1, 294, 692	
	6600 PHYSI CAL THERAPY	2, 108				1, 294, 892	
	6700 OCCUPATI ONAL THERAPY	1, 268				410, 472	
	6800 SPEECH PATHOLOGY	435				233, 664	
	6900 ELECTROCARDI OLOGY	5, 611				1, 188, 425	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,011		0,1,220	0	368, 358	
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	-		0	186, 254	
	7300 DRUGS CHARGED TO PATIENTS	0	0	c	0	14, 742, 704	
	7697 CARDI AC REHABI LI TATI ON	378	378	75, 090	0	105, 299	
7. 00 O	7700 ALLOGENEIC HSCT ACQUISITION	0	0	C	0	0	
3. 00 0	7800 CAR T-CELL IMMUNOTHERAPY	0	0	c	0	0	78.
	UTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	7, 610	7, 610	1, 158, 606	0	1, 722, 293	
	9001 CLINIC - DIABETES	0	-	C	0	-	
	9100 EMERGENCY	5, 902	5, 902	3, 474, 686	0	9, 998, 075	91.
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	THER REIMBURSABLE COST CENTERS		0			0	100
	0200 OPI OI D TREATMENT PROGRAM PECIAL PURPOSE COST CENTERS	0	0	C	0	0	102.
		124 200	124 200	20, 917, 725	16 422 701	40 E04 740	110
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	136, 209	136, 209	20, 917, 725	-16, 432, 701	62, 596, 748	118.
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	960	17, 301		39, 152	100
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSICIANS' PRIVATE OFFICES	45, 036		17, 301		251, 325	
	7950 OCCUPATIONAL HEALTH	2, 628		-		53, 374	
	7952 BLOOMNGTN AMBULANCE AND OCC MED	6, 485			0	27, 075	
	7953 HOME CARE	0	0	C	0		194.
0.00	Cross Foot Adjustments						200.
1.00	Negative Cost Centers						201.
2.00	Cost to be allocated (per Wkst. B,	798, 751	1, 964, 092	3, 687, 136		16, 432, 701	
	Part I)						
3.00	Unit cost multiplier (Wkst. B, Part I)	4. 174991	14. 049600			0. 260970	
4.00	Cost to be allocated (per Wkst. B,			9, 586	)	477, 899	204.
	Part II)						
5.00	Unit cost multiplier (Wkst. B, Part			0.000458		0. 007590	205.
							201
06.00	NAHE adjustment amount to be allocated						206.
				1	1	1	1
07.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.

ST AL	LOCATION - STATISTICAL BASIS		Provider CC	1	Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Pre 5/29/2024 2:1	pared
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (TOTAL PATI ENT DAYS)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	CAFETERI A (FTE)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS				1		1 1.
0 00 0 00 0 00 0 00 0 00	DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING	143, 472 794 1, 817	6, 735 0	89, 34			2. 4. 5. 7. 8. 9.
	D1000 DI ETARY	3, 836	0				10.
	D1100 CAFETERIA	2, 339	0	2, 33		23, 988	
	D1300 NURSI NG ADMI NI STRATI ON	6, 423	0	6, 42		1, 640	
	D1400 CENTRAL SERVICES & SUPPLY	4, 466	0			239	
	D1500 PHARMACY	2, 139	0			875	
. 00 0	D1700 SOCIAL SERVICE	175	0	17	5 0	64	17.
I	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS	11, 712	5, 250			3, 799	
	D3100 I NTENSI VE CARE UNI T	3, 157	1, 485	3, 15	7 1, 485	1, 857	31.
	ANCI LLARY SERVI CE COST CENTERS						
	D5000 OPERATING ROOM	12, 442	0			1, 211	
	D5100 RECOVERY ROOM	0	0		0 0	386	
	D5400 RADI OLOGY-DI AGNOSTI C D5600 RADI OI SOTOPE	6, 428	0	6, 42		1, 446 109	54. 56.
	D5700 CT SCAN	1, 119	0	1, 11		666	
	05800 MRI	1, 119	0		-	370	
	D6000 LABORATORY	4, 685	0			2, 110	
	06500 RESPI RATORY THERAPY	2, 168	0			1, 248	
	D6600 PHYSI CAL THERAPY	2, 386	0	2, 38		997	66.
	06700 OCCUPATIONAL THERAPY	1, 268	0			368	
00 0	D6800 SPEECH PATHOLOGY	435	0	43	5 0	185	68.
00 0	D6900 ELECTROCARDI OLOGY	5, 611	0	5, 61	1 0	446	69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
	D7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	07697 CARDI AC REHABI LI TATI ON	378	0	-		107	
	D7700 ALLOGENEIC HSCT ACQUISITION D7800 CAR T-CELL IMMUNOTHERAPY	0	0			0	
-	DUTPATIENT SERVICE COST CENTERS	0	0		<u> </u>	0	/0.
	DOUD CLINIC	7,610	0	7, 61	o l	1, 432	90.
	D9001 CLINIC - DIABETES	0	0		0 0	0	90.
	D9100 EMERGENCY	5, 902	0	5, 90	2 0	4, 389	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.
-	SPECIAL PURPOSE COST CENTERS	00.0(0)		05.75			1
3.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	88, 363	6, 735	85, 75	2 6, 735	23, 944	1118.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	0	96	o lo		190.
	19200 PHYSICIANS' PRIVATE OFFICES	45, 036	0				190.
	07950 OCCUPATI ONAL HEALTH	2, 628	0		-		194.
	07952 BLOOMNGTN AMBULANCE AND OCC MED	6, 485	0	2, 32	o o		194.
	D7953 HOME CARE	0	0		0 0		194.
0. 00	Cross Foot Adjustments						200.
. 00	Negative Cost Centers	F 440 040		1 400 55	1 005 404	F00 400	201.
2.00	Cost to be allocated (per Wkst. B,	5, 449, 849	265, 004	1, 430, 99	6 1, 025, 494	592, 438	202.
3. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	37. 985454	39. 347290	16. 01741	7 152 262400	24.697265	202
. 00	Cost to be allocated (per Wkst. B, Part I) Part II)	37. 985454 417, 935	39. 347290 18, 197			24. 697265 53, 542	
5. 00	Unit cost multiplier (Wkst. B, Part II)	2. 913007	2. 701856	0. 52439	0 13.088344	2. 232033	205.
. 00	NAHE adjustment amount to be allocated						206.
	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.
7.00		1			1		1207.

		I ANA UNI VERSI TY				u of Form CMS-2552-1
COST	ALLOCATION - STATISTICAL BASIS		Provider CC	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B-1
						Date/Time Prepared: 5/29/2024 2:18 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	SOCI AL SERVI CE	
		(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	(TOTAL PATI ENT DAYS)	
		HR)	REQUIS.)			
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.0
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4. 0 5. 0
7.00	00700 OPERATION OF PLANT					7.0
8.00	00800 LAUNDRY & LINEN SERVICE					8.0
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.0 10.0
11.00	01100 CAFETERI A					10.0
13.00	01300 NURSI NG ADMI NI STRATI ON	9, 446				13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 275, 666			14.0
15.00 17.00	01500 PHARMACY 01700 SOCIAL SERVICE	0	20, 524 0			15. 0 17. 0
	INPATIENT ROUTINE SERVICE COST CENTERS			-		
30.00	03000 ADULTS & PEDIATRICS	3, 293	104, 771			30.0
31.00	03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	1, 370	37, 670	19, 529	1, 485	31.0
50.00	05000 OPERATING ROOM	483	272, 483	35, 188	0	50.0
51.00	05100 RECOVERY ROOM	386	1, 435		0	51.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	1	36, 490			54.0
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	0	512 4, 145	615 3, 225		56. 0 57. 0
58.00	05800 MRI	0	493	312		58.0
60.00	06000 LABORATORY	0	0	0		60.0
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	67, 025 122	0	0	65. 0 66. 0
67.00	06700 OCCUPATIONAL THERAPY	0	0	s s	0	67.0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.0
69.00	06900 ELECTROCARDI OLOGY	237	24, 537	2, 101	0	69.0
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	368, 358 186, 254		0	71.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	14, 742, 704	0	73.0
76.97	07697 CARDIAC REHABILITATION	0	0	0	-	76.9
77.00 78.00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0			77. 0 78. 0
70.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	/0.0
90.00	09000 CLINIC	895	13, 701	35, 374		90.0
90. 01 91. 00	09001 CLINIC - DIABETES 09100 EMERGENCY	0 2, 781	0 137, 114	-	-	90. 0 91. 0
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,701	137, 114	154,000	0	92.0
	OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	102. 0
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	9, 446	1, 275, 634	15, 048, 438	6, 735	118.0
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	., 2, 3, 034			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.0
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	0	32	0		192. 0 194. 0
	07950 OCCOPATIONAL HEALTH	0	0	-	0	194. 0
194.03	07953 HOME CARE	0	0	0	0	194. 0
200.00	,,,,,,,					200. 0
201.00 202.00		3, 746, 303	1, 343, 973	2, 764, 372	88, 765	201. 0 202. 0
	Part I)		., 5.6, , 75			
203.00		396. 602054	1.053546			203.0
204.00	Cost to be allocated (per Wkst. B, Part II)	163, 820	103, 924	66, 045	4, 426	204. 0
205.00		17. 342791	0. 081466	0. 004389	0. 657164	205. 0
001 5						
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206. 0
						207.0
207.00						

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 2:1	pared 8 pm
	_	Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	9, 750, 147		9, 750, 1		0	
1.00 03100 INTENSIVE CARE UNIT	4, 188, 572		4, 188, 5	72 0	0	31. C
ANCI LLARY SERVICE COST CENTERS		-				
0.00 05000 OPERATING ROOM	3, 959, 984		3, 959, 98	84 0	0	50.0
1.00 05100 RECOVERY ROOM	774, 135		774, 1	35 0	0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 364, 765		3, 364, 7	65 0	0	54.0
6. 00 05600 RADI 0I SOTOPE	323, 018		323, 0	18 0	0	56.0
7.00 05700 CT SCAN	931, 161		931, 10	61 0	0	57.0
8. 00 05800 MRI	633, 204		633, 20	0 0	0	58.0
0. 00 06000 LABORATORY	6, 361, 956		6, 361, 9	56 0	0	60. (
5. 00 06500 RESPI RATORY THERAPY	1, 851, 082	0	1, 851, 0	32 0	0	65.0
6. 00 06600 PHYSI CAL THERAPY	1, 749, 934	. 0	1, 749, 93	34 0	0	66.0
7.00 06700 OCCUPATI ONAL THERAPY	595, 158	C	595, 1	58 0	0	67.0
8.00 06800 SPEECH PATHOLOGY	322, 704	. 0	322, 70	0 0	0	68.
9. 00 06900 ELECTROCARDI OLOGY	1, 932, 825		1, 932, 8	25 0	0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	852, 570		852, 5	70 0	0	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	431, 088		431, 08	38 0	0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	21, 298, 346		21, 298, 3	46 0	0	73.0
6. 97 07697 CARDI AC REHABI LI TATI ON	155, 836		155, 83	36 0	0	76.
7.00 07700 ALLOGENEIC HSCT ACQUISITION	C			0 0	0	77. (
8.00 07800 CAR T-CELL IMMUNOTHERAPY	C			0 0	0	78. (
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	2, 993, 980		2, 993, 9	80 0	0	90. (
0. 01 09001 CLINIC - DIABETES	C			0 0	0	90.0
1.00 09100 EMERGENCY	14, 310, 251		14, 310, 2	51 0	0	91. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 025, 953		2, 025, 9	53	0	92. (
OTHER REIMBURSABLE COST CENTERS						
02.00 10200 OPI OI D TREATMENT PROGRAM	C			0	0	102.
00.00 Subtotal (see instructions)	78, 806, 669	0	78, 806, 6	69 0	0	200.
01.00 Less Observation Beds	2, 025, 953		2, 025, 9	53	0	201.
02.00 Total (see instructions)	76, 780, 716	c c	76, 780, 7	16 0	0	202.

	5	DIANA UNIVERSITY				u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 2:1	epared: 8 pm
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
		6.00	7.00	8.00	9.00	Rati o 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
30, 00	03000 ADULTS & PEDIATRICS	11, 989, 328		11, 989, 32	8		30.00
31.00	03100 I NTENSI VE CARE UNI T	10, 084, 357		10, 084, 35			31.00
51.00	ANCI LLARY SERVICE COST CENTERS	10,004,337		10,004,30			31.00
50.00	05000 OPERATING ROOM	2, 994, 028	33, 137, 833	36, 131, 86	0. 109598	0.00000	50.00
51.00	05100 RECOVERY ROOM	184, 630	6, 966, 960			0,000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 212, 611	18,010,984	19, 223, 59		0.000000	54.00
56.00	05600 RADI OI SOTOPE	477, 281	3, 655, 487	4, 132, 76	0. 078160	0. 000000	56.00
57.00	05700 CT SCAN	1, 363, 972	15, 687, 705	17, 051, 67	0. 054608	0. 000000	57.00
58.00	05800 MRI	361, 809	3, 545, 335	3, 907, 14	4 0. 162063	0. 000000	58.00
60.00	06000 LABORATORY	5, 381, 121	26, 495, 469	31, 876, 59	0. 199581	0. 000000	60.00
65.00	06500 RESPI RATORY THERAPY	1, 820, 405	5, 503, 369	7, 323, 77	4 0. 252750	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	539, 074	3, 575, 741	4, 114, 81	5 0. 425276	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	550, 756	1, 636, 311	2, 187, 06	0. 272126	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	255, 624	495, 054	750, 67		0. 000000	
69.00	06900 ELECTROCARDI OLOGY	2, 100, 283	11, 636, 890	13, 737, 17		0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	577, 033	1, 905, 037	2, 482, 07		0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	208, 552	952, 338	1, 160, 89		0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 190, 925	84, 761, 082	92, 952, 00		0. 000000	
76.97	07697 CARDI AC REHABI LI TATI ON	0	1, 733, 652	1, 733, 65		0. 000000	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0.000000	0. 000000	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0.000000	0. 000000	78.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS	10 70/	10 000 175	10,110,00		0.00000	
90.00	09000 CLINIC	13, 726	18, 099, 175	18, 112, 90		0.00000	
90.01	09001 CLINIC - DIABETES	0	0	/ E E A E A A	0 0.00000	0.00000	
91.00	09100 EMERGENCY	2, 229, 321	63, 285, 861	65, 515, 18			
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	55, 431	8,071,738	8, 127, 16	0. 249282	0. 000000	92.00
102.00	OTHER REIMBURSABLE COST CENTERS	0	0		0		102.00
200.00		50, 590, 267	309, 156, 021	359, 746, 28	-		200.00
200.00		30, 390, 207	307, 130, 021	337, 140, 28			200.00
201.00		50, 590, 267	309, 156, 021	359, 746, 28	18		201.00
202.00		30, 370, 207	JU7, 1JU, UZT	337,740,20		l	202.00

	DIANA UNIVERSITI				2002 10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 2:	
		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 I NTENSI VE CARE UNI T					31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
57.00 05700 CT SCAN	0. 000000				57.00
58. 00 05800 MRI	0. 000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY 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
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000				90.00
90. 01 09001 CLINIC - DIABETES	0. 000000				90.01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000				92.00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPI OI D TREATMENT PROGRAM					102.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)					202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 2:1	pared: 8 pm
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	9, 750, 147		9, 750, 14		9, 750, 147	30.0
1.00 03100 INTENSIVE CARE UNIT	4, 188, 572		4, 188, 57	72 0	4, 188, 572	31.0
ANCI LLARY SERVI CE COST CENTERS		-				
0.00 05000 OPERATING ROOM	3, 959, 984		3, 959, 98	34 0	3, 959, 984	50.0
1.00 05100 RECOVERY ROOM	774, 135		774, 13		774, 135	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 364, 765		3, 364, 76	5 0	3, 364, 765	54.C
6. 00 05600 RADI 0I SOTOPE	323, 018		323, 01	18 0	323, 018	56.0
7.00 05700 CT SCAN	931, 161		931, 16	51 0	931, 161	57.0
8. 00 05800 MRI	633, 204		633, 20	04 0	633, 204	58. C
0. 00 06000 LABORATORY	6, 361, 956		6, 361, 95	56 0	6, 361, 956	60. C
5. 00 06500 RESPI RATORY THERAPY	1, 851, 082	0	1, 851, 08	32 0	1, 851, 082	65.0
6. 00 06600 PHYSI CAL THERAPY	1, 749, 934	. 0	1, 749, 93	34 0	1, 749, 934	66.0
7.00 06700 OCCUPATI ONAL THERAPY	595, 158	0	595, 15	58 0	595, 158	67.0
8.00 06800 SPEECH PATHOLOGY	322, 704	. 0	322, 70	04 0	322, 704	68. (
9. 00 06900 ELECTROCARDI OLOGY	1, 932, 825		1, 932, 82	25 0	1, 932, 825	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	852, 570		852, 57	70 0	852, 570	71.(
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	431, 088		431, 08	38 0	431, 088	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	21, 298, 346		21, 298, 34	16 0	21, 298, 346	73.0
6. 97 07697 CARDI AC REHABI LI TATI ON	155, 836		155, 83	36 0	155, 836	76. 9
7.00 07700 ALLOGENEIC HSCT ACQUISITION	C			0 0	0	77.0
8.00 07800 CAR T-CELL IMMUNOTHERAPY	C			0 0	0	78.0
OUTPATIENT SERVICE COST CENTERS	_					
0. 00 09000 CLINIC	2, 993, 980		2, 993, 98	30 0	2, 993, 980	90.0
0.01 09001 CLINIC - DIABETES	C			0 0	0	90.0
1.00 09100 EMERGENCY	14, 310, 251		14, 310, 25	51 0	14, 310, 251	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,025,953		2, 025, 95	53	2, 025, 953	92.0
OTHER REIMBURSABLE COST CENTERS						
02.00 10200 OPI OI D TREATMENT PROGRAM	C			0	0	102. (
00.00 Subtotal (see instructions)	78, 806, 669	0	78, 806, 66	59 0	78, 806, 669	
01.00 Less Observation Beds	2, 025, 953		2, 025, 95	53	2, 025, 953	201. (
02.00 Total (see instructions)	76, 780, 716	0	76, 780, 71	16 0	76, 780, 716	202 1

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2023 To 12/31/2023	5/29/2024 2:1	epared: 8 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	11, 989, 328		11, 989, 32	28		30.00
31.00	03100 I NTENSI VE CARE UNI T	10, 084, 357		10, 084, 35	57		31.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	2, 994, 028	33, 137, 833	36, 131, 86	0. 109598	0. 000000	50.00
51.00	05100 RECOVERY ROOM	184, 630	6, 966, 960	7, 151, 59	0. 108247	0.000000	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 212, 611	18, 010, 984	19, 223, 59	0. 175033	0.000000	54.00
56.00	05600 RADI OI SOTOPE	477, 281	3, 655, 487	4, 132, 76	0. 078160	0.000000	56.00
57.00	05700 CT SCAN	1, 363, 972	15, 687, 705	17, 051, 67	0. 054608	0.000000	57.00
58.00	05800 MRI	361, 809	3, 545, 335	3, 907, 14		0.000000	58.00
60.00	06000 LABORATORY	5, 381, 121	26, 495, 469	31, 876, 59		0.000000	
65.00	06500 RESPI RATORY THERAPY	1, 820, 405	5, 503, 369	7, 323, 77		0.00000	
66.00	06600 PHYSI CAL THERAPY	539, 074	3, 575, 741	4, 114, 81	0. 425276	0.00000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	550, 756	1, 636, 311	2, 187, 06		0.000000	
68.00	06800 SPEECH PATHOLOGY	255, 624	495, 054	750, 67		0.000000	
	06900 ELECTROCARDI OLOGY	2, 100, 283	11, 636, 890	13, 737, 17		0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	577, 033	1, 905, 037	2, 482, 07		0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	208, 552	952, 338	1, 160, 89		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	8, 190, 925	84, 761, 082	92, 952, 00		0.000000	
	07697 CARDI AC REHABI LI TATI ON	0	1, 733, 652	1, 733, 65		0.000000	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0.000000	0.000000	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0.000000	0. 000000	78.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	13, 726	18, 099, 175	18, 112, 90		0.000000	
	09001 CLINIC - DIABETES	0	0		0 0.000000	0.000000	
	09100 EMERGENCY	2, 229, 321	63, 285, 861	65, 515, 18		0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	55, 431	8,071,738	8, 127, 16	0. 249282	0. 000000	92.00
100.00	OTHER REIMBURSABLE COST CENTERS		0				100.00
	10200 OPI OI D TREATMENT PROGRAM		0	250 74/ 20	0		102.00
200.00		50, 590, 267	309, 156, 021	359, 746, 28	50		
201.00		50, 590, 267	309, 156, 021	359, 746, 28	00		201.00
202.00		50, 590, 207	309, 150, 021	337, 740, 20			202.00

Health Financial Systems	INDIANA UNIVERSITY I	HEALTH BEDFORD	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 2:18 pm	:
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					_
30. 00 03000 ADULTS & PEDI ATRI CS				30.00	
31. 00 03100 I NTENSI VE CARE UNI T				31.00	0
ANCI LLARY SERVICE COST CENTERS	0.100500				
50. 00 05000 OPERATI NG ROOM	0. 109598			50.00	
51.00 05100 RECOVERY ROOM	0. 108247			51.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 175033			54.00	
56. 00 05600 RADI OI SOTOPE	0.078160			56.00	
57. 00 05700 CT SCAN	0.054608			57.00	
58.00 05800 MRI	0. 162063			58.00	
60. 00 06000 LABORATORY	0. 199581			60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 252750			65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 425276			66.00	
67.00 06700 OCCUPATIONAL THERAPY	0. 272126			67.00	
68.00 06800 SPEECH PATHOLOGY	0. 429883			68.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 140700			69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 343492			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 371343			72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 229133			73.00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 089889			76. 9	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00	0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 165295			90.00	
90. 01 09001 CLINIC - DIABETES	0. 000000			90. 01	
91. 00 09100 EMERGENCY	0. 218426			91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 249282			92.00	0
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPIOLD TREATMENT PROGRAM				102.00	
200.00 Subtotal (see instructions)				200.00	
201.00 Less Observation Beds				201.00	
202.00  Total (see instructions)				202.00	0

Health Fina	ancial Systems IND	DI ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-	2552-10
CALCULATI O	N OF OUTPATIENT SERVICE COST TO CHARGE RA FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2023 To 12/31/2023	5/29/2024 2:1	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS						
	DO OPERATING ROOM	3, 959, 984	320, 097	3, 639, 8	37 0	0	
51.00 0510	DO RECOVERY ROOM	774, 135	11, 522	762, 6	13 0	0	51.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	3, 364, 765	163, 809	3, 200, 9	56 0	0	54.00
56.00 0560	DO RADI OI SOTOPE	323, 018	2, 255	320, 70	53 0	0	56.00
57.00 0570	DO CT SCAN	931, 161	31, 428	899, 7	33 0	0	57.00
58.00 0580	DO MRI	633, 204	27,640	605, 50	64 0	0	58.00
60.00 0600	DOLABORATORY	6, 361, 956	142, 801	6, 219, 1	55 0	0	60.00
65.00 0650	DO RESPI RATORY THERAPY	1,851,082	65, 470	1, 785, 6	12 0	0	65.00
66.00 0660	DO PHYSI CAL THERAPY	1, 749, 934	63, 880	1, 686, 0	54 0	0	66.00
	DO OCCUPATI ONAL THERAPY	595, 158				0	67.00
68.00 0680	DO SPEECH PATHOLOGY	322, 704	11, 693	311, 0	11 0	0	68.00
	DO ELECTROCARDI OLOGY	1,932,825				0	69.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	852, 570				0	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	431,088				0	72.00
	DO DRUGS CHARGED TO PATIENTS	21, 298, 346				0	73.00
	7 CARDI AC REHABI LI TATI ON	155, 836	9, 260			0	76.97
	DO ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
	DO CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78.00
	PATIENT SERVICE COST CENTERS						
	DOCLINIC	2, 993, 980	198, 440	2, 795, 5	10 0	0	90.00
90.01 0900	D1 CLINIC - DIABETES	0	0		0 0	0	90.01
	DO EMERGENCY	14, 310, 251	275, 201	14, 035, 0	50 0	0	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART	2,025,953	94, 533			0	92.00
	R REIMBURSABLE COST CENTERS	2,020,700	, 1, 000	1 17,0171	-0  0		12100
	DO OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
200.00	Subtotal (sum of lines 50 thru 199)	64, 867, 950	-		0		200.00
201.00	Less Observation Beds	2,025,953					201.00
202.00	Total (line 200 minus line 201)	62, 841, 997					202.00
_02.00		52, 5 , , , , ,	.,			0	

Health Financial Systems IND	DI ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-2552	2-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part II Date/Time Prepare 5/29/2024 2:18 pm	
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
		(Worksheet C,				
	Operating Cost P	Part I, column	Ratio (col.	6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	3, 959, 984	36, 131, 861	0. 1095	98	50.	. 00
51.00 05100 RECOVERY ROOM	774, 135	7, 151, 590	0. 1082	47	51.	. 00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 364, 765	19, 223, 595	0. 1750	33	54.	. 00
56. 00 05600 RADI OI SOTOPE	323, 018	4, 132, 768	0. 0781	60	56.	. 00
57.00 05700 CT SCAN	931, 161	17, 051, 677	0. 0546	28	57.	. 00
58. 00 05800 MRI	633, 204	3, 907, 144	0. 1620	63	58.	. 00
60. 00 06000 LABORATORY	6, 361, 956	31, 876, 590	0. 1995	81	60.	. 00
65. 00 06500 RESPI RATORY THERAPY	1,851,082	7, 323, 774		50	65.	. 00
66. 00 06600 PHYSI CAL THERAPY	1, 749, 934	4, 114, 815	0. 4252	76	66.	. 00
67.00 06700 OCCUPATI ONAL THERAPY	595, 158	2, 187, 067			67.	. 00
68.00 06800 SPEECH PATHOLOGY	322, 704	750, 678		83	68.	. 00
69.00 06900 ELECTROCARDI OLOGY	1,932,825	13, 737, 173				. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	852, 570	2, 482, 070			71.	. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	431,088	1, 160, 890			72.	. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	21, 298, 346	92, 952, 007			73.	. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	155, 836	1, 733, 652				. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				. 00
OUTPATIENT SERVICE COST CENTERS	-1					
90. 00 09000 CLINIC	2, 993, 980	18, 112, 901	0. 1652	95	90.	. 00
90. 01 09001 CLINIC - DIABETES	0	0				. 01
91. 00 09100 EMERGENCY	14, 310, 251	65, 515, 182				. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 025, 953	8, 127, 169				. 00
OTHER REIMBURSABLE COST CENTERS	2,020,700	0, 127, 107	0.2472		72.	
102. 00 10200 OPI 0I D TREATMENT PROGRAM	0	0	0.0000	20	102.	00
200.00 Subtotal (sum of lines 50 thru 199)	64, 867, 950	337, 672, 603			200.	
201.00 Less Observation Beds	2, 025, 953	007, 072, 003 N			200.	
202.00 Total (line 200 minus line 201)	62, 841, 997	337, 672, 603			201.	
	02,041,777	557, 572, 005	I	1	202.	

Health Financial Systems IND	DIANA UNIVERSIT	/ HEALTH BEDFOR	RD	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2023 To 12/31/2023	5/29/2024 2:1	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	320, 097	36, 131, 861	0. 00885	59 756, 360	6, 701	50.00
51.00 05100 RECOVERY ROOM	11, 522	7, 151, 590	0. 00161	1 50, 255	81	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	163, 809	19, 223, 595	0. 00852	493, 309	4, 203	54.00
56. 00 05600 RADI OI SOTOPE	2, 255	4, 132, 768	0. 00054	134, 445	73	56.00
57.00 05700 CT SCAN	31, 428	17, 051, 677	0. 00184	318, 575	587	57.00
58. 00 05800 MRI	27,640	3, 907, 144	0.00707	4 137, 866	975	58.00
60. 00 06000 LABORATORY	142, 801	31, 876, 590		1, 933, 863	8, 664	60.00
65. 00 06500 RESPI RATORY THERAPY	65, 470	7, 323, 774	0. 00893	616, 429	5, 510	65.00
66. 00 06600 PHYSI CAL THERAPY	63, 880			24 228, 992	3, 555	66.00
67.00 06700 OCCUPATI ONAL THERAPY	31, 547	2, 187, 067	0. 01442	24 234, 154	3, 377	67.00
68.00 06800 SPEECH PATHOLOGY	11, 693	750, 678	0. 01557	7 127, 681	1, 989	68.00
69. 00 06900 ELECTROCARDI OLOGY	137, 857				8, 389	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32, 805	2, 482, 070	0. 01321	7 185, 699	2, 454	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 587				789	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	176, 575				5, 560	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	9,260				0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000		0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000		0	78.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	198, 440	18, 112, 901	0. 01095	6 0	0	90.00
90. 01 09001 CLINIC - DIABETES	0				0	90.01
91. 00 09100 EMERGENCY	275, 201	65, 515, 182			441	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	94, 533				212	
200.00 Total (lines 50 through 199)	1, 813, 400			9, 158, 303		

Health Financial Systems IN	DIANA UNIVERSITY	HEALTH BEDFOR	RD	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-1328	Period: From 01/01/2023 To 12/31/2023		pared: 8 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	0	1	0 0	0	56.00
57.00 05700 CT SCAN	0	0	1	0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS	-I I		ı			
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
90. 01 09001 CLINIC - DIABETES	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	-	200.00
······································	-1	-	1	-1	-	

Health Financial Systems	IDI ANA UNI VERSI T	Y HEALTH BEDFOR	RD	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS	ERVICE OTHER PASS	S Provider C		Period: From 01/01/2023 To 12/31/2023		
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	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	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	0		0 36, 131, 861		
51.00 05100 RECOVERY ROOM	0	0		0 7, 151, 590		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 19, 223, 595	0. 000000	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 4, 132, 768	0.000000	56.00
57.00 05700 CT SCAN	0	0		0 17, 051, 677	0.000000	57.00
58. 00 05800 MRI	0	0		0 3, 907, 144	0.000000	58.00
60. 00 06000 LABORATORY	0	0		0 31, 876, 590	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 7, 323, 774	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 114, 815	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 187, 067	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 750, 678	0. 000000	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 13, 737, 173	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 482, 070	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 160, 890	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 92, 952, 007	0. 000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 733, 652	0. 000000	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0. 000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0. 000000	78.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 18, 112, 901	0.000000	90.00
90. 01 09001 CLINIC - DIABETES	0	0		0 0	0. 000000	90.01
91.00 09100 EMERGENCY	0	0		0 65, 515, 182	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 8, 127, 169	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 337, 672, 603		200. 00

Health Financial Systems IND	DI ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS			Period: From 01/01/2023 To 12/31/2023	5/29/2024 2:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	756, 360		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	50, 255		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	493, 309		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	134, 445		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	318, 575		0 0	0	57.00
58.00 05800 MRI	0. 000000	137, 866		0 0	0	58.00
60.00 06000 LABORATORY	0. 000000	1, 933, 863		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	616, 429		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	228, 992		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	234, 154		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	127, 681		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	835, 951		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	185, 699		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0, 000000	55, 224		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0, 000000	2, 926, 378		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0, 000000	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0, 000000	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90, 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 CLINIC - DIABETES	0, 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0.000000	104, 858		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	18, 264		0 0	0	92.00
200.00 Total (lines 50 through 199)		9, 158, 303		0 0	0	200.00
<b>3</b>			•			•

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST         Provider CCN: 15-1328         Period: From 01/01/2023         Worksheet D Part V To 12/31/2023         Worksheet D Part V Cost           Cost Center Description         Cost to Charge Ratio From Worksheet C, Part I, col. 9         Title XVIII         Hospital         Cost         Cost         PS Senvices Subject To Ded. & Coin s.         PS Services (see inst.)         Cost         Cost         PS Services Subject To Ded. & Coin s.         PS Services (see inst.)         PS Services Subject To Ded. & Coin s.         PS Services (see inst.)         PS Services Subject To Ded. & Coin s.         PS Services (see inst.)         PS Services (see inst.)         PS Services Subject To Ded. & Coin s.         PS Services (see inst.)         PS Services Subject To Ded. & Coin s.         PS Services (see inst.)         So 00			DIANA UNIVERSITY				u of Form CMS-	2552-10
Image: Construction         To         12/31/2023         Date/Time Prepared: 5/29/2024 2:18 pm           Cost Center Description         Cost to Charge         Cost center Description         Cost to Charge         Cost         Cost         Cost         Cost         PPS Services         Cost	APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C			Worksheet D	
ANCI LLARY SERVICE COST CENTERS         Cost         Cost         Cost         Cost         Cost           ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           Soudo RADIO RECOVERY ROM         0.109598         0         6.716,973         0         0           50.00         05000 (PREDVERY ROM         0.109598         0         6.716,973         0         0           50.00         05000 (PREDVERY ROM         0.108247         0         1.300         2.00         5.00           54.00         05000 (PREDVERY ROM         0.108247         0         1.300,012         0         51.00           54.00         05000 (PREDVERY ROM         0.108247         0         1.00         2.00         56.00           55.00         05000 (PREDVERY ROM         0.108247         0         1.300,012         0         0         51.00           54.00         05400 (RADI LLARY SERVICE COST CENTERS         0.078160         0         1.608,865         0         56.00           55.00         05000 (RADI OLGY-PI AGNOSTIC         0.175033         0         3.345,372         0         0         55.00           65.00         0500 (RADI OLGY-PI AGNATORY         0.29755						From $01/01/2023$	Part V	narodi
Cost Center Description         Cost to Charges Cost to Charges PFS Reinbursed Worksheet C, Part I, col. 9         Title XVIII (see inst.)         Cost Cost (see inst.)         Cost Reinbursed Services Subject To Ded. & Coins.         Cost (see inst.)         PPS Services (see inst.)           NACLLLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           05000 OPERATING ROOM         0.109598         0         6,776,973         0         0         50.00           0.00         05000 RPENATING ROOM         0.109598         0         6,776,973         0         0         51.00           0.00         05000 RADIOLOGY-DIAGNOSTIC         0.175033         0         3.345,372         0         0         51.00           0.00 05600 RADIOLOGY-DIAGNOSTIC         0.178063         0         753,820         0         0         56.00           0.00 06000 RESPI RATORY         0.199981         0         6,009,553         0         0         58.00           0.000 RESPI RATORY THERAPY         0.222276         0         895,859         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.0						10 12/31/2023		pareu. 8 pm
Cost Center Description         Cost to Charge Ratio From Worksheet C, Part I, col. 9         Cost to Charge Services (see inst.)         Cost Reimbursed Services (see inst.)         Cost Reimbursed Services Subject To Ded. & Coins.         PPS Services (see inst.)         (see inst.)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 OPERATING ROM         0.109598         0         6,176,973         0         0         50.00           51.00         05000 RADICLORY DIAMONTIC         0.109598         0         6,176,973         0         0         51.00           56.00         05000 RADICLORY DIAMONTIC         0.109598         0         6,176,973         0         0         56.00           56.00         05000 RADICLORY DIAMONTIC         0.175033         0         3.345,372         0         0         56.00           57.00         05700 CT SCAN         0.56408         0         4,126,143         0         0         57.00           58.00         0800 RESPI RATORY         0.199581         0         6,009,553         0         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         6				Title	XVIII	Hospi tal		
ANCI LLARY SERVICE COST CENTERS         Ratio From Part I, col. 9         Relimbursed inst.)         Relimbursed subject To Ded. & Coin S. (see inst.)         Relimbursed Subject To Ded. & Coin S.         Relimbursed S					Charges		Costs	
ANCI LLARY SERVICE COST CENTERS         Ratio From Part I, col. 9         Relimbursed inst.)         Relimbursed subject To Ded. & Coin S. (see inst.)         Relimbursed Subject To Ded. & Coin S.         Relimbursed S		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
ANCILLARY SERVICE COST CENTERS         Subject To Ded. & Coins. (see inst.)         Subject To Ded. & Coins. (see inst.)         Subject To Ded. & Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           ANCILLARY SERVICE COST CENTERS         0         6.776,973         0         0         5.00           50.00         05400 RADI LOGY-DI AGNOSTI C         0.109598         0         6.776,973         0         0         51.00           56.00         05400 RADI LOGY-DI AGNOSTI C         0.175033         0         3.45,372         0         0         54.00           57.00         05700 CT SCAN         0.054608         0         1,26,143         0         0         57.00           58.00         05800 MRI         0.162063         753,820         0         0         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         68.00			Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
ANCILLARY SERVICE COST CENTERS         Ded. % Coins. (see inst.)         Ded. % Coins. (see inst.)         Ded. % Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           ANCILLARY SERVICE COST CENTERS         0         0.109598         0         6,176,973         0         0.50.00           51.00         05100 RECOVERY ROUM         0.109247         1,330,012         0         51.00           54.00         56.00         05600 RADIOSTIC         0.175033         0         3.45.372         0         0.54.00           56.00         05600 RADIOSTOPE         0.078160         1,068,865         0         0.56.00           57.00         05700 CT SCAN         0.1026430         0.753,820         0         58.00           60.00         06000 RESPI RATORY THERAPY         0.122750         0         1,280,765         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00 <td></td> <td></td> <td></td> <td>inst.)</td> <td>Servi ces</td> <td>Services Not</td> <td></td> <td></td>				inst.)	Servi ces	Services Not		
ANCI LLARY SERVICE COST CENTERS         (see inst.)         (see inst.)         (see inst.)         (see inst.)         (see inst.)           ANCI LLARY SERVICE COST CENTERS         0         0.109598         0         6,176,973         0         0         50.00           50.00         OPERATI NG ROOM         0.109598         0         6,176,973         0         0         51.00           51.00         DS100 RECOVERY ROOM         0.109247         0         1,330.012         0         54.00           56.00         05600 RADI OLOGY-DI AGNOSTI C         0.175033         0         3,345,372         0         0         55.00           57.00         DS700 CT SCAN         0.054608         0         4,126,143         0         0         57.00           58.00         06300 RESPI RATORY THERAPY         0.162663         753.820         0         0         66.00           66:00         06600 RESPI RATORY THERAPY         0.252750         0         1.280,765         0         0         66.00           66:00         06600 PHYSI CAL THERAPY         0.2425276         0         895,859         0         0         66.00           69:00         06000 ELECTROCARDI LOGY         0.429833         0         55.483			Part I, col. 9		Subject To	Subject To		
ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000         OPERATING ROM         0.109598         0         6,176,973         0         0         50.00           51.00         05400         RADIOLOGY-DIAGNOSTIC         0.108247         0         1,330,012         0         0         51.00           54.00         05400         RADIOLOGY-DIAGNOSTIC         0.175033         0         3,345,372         0         0         54.00           56.00         05600         RADIOLOGY-DIAGNOSTIC         0.078160         1,068,865         0         0         55.00           58.00         06000         LABORATORY         0.19581         0         6.009,553         0         66.00           65.00         06500         RESPI RATORY THERAPY         0.252750         1,280,765         0         0         67.00           67.00         06700         0CUPATIONAL THERAPY         0.272126         0         417,308         0         68.00           68.00         06900         ELECTRCARDIOLOGY         0.242983         0         54.433         0         68.00           71.00         07000         MEDI CAL SUPPLIES CHARGED TO PATIEN					Ded. & Coins	Ded. & Coins.		
ANCILLARY SERVICE COST CENTERS           50.00         05000 OPERATING ROOM         0.109598         0         6.176, 973         0         0         50.00           51.00         05100 RECOVERY ROOM         0.108247         0         1.330, 012         0         0         51.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.175033         0         3.345, 372         0         0         54.00           56.00         05500 RD IOSTOPE         0.078160         1.068, 865         0         57.00         57.00         57.00         57.00         57.00         57.00         57.00         58.00         60.00         6.000 LABORATORY         0.162063         0         753, 82.0         0         68.00         66.00         66.00         65.00         65.00         66.00         65.00         66.00         65.00         66.00         65.00         66.00         67.00         67.00         67.00         66.00         67.00								
50.00       05000       0PERATI NC ROOM       0.109598       0       6, 176, 973       0       0       50.00         51.00       RECOVERY ROOM       0.108247       0       1, 330, 012       0       0       51.00         54.00       05400       RADI LOCY-DI AGNOSTI C       0.175033       0       3, 345, 372       0       0       54.00         56.00       05600       RADI OLOCY-DI AGNOSTI C       0.078160       0       1, 068, 865       0       56.00         57.00       05700 CT SCAN       0.054608       0       4, 126, 143       0       0       57.00         60.00       06500 ARDI OLOCY-DI AGNOSTI C       0.162063       0       753, 820       0       0       58.00         65.00       06500 RESPI RATORY THERAPY       0.252750       0       1, 280, 765       0       0       66.00         66.00       06600 PHYSI CAL THERAPY       0.272126       0       417, 308       0       0       68.00         069.00       06200 CLETROCARDI OLOGY       0.140700       2, 516, 543       0       0       68.00         06900       ELCROCARDI OLOGY       0.140700       2, 55, 690       0       71.00       69.00         71.00			1.00	2.00	3.00	4.00	5.00	
51.00       05100       RECOVERY ROOM       0.108247       0       1,330,012       0       51.00         54.00       O5400       RADI OLOGY-DI AGNOSTI C       0.175033       0       3,345,372       0       0       54.00         56.00       O5600       RADI OLOGY-DI AGNOSTI C       0.078160       0       0.68,865       0       0       56.00         57.00       05700       CT SCAN       0.054608       4,126,143       0       57.00         58.00       OS800       NRI       0.162663       753,820       0       66.00         65.00       O6500       CADRATORY       0.199581       0       6.009,553       0       65.00         66.00       06500       RESPI RATORY THERAPY       0.252750       0       1,280,765       0       65.00         66.00       06600       SPEECH PATHOLOGY       0.4225276       895,859       0       66.00       66.00         69.00       06900       ELECTROCARDI OLOGY       0.429883       0       55,483       0       68.00       69.00       67.00       69.00       71.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.								
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.175033       0       3,345,372       0       0       54.00         56.00       05600       RADI OLOGY-DI AGNOSTI C       0.078160       0       1,068,865       0       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       58.00       60.00       58.00       60.00       58.00       60.00       58.00       66.00       66.00       66.00       55.00       0       65.00       0       65.00       0       65.00       0       65.00       0       66.00       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       67.00       0       0       0       77.00 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td>				0			-	
56.00       05600       RADI 0I SOTOPE       0.078160       1,068,865       0       0       56.00         57.00       05700       CT SCAN       0.054608       4,126,143       0       0       57.00         58.00       05800       MRI       0.162063       753,820       0       0       60.00         60.00       06000       LABORATORY       0.199581       0       6.009,553       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.222750       1.280,765       0       65.00         66.00       06700       0CCUPATI ONAL THERAPY       0.272126       417,308       0       66.00         06800       SPEECH PATHOLOGY       0.272126       417,308       0       68.00       69.00         69.00       OTOO OCUPATI ONAL THERAPY       0.2429883       55,483       0       68.00       69.00       71.00       67.00       69.00       71.00       71.00       71.00       71.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00				0			0	
57.00       05700       CT SCAN       0.054608       0       4, 126, 143       0       0       57.00         58.00       05800       MRI       0.162063       0       753, 820       0       0       58.00         60.00       06000       LABORATORY       0.199581       0       6, 009, 553       0       0       65.00         65.00       06500       RESPI RATORY THERAPY       0.252750       0       1, 280, 765       0       66.00         66.00       06400       PHYSI CAL THERAPY       0.425276       0       895, 859       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.227126       0       417, 308       0       67.00         68.00       06800       SPELCTROCARDI OLOGY       0.429883       0       55, 483       0       0       69.00         69.00       06900       ELECTROCARDI OLOGY       0.140700       0       2, 616, 547       0       69.00       71.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       7				0			0	
58.00       05800       MRI       0.162063       0       753,820       0       0       58.00         60.00       06000       LABORATORY       0.199581       0       6,009,553       0       0       65.00         65.00       06500       RESPI RATORY THERAPY       0.252750       0       1,280,765       0       0       65.00         64.00       06000       PHYSI CAL       THERAPY       0.425276       0       895,859       0       0       66.00         67.00       06700       OCCUPATI ONAL       THERAPY       0.272126       0       417,308       0       68.00       68.00       69.00       65.483       0       68.00       68.00       69.00       69.00       69.00       65.483       0       68.00       69.00       0       67.00       69.00       0       71.00       73.00				0			0	
60.00       LABORATORY       0.199581       0       6.009, 553       0       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.252750       0       1.280, 765       0       0       65.00         66.00       06700       0CCUPATI ONAL THERAPY       0.252750       0       895, 859       0       0       66.00         67.00       0CCUPATI ONAL THERAPY       0.272126       0       417, 308       0       0       67.00         68.00       06900       ELECTROCARDI OLOGY       0.140700       2.616, 547       0       0       69.00         71.00       OTIO       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.343492       0       255, 690       0       72.00       72.00       72.00       72.00       072.01       0       72.00       72.00       72.00       72.00       72.00       72.00       72.00       73.00       74.97       67.97       74.97       0				0			0	1
65.00       06500       RESPI RATORY THERAPY       0.252750       0       1,280,765       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.425276       0       895,859       0       0       66.00         67.00       06700       OCUPATI ONAL THERAPY       0.272126       0       417,308       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.272126       0       417,308       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.140700       2,616,547       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.343492       255,690       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.371343       0       152,322       0       0       72.00         73.00       DRUGS CHARGED TO PATI ENTS       0.229133       0       34,502,644       3,694       0       73.00         76.97       ORADI AC REHABLI LTATI ON       0.089889       0       697,382       0       0       76.97         77.00       0700       ALLOGENEI C HSCT ACQUI SI TI ON       0.000000       0       0       0       0				0	753, 82	0 0	0	
66.00       06600       PHYSI CAL THERAPY       0. 425276       0       895,859       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0. 272126       0       417,308       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0. 429883       0       55,483       0       0       69.00         69.00       06900       ELECTROCARDI OLOGY       0. 140700       0       2,616,547       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0. 343492       0       255,690       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0. 371343       0       152,322       0       72.00       73.00         76.97       CARDI AC REHABI LI TATI ON       0. 089889       0       697,382       0       73.00         77.00       0700       CAR T-CELL IMMUNOTHERAPY       0. 000000       0       0       77.00         78.00       07800       CAR T-CELL IMMUNOTHERAPY       0. 000000       0       0       0       90.00         90.01       09000       CLINIC       DI ABETES       0. 0000000       0       0				0	6, 009, 55	3 0	0	
67.00       06700       0CCUPATIONAL THERAPY       0.272126       0       417, 308       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.429883       0       55, 483       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.140700       0       2, 616, 547       0       69.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.343492       0       255, 690       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.229133       0       34, 502, 644       3, 694       0       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.299133       0       407, 382       0       76.97         77.00       07697       CARDI AC REHABILITATION       0.000000       0       0       0       76.97         77.00       07800       CART -CELL IMMUNOTHERAPY       0.000000       0       0       0       0       77.00         78.00       09001       CLI NI C       DI ABETES       0.000000       0       0       0       0       0       0       90.00         90.00       O9000       CLI NI C       DI ABETES       0.0000000	65.00 0650	0 RESPI RATORY THERAPY	0. 252750	0	1, 280, 76	5 0	0	65.00
68.00       06800       SPEECH PATHOLOGY       0.429883       0       55,483       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.140700       0       2,616,547       0       0       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.343492       0       255,640       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.371343       0       152,322       0       0       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.29133       0       34,502,644       3,694       0       73.00         76.97       07697       CARDIA C REHABILITATION       0.089889       0       697,382       0       0       76.97         77.00       0700       ALLOGENEI C HSCT ACQUISITION       0.000000       0       0       0       77.00       77.00       77.00       77.00       0       70.00       78.00       78.00       78.00       78.00       78.00       78.00       79.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<	66.00 0660	0 PHYSI CAL THERAPY		0			0	66.00
69.00       06900       ELECTROCARDIOLOGY       0.140700       0       2,616,547       0       0       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.343492       0       255,690       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.371343       0       152,322       0       0       72.00         73.00       07697       CARDIAC REHABILITATION       0.089889       0       697,382       0       0       73.00         76.97       07600       CARDIAC REHABILITATION       0.089889       0       697,382       0       0       77.00         77.00       07800       CART - CELL IMMUNOTHERAPY       0.000000       0       0       0       78.00         90.00       09000       CLINIC       0.165295       0       5,916,273       679       0       90.00         90.01       09001       CLINIC - DIABETES       0.000000       0       0       0       90.00       90.01         91.00       BSERVATION BEDS (NON-DISTINCT PART       0.249282       0       1,837,066       1,345       0       92.00         90.00       Subtotal (see instructions)       0	67.00 0670	0 OCCUPATI ONAL THERAPY	0. 272126	0	417, 30	0 8	0	67.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.343492       0       255,690       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.371343       0       152,322       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.229133       0       34,502,644       3,694       0       73.00         76.97       07607       CARDI AC REHABI LI TATI ON       0.089889       0       697,382       0       0       76.97         77.00       07700       ALLOGENEI C HSCT ACQUI SI TI ON       0.000000       0       0       0       77.00         78.00       07800       CAR T - CELL I MUNOTHERAPY       0.000000       0       0       0       78.00         90.00       09000       CLINI C       DI ABETES       0.000000       0       0       0       90.00         90.10       09001       CLINI C       DI ABETES       0.000000       0       0       0       90.00       90.01         91.00       09000       CLINI C       DI ABETES       0.218426       12,995,770       448       0       91.00         92.00       085ERVATI ON BEDS (NON-DI STINCT	68.00 0680	O SPEECH PATHOLOGY	0. 429883	0	55, 48	3 0	0	68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.371343       0       152,322       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.229133       0       34,502,644       3,694       0       73.00         76.97       07407       CARDIA C REHABILITATION       0.089889       0       697,382       0       0       76.97         77.00       0700       ALLOGENEIC HSCT ACQUISITION       0.000000       0       0       0       77.00         78.00       07800       CAR T-CELL IMMUNOTHERAPY       0.000000       0       0       0       0       78.00         0000       01000       CLINIC       DIABETES       0.165295       0       5,916,273       679       90.00       90.01         90.00       09000       CLINIC - DIABETES       0.000000       0       0       0       90.00       90.01         91.00       09100       EMERGENCY       0.218426       12,995,770       448       0       91.00         92.00       0826EVATION BEDS (NON-DISTINCT PART       0.249282       1,837,066       1,345       0       92.00         201.00       Less PBP Clinic Lab. Services-Program       0       0	69.00 0690	0 ELECTROCARDI OLOGY	0. 140700	0	2, 616, 54	7 0	0	69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0.229133       0       34, 502, 644       3, 694       0       73.00         76.97       07697       CARDIAC REHABILITATION       0.089889       0       697, 382       0       0       76.97         77.00       0700       ALLOGENEIC HSCT ACQUISITION       0.000000       0       0       0       0       77.00         78.00       07800       CAR T-CELL IMMUNOTHERAPY       0.00000       0       0       0       0       0       78.00         00TPATIENT SERVICE COST CENTERS       0.165295       0       5,916,273       679       0       90.00         90.00       09001       CLINIC - DI ABETES       0.000000       0       0       0       90.01         91.00       09001       EMERGENCY       0.218426       0       12,995,770       448       0       91.00         92.00       0BSERVATION BEDS (NON-DISTINCT PART       0.249282       1,837,066       1,345       92.00       200.00         201.00       Less PBP Clinic Lab. Services-Program Only Charges       0       0       0       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00 <td>71.00 0710</td> <td>O MEDICAL SUPPLIES CHARGED TO PATIENT</td> <td>0. 343492</td> <td>0</td> <td>255, 69</td> <td>0 0</td> <td>0</td> <td>71.00</td>	71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 343492	0	255, 69	0 0	0	71.00
76. 97       07697       CARDI AC REHABI LI TATI 0N       0.089889       0       697, 382       0       0       76. 97         77. 00       07700       ALLOGENEI C HSCT ACQUI SI TI 0N       0.000000       0       0       0       0       0       77. 00         78. 00       07800       CAR T-CELL I MMUNOTHERAPY       0.000000       0       0       0       0       0       78. 00         0017PATI ENT SERVICE COST CENTERS       0       0.165295       0       5, 916, 273       679       0       90. 00       90. 01         90. 00       09000       CLINIC       0.165295       0       5, 916, 273       679       0       90. 00         91. 00       09001       CLINIC - DI ABETES       0.000000       0       0       0       90. 01         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.249282       0       1, 837, 066       1, 345       0       92. 00         200. 00       Subtotal (see instructions)       0       84, 433, 847       6, 166       0       200. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00       201. 00 </td <td>72.00 0720</td> <td>OIMPL. DEV. CHARGED TO PATIENTS</td> <td>0. 371343</td> <td>0</td> <td>152, 32</td> <td>2 0</td> <td>0</td> <td>72.00</td>	72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0. 371343	0	152, 32	2 0	0	72.00
77.00         07700         ALLOGENEIC HSCT ACQUISITION         0.000000         0         0         0         0         77.00           78.00         07800         CAR T-CELL IMMUNOTHERAPY         0.000000         0         0         0         0         78.00           0UTPATIENT SERVICE COST CENTERS         0.000000         0         5,916,273         679         0         90.00           90.00         09000         CLINIC         01ABETES         0.000000         0         0         0         90.01         90.01         90.01         0         0         0         90.01         90.01         90.01         0.18ETES         0.000000         0         0         0         90.01         90.01         90.01         90.01         90.01         91.00         92.00         08SERVATION BEDS (NON-DISTINCT PART         0.218426         0         12,995,770         448         0         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0.249282         0         1,837,066         1,345         0         92.00           200.00         Subtotal (see instructions)         0         84,433,847         6,166         0         200.00         201.00         201.00         201.00	73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 229133	0	34, 502, 64	4 3, 694	0	73.00
78.00         07800         CAR T-CELL IMMUNOTHERAPY         0.00000         0         0         0         0         0         0         78.00           0UTPATI ENT SERVICE COST CENTERS         0.00000         0	76.97 0769	7 CARDIAC REHABILITATION	0. 089889	0	697, 38	2 0	0	76.97
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         0.165295         0         5,916,273         679         0         90.00           90.01         09000         CLINIC - DIABETES         0.000000         0         0         0         90.01           91.00         09100         EMERGENCY         0.218426         0         12,995,770         448         0         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0.249282         0         1,837,066         1,345         0         92.00           200.00         Subtotal (see instructions)         0         84,433,847         6,166         0         200.00           201.00         Less PBP Clinic Lab. Services-Program         0         0         201.00	77.00 0770	O ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
90.00         09000         CLINIC         0.165295         0         5,916,273         679         0         90.00           90.01         09001         CLINIC - DIABETES         0.000000         0         0         0         90.01           91.00         09100         EMERGENCY         0.218426         0         12,995,770         448         0         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0.249282         0         1,837,066         1,345         0         92.00           200.00         Subtotal (see instructions)         0         84,433,847         6,166         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         201.00	78.00 0780	O CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78.00
90. 01         09001         CLINIC - DIABETES         0.000000         0         0         0         0         90. 01           91. 00         09100         EMERGENCY         0.218426         0         12,995,770         448         0         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0.249282         0         1,837,066         1,345         0         92. 00           200. 00         Subtotal (see instructions)         0         84,433,847         6,166         0         200. 00           201. 00         Unit y Charges         0         0         0         0         201. 00	OUTP	ATIENT SERVICE COST CENTERS					_	
91.00         09100         EMERGENCY         0.218426         0         12,995,770         448         0         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0.249282         0         1,837,066         1,345         0         92.00           200.00         Subtotal (see instructions)         201.00         84,433,847         6,166         0         200.00           201.00         Only Charges         Only Charges         0         0         0         201.00	90.00 0900		0. 165295	0	5, 916, 27	3 679	0	90.00
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0. 249282         0         1, 837, 066         1, 345         0         92. 00           200. 00         Subtotal (see instructions)         0         84, 433, 847         6, 166         0         200. 00           201. 00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         201. 00	90.01 0900	1 CLINIC - DIABETES	0. 000000	0		0 0	0	90.01
200.00         Subtotal (see instructions)         0         84, 433, 847         6, 166         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         201.00				0				
201.00     Less PBP Clinic Lab. Services-Program     0     0     201.00       Only Charges     0     0     201.00			0. 249282	0	1, 837, 06			
Only Charges				0	84, 433, 84	7 6, 166	0	
	201.00					0 0		201.00
202.00         Net Charges (line 200 - line 201)         0         84, 433, 847         6, 166         0 202.00								
	202.00	Net Charges (line 200 - line 201)		0	84, 433, 84	6, 166	0	202.00

		I ANA UNI VERSI TY				u of Form CMS-	2552-10
APPORTI ONN	MENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1328	Period: From 01/01/2023	Worksheet D Part V	
					To 12/31/2023	Date/Time Pro	-pared
					10 12/01/2020	5/29/2024 2:	
			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	I LLARY SERVICE COST CENTERS	(7( 00)					
	OO OPERATING ROOM	676, 984	0				50.00
	00 RECOVERY ROOM	143, 970	0				51.00
	00 RADI OLOGY-DI AGNOSTI C	585, 550	0				54.00
	00 RADI OI SOTOPE	83, 542	0				56.00
	00 CT SCAN	225, 320	0				57.00
	OO MRI	122, 166	0				58.00
	00 LABORATORY	1, 199, 393	0				60.00
	00 RESPI RATORY THERAPY	323, 713	0				65.00
	00 PHYSI CAL THERAPY	380, 987	0				66.00
	00 OCCUPATI ONAL THERAPY	113, 560	0				67.00
	00 SPEECH PATHOLOGY	23, 851	0				68.00
	00 ELECTROCARDI OLOGY	368, 148	0				69.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	87, 827	0				71.00
	00 IMPL. DEV. CHARGED TO PATIENTS	56, 564	0				72.00
	00 DRUGS CHARGED TO PATIENTS	7, 905, 694	846				73.00
	97 CARDI AC REHABI LI TATI ON	62, 687	0				76.97
	OO ALLOGENEIC HSCT ACQUISITION	0	0				77.00
	00 CAR T-CELL IMMUNOTHERAPY	0	0				78.00
	PATIENT SERVICE COST CENTERS	T					_
	00 CLINIC	977, 930	112				90.00
	01 CLINIC - DIABETES	0	0				90.01
	00 EMERGENCY	2, 838, 614	98				91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART	457, 947	335				92.00
200.00	Subtotal (see instructions)	16, 634, 447	1, 391				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	16, 634, 447	1, 391				202.00

Health Financial Systems IND	IANA UNIVERSIT	Y HEALTH BEDFOR	RD	In Lie	eu of Form CMS-	2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-1328	Period: From 01/01/2023	Worksheet D Part I		
				To 12/31/2023		pared: 8 pm	
		Titl	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 & PEDI ATRI CS	454, 953	0	454, 95	6, 627	68.65	30.00	
31.00 INTENSIVE CARE UNIT	143, 196		143, 19	76 1, 485	96.43	31.00	
200.00 Total (lines 30 through 199)	598, 149		598, 14	19 8, 112		200.00	
Cost Center Description	I npati ent	Inpati ent			•		
· ·	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6.00	7.00	1				
INPATIENT ROUTINE SERVICE COST CENTERS			•				
30. 00 ADULTS & PEDIATRICS	111	7,620	)			30.00	
31.00 INTENSIVE CARE UNIT	37					31.00	
200.00 Total (lines 30 through 199)	148					200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS         Provider CCN: 15-1328         Period: From 01/01/2023 To 12/31/2024         Worksheet D Date/Time Prepared: 15/29/2024         Displate                  Cost Center Description               Capital Related Cost (From Wist. B, Part II, col. 260               Total Charges (Col. 1 + col. 8)               Capital (Col. Ration of Cost Col. Ration of Cost (Col. Ration of Cost Col. Ration of Cost (Col. Ration of Cost	Health Financial Systems IN	DI ANA UNI VERSI T'	Y HEALTH BEDFOR	RD	In Lie	u of Form CMS-:	2552-10
Cost Center Description         Capital Related Cost (from Wkst. B, Part II, col. 26)         Ratio of Cost (stal Charges (and Cost (from Wkst. B, Part II, col. 2)         Inpatient Program (col umn 3 x col umn 4)         Capital Cost (col umn 3 x col umn 4)           50:00         05000 OPERATI NG ROOM         320,097         36,131,861         0.008859         8,140         72         50.00           50:00         05000 OPERATI NG ROOM         320,097         36,131,861         0.008859         8,140         72         50.00           51:00         05000 RDECOVERY ROOM         11,522         7,151,590         0.001611         0         0         51.00           56:00         05600 RADI LOCY-DI AGNOSTI C         163,809         19,22,555         0.008521         19,63         167         54.00           57:00         05700 CT SCAN         31,428         17,051,677         0.001843         44,677         82         57.00           58:00         06600 RESPI RATORY THERAPY         142,801         31,876,590         0.004440         137,028         614         60.00           66:00         06600 RESPI RATORY THERAPY         63,880         4,114,815         0.015577         5,955         93         68.00           69:00         06400 SPEECH PATHOLOGY         11,693         750,678	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS			From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 5/29/2024 2:1	
Related Cost (From Wkst. C), Part II, col.         to Charges (col. 1 + col.) 2)         Program (Col umn 3 x col umn 4)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 OPERATING ROOM         320,097         36,131,861         0.008859         8,140         72         50.00           54.00         05100 RECOVERY ROOM         11,522         7,151,590         0.001611         0         0         51.00           54.00         05400 RADI OLGY-DI AGNOSTIC         163,809         19,223,595         0.008521         19,634         167         54.00           56.00         05500 CT SCAN         31,428         17,051,677         0.001843         44,677         82         57.00           57.00         05500 RADI OLGYT PLERAPY         142,801         31,876,590         0.004840         137,028         614         60.00           66.00         06600 DHABORATORY         142,801         31,876,590         0.004840         137,028         614         60.00           66.00         06600 PHYSI CAL THERAPY         63,880         4,114,815         0.015524         7,139         111         66.00           66.00         06600 SPECH PATHOLOGY         11,693         13,857<						PPS	
Image: constraint of the service of the ser	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II, col. 26)         8)         2)         0         1           26)         1.00         2.00         3.00         4.00         5.00           ANCI LLARY SERVICE COST CENTERS         320.097         36, 131, 861         0.008859         8, 140         72         50.00           51.00         05000 OPERATI NG ROOM         320.097         36, 131, 861         0.008859         8, 140         72         50.00           54.00         05400 RADI OLGY-DI AGNOSTI C         163, 809         19, 223, 595         0.008521         19, 634         167         54.00           56.00         05500 INSTOPE         2, 255         4, 132, 766         0.001843         44, 677         82         57.00           57.00         05700 CT SCAN         31, 428         17, 051, 677         0.001843         44, 677         82         57.00           58.00         06600 MRI         27, 640         3, 907, 144         0.00774         1, 744         12         58.00           66.00         06600 PHYSI CAL THERAPY         65, 470         7, 323, 774         0.008399         50, 043         447         65.00           67.00         06700 OCCUPATI ONAL THERAPY         63, 867         11, 875, 678         0.015577         5, 955							
26)         1.00         2.00         3.00         4.00         5.00           ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 0PERATI NG ROOM         320.097         36,131,861         0.008859         8,140         72         50.00           51.00         05100 RECOVERY ROOM         11,522         7,151,590         0.001611         0         0         51.00           56.00         05600 RADI OLOGY-DI AGNOSTI C         163,809         19,23,595         0.008521         19,634         167         54.00           56.00         05600 RADI OLOGY-DI AGNOSTI C         12,255         4,132,768         0.000546         4,308         2         56.00           57.00         05700 CT SCAN         31,428         17,051,677         0.001843         44,677         82         57.00           60.00         06000 LABORATORY         142,801         31,876,590         0.004480         137,028         614         60.00           66.00         06600 PHYSI CAL THERAPY         63,880         4,114,815         0.15524         7,139         111         66.00           67.00         0CUPATI ONAL THERAPY         31,8747         2,187,067         0.014		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
ANCI LLARY SERVICE COST CENTERS           ANCI LLARY SERVICE COST CENTERS           ANCI LLARY SERVICE COST CENTERS           50.00         05000         0PERATI NG ROOM         320,097         36,131,861         0.008859         8,140         72         50.00           51.00         05100         RECOVERY ROOM         11,522         7,151,590         0.001611         0         0         51.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         163,809         19,223,595         0.008546         4,308         2         56.00           55.00         05500         RT SCAN         31,428         17,051,677         0.001843         44,677         82         57.00           58.00         05500         RESPI RATORY THERAPY         142,801         31,876,590         0.00480         137,028         6414         60.00           60.00         06000         LABORATORY         11,693         732,774         0.008939         50,043         447         65.00           65.00         066000         PHYSI CAL THERAPY         63,880         4,114,815         0.015524         7,139         111         66.00           66.00         066000         SPEECH PATHOLOGY         11,693         750,678		Part II, col.	8)	2)			
ANCL LLARY SERVICE COST CENTERS           50.00         D5000         DPERATI NG ROOM         320,097         36,131,861         0.008859         8,140         72         50.00           51.00         DS100 RECOVERY ROOM         11,522         7,151,590         0.001611         0         0         51.00           54.00         D5400 RADI OLOGY-DI AGNOSTI C         163,809         19,223,595         0.008521         19,634         167         54.00           55.00         D5600 OSTOPE         2,255         4,132,768         0.000546         4,308         2         55.00           57.00         D5700 CT SCAN         31,428         17,051,677         0.001843         44,677         82         57.00           58.00         D6500 RESPI RATORY THERAPY         142,801         31,876,590         0.004480         137,028         614         60.00           65.00         D6500 OCULABORATORY         142,801         31,876,590         0.004480         137,028         614         60.00           66.00         D6500 OCULABORATORY         142,801         31,876,590         0.004480         137,028         614         60.00           66.00         D6500 OCULABORATORY         63,880         4,114,815         0.015524         7,1							
50.00       05000       0PERATI NG ROOM       320,097       36,131,861       0.008859       8,140       72       50.00         51.00       05100       RECOVERY ROOM       11,522       7,151,590       0.001611       0       0       51.00         54.00       05400       RADI OLGY-DI AGNOSTI C       163,809       19,233,595       0.008521       19,634       167       54.00         55.00       05500       CT SCAN       31,428       17,051,677       0.001843       44,677       82       57.00         58.00       05600       RADI OI SOTOPE       27,640       3,907,144       0.007074       1,744       12       58.00         60.00       06000       LABORATORY       142,801       31,876,590       0.004480       137,028       614       60.00         65.00       06500       RESPI RATORY THERAPY       65,470       7,323,774       0.008939       50.043       447       65.00         66.00       06400       PHYSI CAL THERAPY       31,547       2.187,067       0.01424       8,735       126       67.00         69.00       06400       SPEECH PATHOLOGY       11,693       750,678       0.015577       5,955       93       68.00       69.00 <td< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></td<>		1.00	2.00	3.00	4.00	5.00	
51.00       05100       RECOVERY ROOM       11,522       7,151,590       0.001611       0       0       51.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       163,809       19,223,595       0.008521       19,634       167       54.00         56.00       0500       RADI OLOGY-DI AGNOSTI C       2,255       4,132,768       0.000546       4,308       2       56.00         57.00       05700       CT SCAN       31,428       17,051,677       0.001843       44,677       82       57.00         58.00       05800       MRI       27,640       3,907,144       0.007074       1,744       12       58.00         60.00       06000       LABORATORY       142,801       31,876,590       0.004480       137,028       614       60.00         65.00       05600       RSPI RATORY THERAPY       65,470       7.332,774       0.008939       50,043       447       65.00         65.00       06600       PHYSI CAL THERAPY       63,880       4,114,815       0.015524       7,139       111       66.00         67.00       06700       0C2UPATI ONAL THERAPY       31,547       2,187,067       0.01424       8,735       126       67.00         6	ANCILLARY SERVICE COST CENTERS						
54.00       05400       RADI OLOGY-DI AGNOSTI C       163, 809       19, 223, 595       0.008521       19, 634       167       54.00         56.00       05600       RADI OL OSTOPE       2, 255       4, 132, 768       0.000546       4, 308       2       56.00         57.00       05700       CT SCAN       31, 428       17, 051, 677       0.001843       44, 677       82       57.00         60.00       06000       LABORATORY       142, 801       31, 876, 590       0.004480       137, 028       614       60.00         65.00       06500       RESPI RATORY THERAPY       63, 880       4, 114, 815       0.015524       7, 139       111       66.00         66.00       06600       PHYSI CAL THERAPY       63, 880       4, 114, 815       0.015524       7, 139       111       66.00         67.00       06700       OCCUPATI ONAL THERAPY       31, 547       2, 187, 067       0.014424       8, 735       126       67.00         68.00       06800       SPEECH PATHOLOGY       137, 857       13, 737, 173       0.01035       42, 196       423       69.00       0       72.00       73.00       0.013217       7, 029       93       71.00       72.00       73.00       73.00 <td></td> <td>320, 097</td> <td></td> <td></td> <td>59 8, 140</td> <td>72</td> <td>50.00</td>		320, 097			59 8, 140	72	50.00
56.00       05600       RADI 0I SOTOPE       2,255       4,132,768       0.000546       4,308       2       56.00         57.00       05700       CT SCAN       31,428       17,051,677       0.001843       44,677       82       57.00         58.00       MRI       27,640       3,907,144       0.007074       1,744       12       58.00         60.00       06000       LABORATORY       142,801       31,876,590       0.004480       137,028       614       60.00         65.00       06500       RESPI RATORY THERAPY       65,470       7,323,774       0.008939       50,043       447       65.00         66.00       06600       PHYSI CAL THERAPY       63,880       4,114,815       0.015524       7,139       111       66.00         67.00       06700       0CCUPATI ONAL THERAPY       31,547       2,187,067       0.01424       8,735       126       67.00         68.00       06800       SPEECH PATHOLOGY       11,693       750,678       0.015577       5,955       93       68.00         07100       MEICAL SUPPLIES CHARGED TO PATI ENT       32,805       2,482,070       0.013217       7,029       93       71.00       72.00       73.00       0.010900	51.00 05100 RECOVERY ROOM	11, 522	7, 151, 590	0.00161	1 0	0	51.00
57.00       05700       CT SCAN       31,428       17,051,677       0.001843       44,677       82       57.00         58.00       05800       MRI       27,640       3,907,144       0.007074       1,744       12       58.00         60.00       06000       LABORATORY       142,801       31,876,590       0.004480       137,028       614       60.00         65.00       06500       RESPI RATORY THERAPY       65,470       7,323,774       0.008939       50,043       447       65.00         66.00       06600       PHYSI CAL THERAPY       63,880       4,114,815       0.015524       7,139       111       66.00         67.00       06700       OCCUPATI ONAL THERAPY       31,547       2,187,067       0.014424       8,735       126       67.00         68.00       06900       ELECTROCARDI OLOGY       11,693       750,678       0.015577       5,955       93       68.00         69.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       32,805       2,482,070       0.013217       7,029       93       71.00         71.00       07000       RUGS CHARGED TO PATI ENTS       16,587       1,160,890       0.014288       0       0       72.00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	163, 809	19, 223, 595	0. 00852	19, 634	167	54.00
58.00       05800       MRI       27,640       3,907,144       0.007074       1,744       12       58.00         60.00       06000       LABORATORY       142,801       31,876,590       0.004480       137,028       614       60.00         65.00       06500       RESPI RATORY THERAPY       65,470       7,323,774       0.008939       50,043       447       65.00         64.00       06600       PHYSI CAL THERAPY       63,880       4,114,815       0.015524       7,139       111       66.00         67.00       06700       0CCUPATI ONAL THERAPY       31,547       2,187,067       0.014224       8,735       126       67.00         68.00       06800       SPEECH PATHOLOGY       11,693       750,678       0.015577       5,955       93       68.00         69.00       06900       ELCTROCARDI OLOGY       137,857       13,737,173       0.010035       42,196       423       69.00         71.00       07100       MEIGA SCHARGED TO PATI ENT       32,805       2,482,070       0.013217       7,029       93       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       176,575       92,952,007       0.001900       232,898       443       73.00	56. 00 05600 RADI OI SOTOPE	2, 255	4, 132, 768	0.00054	4, 308	2	56.00
60.00       06000       LABORATORY       142,801       31,876,590       0.004480       137,028       614       60.00         65.00       06500       RESPI RATORY THERAPY       65,470       7,323,774       0.008939       50,043       447       65.00         66.00       06600       PHYSI CAL THERAPY       63,880       4,114,815       0.015524       7,139       111       66.00         67.00       06700       OCCUPATI ONAL THERAPY       31,547       2,187,067       0.014424       8,735       126       67.00         68.00       06800       SPEECH PATHOLOGY       111,693       750,678       0.015577       5,955       93       68.00         69.00       06900       ELECTROCARDI OLOGY       137,857       13,737,173       0.010035       42,196       423       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       16,587       1,160,890       0.014228       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       176,575       92,952,007       0.001900       232,898       443       73.00         76.97       CARDI AC REHABI LI TATI ON       9,260       1,733,652       0.005341       0       77.00       7	57.00 05700 CT SCAN	31, 428	17, 051, 677	0. 00184	44, 677	82	57.00
60.00       06000       LABORATORY       142,801       31,876,590       0.004480       137,028       614       60.00         65.00       06500       RESPI RATORY THERAPY       65,470       7,323,774       0.008939       50,043       447       65.00         66.00       06600       PHYSI CAL THERAPY       63,880       4,114,815       0.015524       7,139       111       66.00         67.00       06700       OCCUPATI ONAL THERAPY       31,547       2,187,067       0.014424       8,735       126       67.00         68.00       06800       SPEECH PATHOLOGY       111,693       750,678       0.015577       5,955       93       68.00         69.00       06900       ELECTROCARDI OLOGY       137,857       13,737,173       0.010035       42,196       423       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       16,587       1,160,890       0.014228       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       176,575       92,952,007       0.001900       232,898       443       73.00         76.97       CARDI AC REHABI LI TATI ON       9,260       1,733,652       0.005341       0       77.00       7	58. 00 05800 MRI	27, 640	3, 907, 144	0.00707	4 1, 744	12	58.00
65.00       06500       RESPI RATORY THERAPY       65,470       7,323,774       0.008939       50,043       447       65.00         66.00       06600       PHYSI CAL THERAPY       63,880       4,114,815       0.015524       7,139       111       66.00         67.00       06700       OCUPATI ONAL THERAPY       31,547       2,187,067       0.014424       8,735       126       67.00         68.00       06800       SPEECH PATHOLOGY       11,693       750,678       0.015577       5,955       93       68.00         69.00       0E400       ELECTROCARDI OLOGY       137,857       13,737,173       0.010035       42,196       423       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       32,805       2,482,070       0.013217       7,029       93       71.00         72.00       07200       IMPL       DEV. CHARGED TO PATI ENTS       16,587       1,160,890       0.014288       0       0       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       176,575       92,952,007       0.001900       232,898       443       73.00         75.00       07500       ALRGEN TO ACRUI SI TI ON       0       0.005341       0       76.97 </td <td>60. 00 06000 LABORATORY</td> <td>142, 801</td> <td></td> <td></td> <td>137, 028</td> <td>614</td> <td>60.00</td>	60. 00 06000 LABORATORY	142, 801			137, 028	614	60.00
66.00       06600       PHYSI CAL THERAPY       63,880       4,114,815       0.015524       7,139       111       66.00         67.00       06700       OCCUPATI ONAL THERAPY       31,547       2,187,067       0.014424       8,735       126       67.00         68.00       06800       SPEECH PATHOLOGY       11,693       750,678       0.015577       5,955       93       68.00         69.00       06900       ELECTROCARDI OLOGY       137,857       13,737,173       0.010035       42,196       423       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       32,805       2,482,070       0.013217       7,029       93       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       16,587       1,160,890       0.014288       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       176,575       92,92,007       0.001900       232,898       443       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       9,260       1,733,652       0.005341       0       0       76.97         78.00       07000       ALLOGENEI C HSCT ACQUI SI TI ON       0       0       0.000000	65. 00 06500 RESPI RATORY THERAPY	65, 470			50, 043	447	65.00
68.00       06800       SPEECH PATHOLOGY       11, 693       750, 678       0.015577       5, 955       93       68.00         69.00       06900       ELECTROCARDIOLOGY       137, 857       13, 737, 173       0.010035       42, 196       423       69.00         71.00       O7100       MEDICAL SUPPLIES CHARGED TO PATIENT       32, 805       2, 482, 070       0.013217       7, 029       93       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       16, 587       1, 160, 890       0.014288       0       0       72.00         73.00       07300       RCMS CHARGED TO PATIENTS       176, 575       92, 952, 007       0.001900       232, 898       443       73.00         76.97       07697       CARDIAC REHABILITATION       9, 260       1, 733, 652       0.005341       0       0       76.97         77.00       07700       ALLOGENEIC HSCT ACQUISITION       0       0       0.000000       0       77.00         78.00       07800       CAR T-CELL IMMUNOTHERAPY       0       0.000000       0       78.00         70.01       09001       CLINIC       DIABETES       0       0       0.000000       0       90.01         90.01       09	66. 00 06600 PHYSI CAL THERAPY	63, 880			7, 139	111	66.00
69.00       06900       ELECTROCARDIOLOGY       137,857       13,737,173       0.010035       42,196       423       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       32,805       2,482,070       0.013217       7,029       93       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       16,587       1,160,890       0.014288       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       176,575       92,952,007       0.001900       232,898       443       73.00         76.97       07697       CARDIAC REHABILITATION       9,260       1,733,652       0.005341       0       0       77.00         78.00       07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       0       77.00         78.00       09000       CLINIC       198,440       18,112,901       0.010956       0       90.00       90.00       90.00       90.01       90.01         90.01       09000       CLINIC       DIABETES       0       0       0.000000       0       90.00       90.01         91.00       09100       EMERGENCY       275,201       65,515,182       0	67.00 06700 OCCUPATI ONAL THERAPY	31, 547	2, 187, 067	0. 01442	8, 735	126	67.00
69.00       06900       ELECTROCARDIOLOGY       137,857       13,737,173       0.010035       42,196       423       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       32,805       2,482,070       0.013217       7,029       93       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       16,587       1,160,890       0.014288       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       176,575       92,952,007       0.001900       232,898       443       73.00         76.97       07697       CARDIAC REHABILITATION       9,260       1,733,652       0.005341       0       0       77.00         78.00       07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       0       77.00         78.00       09000       CLINIC       198,440       18,112,901       0.010956       0       90.00       90.00       90.00       90.01       90.01         90.01       09000       CLINIC       DIABETES       0       0       0.000000       0       90.00       90.01         91.00       09100       EMERGENCY       275,201       65,515,182       0	68.00 06800 SPEECH PATHOLOGY	11, 693	750, 678	0.01557	7 5,955	93	68.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       32,805       2,482,070       0.013217       7,029       93       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       16,587       1,160,890       0.014288       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       176,575       92,952,007       0.001900       232,898       443       73.00         76.97       07697       CARDI AC REHABILITATION       9,260       1,733,652       0.005341       0       0       76.97         77.00       07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       0       77.00         09000       CLINIC       198,440       18,112,901       0.01956       0       0       90.00         90.01       09000       CLINIC       DI ABETES       0       0       0.000000       0       90.01         91.00       09100       EMERGENCY       275,201       65,515,182       0.004201       198,842       835       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       94,533       8,127,169       0.011632       0       0       92.00	69. 00 06900 ELECTROCARDI OLOGY	137, 857				423	69.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       16,587       1,160,890       0.014288       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       176,575       92,952,007       0.001900       232,898       443       73.00         76.97       07697       CARDI AC REHABILITATION       9,260       1,733,652       0.005341       0       0       76.97         77.00       0700       ALLOGENEI C HSCT ACQUISITION       0       0       0.000000       0       0       77.00         78.00       07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       0       78.00         00100       CLINIC       09000       CLINIC       198,440       18,112,901       0.010956       0       90.01         90.01       09001       CLINIC       10 ABETES       0       0       0.000000       0       90.01         91.00       09100       EMERGENCY       275,201       65,515,182       0.004201       198,842       835       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       94,533       8,127,169       0.011632       0       0       92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32, 805				93	71.00
73. 00       07300       DRUGS CHARGED TO PATIENTS       176, 575       92, 952, 007       0.001900       232, 898       443       73. 00         76. 97       07697       CARDI AC REHABILITATION       9, 260       1, 733, 652       0.005341       0       0       76. 97         77. 00       07700       ALLOGENEIC HSCT ACQUISITION       0       0       0       0.000000       0       0       77. 00         78. 00       07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       0       78. 00         00       09000       CLINIC       0       198, 440       18, 112, 901       0.010956       0       90. 01         90. 00       09000       CLINIC       DIABETES       0       0       0.000000       0       90. 01         91. 00       09100       EMERGENCY       275, 201       65, 515, 182       0.004201       198, 842       835       91. 00         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART       94, 533       8, 127, 169       0.011632       0       0       92. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 587				0	72.00
76. 97       07697       CARDI AC REHABILITATION       9, 260       1, 733, 652       0.005341       0       0       76. 97         77. 00       07700       ALLOGENEI C HSCT ACQUISITION       0       0       0.000000       0       0       77. 00         78. 00       07800       CAR T-CELL IMMUNOTHERAPY       0       0       0.000000       0       0       78. 00         0UTPATIENT SERVICE COST CENTERS       0       0       0.010956       0       0       90. 00         90. 00       09000       CLINIC       198, 440       18, 112, 901       0.010956       0       90. 01         90. 10       09010       EMERGENCY       275, 201       65, 515, 182       0.004201       198, 842       835       91. 00         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART       94, 533       8, 127, 169       0.011632       0       0       92. 00						443	73.00
77. 00         07700         ALLOGENEIC HSCT ACQUISITION         0         0         0.000000         0         77. 00           78. 00         07800         CAR T-CELL IMMUNOTHERAPY         0         0         0.000000         0         78. 00           0UTPATIENT SERVICE COST CENTERS         0         0         0.010956         0         0         90. 00           90. 00         09000         CLINIC         198, 440         18, 112, 901         0.010956         0         90. 00           90. 01         09001         CLINIC         DIABETES         0         0         0.000000         0         90. 01           91. 00         09100         EMERGENCY         275, 201         65, 515, 182         0.004201         198, 842         835         91. 00           92. 00         09200         OBSERVATION BEDS (NON-DISTINCT PART         94, 533         8, 127, 169         0.011632         0         0         92. 00							
78. 00         07800         CAR         T-CELL         IMMUNOTHERAPY         0         0         0.000000         0         78. 00           0UTPATI ENT         SERVICE         COST         CENTERS         0         0.010956         0         0         90. 00           90. 00         09000         CLINIC         DIABETES         0         0         0.000000         0         90. 01           91. 00         09100         EMERGENCY         275, 201         65, 515, 182         0.004201         198, 842         835         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART         94, 533         8, 127, 169         0.011632         0         0         92. 00		-	0			0	
OUTPATI ENT_SERVICE_COST_CENTERS           90. 00         09000         CLINIC         198, 440         18, 112, 901         0. 010956         0         0         90. 00           90. 01         09001         CLINIC - DI ABETES         0         0         0.00000         0         90. 01           91. 00         09100         EMERGENCY         275, 201         65, 515, 182         0. 004201         198, 842         835         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART         94, 533         8, 127, 169         0. 011632         0         0         92. 00		0	0			0	
90. 00         09000         CLI NI C         198, 440         18, 112, 901         0. 010956         0         0         90. 00           90. 01         09001         CLI NI C         DI ABETES         0         0         0. 000000         0         90. 01           91. 00         09100         EMERGENCY         275, 201         65, 515, 182         0. 004201         198, 842         835         91. 00           92. 00         09200         0BSERVATI ON         BEDS (NON-DI STI NCT PART         94, 533         8, 127, 169         0. 011632         0         0         92. 00						-	
90. 01         09001         CLINIC - DIABETES         0         0         0.00000         0         90. 01           91. 00         09100         EMERGENCY         275, 201         65, 515, 182         0.004201         198, 842         835         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DISTINCT PART         94, 533         8, 127, 169         0.011632         0         0         92. 00		198, 440	18, 112, 901	0, 0109	i6 0	0	90.00
91. 00         09100         EMERGENCY         275, 201         65, 515, 182         0. 004201         198, 842         835         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DISTINCT PART         94, 533         8, 127, 169         0. 011632         0         0         92. 00						-	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 94, 533 8, 127, 169 0. 011632 0 0 92. 00		-	-			-	
						-	

Health Financial Systems	INDIANA UNIVERSITY	Y HEALTH BEDFOR	RD	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	OTHER PASS THROUGH COST	rs Provider C		Period: From 01/01/2023 To 12/31/2023		
		Titl	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	5	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTE	RS			-		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	6, 62	7 0.00	111	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 48	5 0.00	37	31.00
200.00 Total (lines 30 through 199)		0	8, 11		148	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30. 00 03000 ADULTS & PEDI ATRI CS	0					1 30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
200.00 Total (lines 30 through 199)	0					200.00
		I				1200.00

Health Financial Systems IN	DI ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 2:1	pared: 8 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown	-	Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 CLINIC - DIABETES	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
			•			

Health Financial Systems IN	DI ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2023 To 12/31/2023		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 36, 131, 861		
51.00 05100 RECOVERY ROOM	0	0		0 7, 151, 590		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 19, 223, 595		
56. 00 05600 RADI OI SOTOPE	0	0		0 4, 132, 768		
57.00 05700 CT SCAN	0	0		0 17, 051, 677		
58. 00 05800 MRI	0	0		0 3, 907, 144		
60. 00 06000 LABORATORY	0	0		0 31, 876, 590	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 7, 323, 774	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 114, 815	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 187, 067	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 750, 678	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 13, 737, 173	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 482, 070	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 160, 890	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 92, 952, 007	0.000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	)	0 1, 733, 652	0.000000	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	)	0 0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	)	0 0	0. 000000	78.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 18, 112, 901	0. 000000	90.00
90. 01 09001 CLINIC - DIABETES	0	0		0 0	0. 000000	90.01
91.00 09100 EMERGENCY	0	0	)	0 65, 515, 182	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	)	0 8, 127, 169	0. 000000	92.00
200.00   Total (lines 50 through 199)	0	0		0 337, 672, 603		200. 00

Health Financial Systems IND	DI ANA UNI VERSI TY	HEALTH BEDFOR	RD	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/29/2024 2:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		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	8, 140		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	19, 634		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	4, 308		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	44, 677		0 0	0	57.00
58. 00 05800 MRI	0. 000000	1, 744	1	0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	137, 028		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	50, 043		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	7, 139		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	8, 735		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	5, 955		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0,000000	42, 196		0 0	0	69,00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,029		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	232, 898		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0, 000000	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0, 000000	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS	01000000			0		10100
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 CLINIC - DIABETES	0, 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 000000	198, 842		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		768, 368		0 0	-	200.00

		DI ANA UNI VERSI TY				u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2023	Worksheet D Part V	
					To 12/31/2023		pared.
					10 12/01/2020	5/29/2024 2:1	8 pm
			Titl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 109598	0	272, 90		0	
	0 RECOVERY ROOM	0. 108247	0	53, 20		0	
	0 RADI OLOGY-DI AGNOSTI C	0. 175033	0	180, 05		0	
	0 RADI 0I SOTOPE	0. 078160	0	22, 80	09 0	0	56.00
	O CT SCAN	0. 054608	0	186, 39		0	
58.00 0580	O MRI	0. 162063	0	35, 07	4 0	0	58.00
	0 LABORATORY	0. 199581	0	336, 60	04 0	0	60.00
65.00 0650	0 RESPI RATORY THERAPY	0. 252750	0	68, 99	09 0	0	65.00
66.00 0660	0 PHYSI CAL THERAPY	0. 425276	0	22, 89	0 0	0	66.00
67.00 0670	O OCCUPATI ONAL THERAPY	0. 272126	0	13, 31	9 0	0	67.00
68.00 0680	O SPEECH PATHOLOGY	0. 429883	0	2, 46	02 0	0	68.00
69.00 0690	0 ELECTROCARDI OLOGY	0. 140700	0	106, 12	0 0	0	69.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 343492	0	20, 52	.6 0	0	71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0. 371343	0	1, 99	0 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 229133	0	1, 415, 54	2 0	0	73.00
76. 97 0769	7 CARDI AC REHABI LI TATI ON	0. 089889	0	12, 47	3 0	0	76.97
77.00 0770	O ALLOGENEIC HSCT ACQUISITION	0. 000000	0	1	0 0	0	77.00
78.00 0780	O CAR T-CELL IMMUNOTHERAPY	0.000000	0		0 0	0	78.00
OUTP	ATIENT SERVICE COST CENTERS			•			1
90.00 0900	O CLINIC	0. 165295	0	391, 03	5 0	0	90.00
90.01 0900	1 CLINIC - DIABETES	0. 000000	0		0 0	0	90.01
91.00 0910	0 EMERGENCY	0. 218426	0	1, 137, 89	04 0	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	0. 249282	0	73, 91	9 0	0	92.00
200.00	Subtotal (see instructions)		0	4, 354, 20	0 8	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	0	4, 354, 20	0 8	0	202.00

Health Financial Systems	I ND	IANA UNIVERSIT	Y HEALTH BEDFOR	RD	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER	R HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1328	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 5/29/2024 2:	
			Titl	e XIX	Hospi tal	PPS	
		Cos	sts		· · · · · · · · · · · · · · · · · · ·		
Cost Center Descri	ption	Cost	Cost	1			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCILLARY SERVICE COST C	ENTERS						_
50.00 05000 OPERATING ROOM		29, 910					50.00
51.00 05100 RECOVERY ROOM		5, 759					51.00
54.00 05400 RADI OLOGY-DI AGNOST	IC	31, 516	0				54.00
56. 00 05600 RADI 0I SOTOPE		1, 783					56.00
57.00 05700 CT SCAN		10, 178	0				57.00
58.00 05800 MRI		5, 684	0				58.00
60.00 06000 LABORATORY		67, 180	0				60.00
65.00 06500 RESPI RATORY THERAP	Y	17, 439	0				65.00
66.00 06600 PHYSI CAL THERAPY		9, 735	0				66.00
67.00 06700 OCCUPATIONAL THERA	РҮ	3, 624	0				67.00
68.00 06800 SPEECH PATHOLOGY		1,058	0				68.00
69.00 06900 ELECTROCARDI OLOGY		14, 931	0				69.00
71.00 07100 MEDICAL SUPPLIES C	HARGED TO PATIENT	7, 051	0				71.00
72.00 07200 I MPL. DEV. CHARGED	TO PATI ENTS	739	0				72.00
73.00 07300 DRUGS CHARGED TO P	ATIENTS	324, 347	0				73.00
76. 97 07697 CARDI AC REHABI LI TA	TION	1, 121	0				76.97
77.00 07700 ALLOGENEIC HSCT AC	QUISITION	0	0				77.00
78.00 07800 CAR T-CELL IMMUNOT	HERAPY	0	0				78.00
OUTPATIENT SERVICE COST	CENTERS						
90. 00 09000 CLINIC		64, 636	0				90.00
90.01 09001 CLINIC - DIABETES		0					90.01
91.00 09100 EMERGENCY		248, 546	0				91.00
92.00 09200 OBSERVATION BEDS (	NON-DISTINCT PART	18, 427	0				92.00
200.00 Subtotal (see inst		863, 664	0				200.00
	b. Services-Program	0					201.00
Only Charges		_					
202.00 Net Charges (line	200 - line 201)	863, 664	0				202.00
	-						

Health Financial Systems

I NDI ANA	UNI VERSI TY	HEALTH	BEDFORD

	Financial Systems INDIANA UNIVERSITY H	EALTH BEDFORD	In Lie	u of Form CMS-2	2552-1
COMPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Peri od:	Worksheet D-1	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	nared
			10 12/31/2023	5/29/2024 2:1	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
				1.00	
-	PART I - ALL PROVIDER COMPONENTS				-
-	NPATLENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		6, 627	1.0
	Inpatient days (including private room days and swrig-bed days)			6, 627	2.0
	Private room days (excluding private room days, excluding swing-		rivate room davs	0, 027	3.0
	do not complete this line.	(3). If you have only p	rivato room days,	0	0.0
	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 250	4.0
. 00   1	Total swing-bed SNF type inpatient days (including private roo	om days) through Decemb	er 31 of the cost	0	5.0
	reporting period				
	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line) Tatal guing had NE type impatient days (including private rear	n dava) through Decembe	n 21 of the east	0	7.0
	Total swing-bed NF type inpatient days (including private room reporting period	i days) through beceilibe	1 31 OF THE COST	0	/.0
	Total swing-bed NF type inpatient days (including private room	n days) after December	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)	augo) arter becomber		0	0.0
	Total inpatient days including private room days applicable to	o the Program (excludin	g swing-bed and	2, 162	9.0
	newborn days) (see instructions)				
	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10.0
1 00 0	through December 31 of the cost reporting period (see instruct	tions)			
	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		room days) after	0	11. C
	Swing-bed NF type inpatient days applicable to titles V or XI)		te room days)	0	12.0
	through December 31 of the cost reporting period		to room days)	0	12.0
	Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including priva	te room days)	0	13.0
a	after December 31 of the cost reporting period (if calendar ye	ear, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16. C
	WING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	c through December 21	of the cost		17. C
	reporting period	es through becember 31	of the cost		17.0
	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18.0
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 o	f the cost	266.32	19.0
	reporting period				
	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of	the cost	0.00	20. C
	reporting period Tatal gameral inpatient routing convice cost (cost instructions	->		0 750 147	21 0
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ting pariod (line	9, 750, 147 0	
	5 x line 17)	el 31 Ul the cost repor	ting period (inte	0	22.0
	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23.0
	x line 18)		51 (		
4.00 5	Swing-bed cost applicable to NF type services through December	r 31 of the cost report	ing period (line	0	24.0
	7 x line 19)			_	
	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25. C
26.00   1	x line 20) Total swing-bed cost (see instructions)			0	26. C
	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		9, 750, 147	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			7,700,117	27.0
	General inpatient routine service charges (excluding swing-bed	d and observation bed c	harges)	0	28.0
	Private room charges (excluding swing-bed charges)		5 /	0	
	Semi -private room charges (excluding swing-bed charges)			0	30.0
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average sem diem private room charge differential (line 22 min	un line 22) ( i i	ati ana)	0.00	
	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lir		utions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	ic 31 <i>)</i>		0.00	
	General inpatient routine service cost net of swing-bed cost a	and private room cost d	ifferential (line	9, 750, 147	
	27 minus line 36)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	ROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			]
	Adjusted general inpatient routine service cost per diem (see	-		1, 471. 28	
	Program general inpatient routine service cost (line 9 x line			3, 180, 907	
0.00	Medically necessary private room cost applicable to the Progra			0 3, 180, 907	
	Total Program general inpatient routine service cost (line 39				

Construct         This		Financial Systems IND ATION OF INPATIENT OPERATING COST	I ANA UNI VERSI TY	Y HEALTH BEDFOR Provider CC	N: 15-1328	Period:	eu of Form CMS-: Worksheet D-1		
Cost Center Description         Total (ngatieft cost partieft cost p						From 01/01/2023 To 12/31/2023	Date/Time Pre		
Image: Provide the state only in the state only in the state of the state		Cost Center Description		Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.		
Intensive Care Type Inpatt ion: Hospital Units         Intensive Care Type Inpatt ion: Hospital Units         Intensive Care Type Inpatt ion: Hospital Units           14.00         Commer Cast, UNI         1, 186, 72         1, 45         2, 220, 59         562         1, 586, 172         4, 00           44.00         Commer Cast, UNI         1, 186, 72         1, 45         2, 220, 59         562         1, 586, 172         4, 00           45.00         Others Sectual, Case (SPECIPY)         1         1         60         1, 600, 114         1, 600, 114         1, 600, 114         1, 600, 114         1, 600, 114         1, 600, 114         1, 600, 114         1, 600, 114         0         8, 600, 114			1.00	2.00		4.00			
43.00       INTERSIVE CARE UNIT       4.188_072       1.481_072       2.320_079       622       1.681_772       43.00         45.00       DORMANT CARE_UNIT       4.188_072       1.481_072       62.00       1.681_772       43.00         45.00       DORMANT CARE_UNIT       4.188_072       1.481_072       62.00       77.00	42.00							42.00	
42.00         UNION INTERSIVE CARE UNIT         45.00           45.00         UNION INTERSIVE CARE UNIT         45.00           47.00         UNITY STRICLAL CARE (SPECIFY)         47.00           47.00         UNITY STRICLAL CARE (SPECIFY)         47.00           46.00         Program ingation and Unity therapy acquisition cost (West. D. 3. col. 3. Line 200)         1.00           47.00         Dial Program ingation acquisition cost (West. D. 3. col. 7. Line 10, column 1)         6.48.00           47.00         Total Program ingation acquisition cost (West. D. 3. on of Parts II and II)         0         6.00           0.00         Pross through cost uppl table to Program ingation cost (line 11 related, non-physician anesthetist, and part and IV)         0         7.00           0.01         Pross through cost uppl table to Program ingation cost (line 40 minus line 52)         0         7.00           1.00         Pross through cost uppl table to Program ingation tackling acquisition cost (line 60 minus line 53)         0         5.00           0.01         Pross through cost uppl table (cost rescue acquisition cost (line 40 minus line 53)         0         5.00           0.02         Total Program ingation cost (line 60 minus line 53)         0         5.00           0.03         Program ingation cost (line 60 minus line 53)         0         5.00           0.04 <td>43.00</td> <td></td> <td>4, 188, 572</td> <td>1, 485</td> <td>2, 820. 5</td> <td>9 562</td> <td>1, 585, 172</td> <td>43.00</td>	43.00		4, 188, 572	1, 485	2, 820. 5	9 562	1, 585, 172	43.00	
46.00       SURGICAL INTERVISE CARE UNIT       46.00         700       Cost Center Description       100         700       Cost Center Description       100         700       Cost Center Description       100         700       Cost Center Description       1.602.503         700       Total Program Inpatient cellular therapy acquisition cost (Worksheet D.6. Part III, Line 10, colum 1)       0.648.602         700       Total Program Inpatient cellular therapy acquisition cost (Worksheet D.6. Part III, Line 10, colum 1)       0.648.602         700       Total Program Inpatient cellular therapy acquisition cost (Worksheet D.6. Part III, Line 10, colum 1)       0.648.602         700       Pass through costs applicable to Program Inpatient ancillary services (from West. D. sum of Parts II and 0       0.00         700       Program Indication Costs (Sum of Lines 40 months IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII									
47.00       OTHER SPECIAL CARE (SPECIPY)       47.00         48.00       Program inpatient sociliary services cost (Mexhout 2-A, Cut 3, Line 200)       1.00         48.00       Program inpatient sociliary services (sum of lines 41 through 48.01)(see instructions)       6.648.662         49.00       Program inpatient costs (sum of lines 51 through 48.01)(see instructions)       6.648.662         49.00       Program inpatient costs (sum of lines 50 mol 51)       6.648.662         50.00       Prost through costs applicable to Program inpatient ancillary services (from Mext. 0, sum of Parts II on on and V)       6.648.662         50.00       Prost through costs applicable to Program inpatient ancillary services (from Mext. 0, sum of Parts II on on and V)       6.600.620         50.00       Tradit Program excludable cost (sum of lines 50 mol 51)       0.620.00         50.00       Tradit Program isotherges       0.000.500.00         50.01       Tradit and costaring cost excluding capital related, non-physician anesthetist, and immediate anount per discharge       0.000.500.00         50.01       Target anount for discharge       0.000.500.00       0.000.500.00         50.01       Target anount for discharge costarget in the start of a start of the star								1	
48.00       Program inpatient uncillary service cost (Rest. D-3, col. 3, line 200)       1.00       1.00       1.00       1.882,683 48.00         48.00       Program inpatient cellular therapy acquisition cost (Roksken D-6, Part III, line 10, column 1)       0.848,44       0.440         49.00       Program inpatient cellular therapy acquisition cost (Roksken D-6, Part III, line 10, column 1)       0.848,44         50.00       Pass through costs applicable to Program inpatient acclilary services (from Rest. D, sum of Parts I and Dillar Costs applicable cost (sum of Thies 50 and 51)       0.520         51.00       Pass through costs applicable is program inpatient acclilary services (from Rest. D, sum of Parts II       0.520         51.00       Pass through costs applicable is program inpatient acclilary services (from Rest. D, sum of Parts II       0.520         52.00       Total Program exipable cost (sum of Thies 50 and 51)       0.520       0.520         52.00       Total Program inpatient amount per discharge       0.000       55.00         52.01       Darget amount (line 54 sum of lines 55, 0.5, 0.1, and 55.02)       0.000       55.00       0.000       55.00         53.02       Darget amount (line 54 sum of lines 55, 0.5, 0.1, and 55.02)       0.000       55.00       0.000       55.00       0.000       55.00       0.000       55.00       0.000       55.00       0.000       55.00		OTHER SPECIAL CARE (SPECIFY)						1	
48.00       Program inpatient ancillary service cost (Mext. 0-3, col. 3, line 200)       1, 882, 683       48.00         48.00       Program inpatient accular theory acquisition costs (Morkhedte De, Part III, line 10, column 1)       6, 648, 624       48.01         40.00       Program inpatient accuts (sum of lines 41 through 86.01)(see instructions)       6, 648, 624       6, 600         40.00       Prost Program inpatient accuts (sum of lines 50 and 51)       6, 648, 624       6, 600         10.00       Prost Program opticable to Program inpatient accuts (sum of Parts II and line accuts)       6, 648, 624       6, 600         10.00       Prost Program opticable to Program inpatient accuts (sum of Parts II and line accuts)       6, 648, 624       6, 600         10.00       Prost Program opticable to Program inpatient accuts (sum of Parts II and line Accuts)       6, 648, 624       64, 600         10.00       Tronst Program opticable to Program inpatient accuts (sum of Parts II and line Accuts)       6, 648, 624       64, 600         10.00       Torget and scharges       0, 65, 600       64, 600       65, 600       65, 600       65, 600       65, 600       65, 600       65, 600       65, 600       65, 600       65, 600       65, 600       65, 600       65, 600       66, 600       66, 600       66, 600       66, 600       66, 600       66, 600       66, 600 <td< td=""><td></td><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td>1.00</td><td></td></td<>		Cost Center Description					1.00		
40.00       Total Program Inpatient costs (sum of lines 41 through 48.01)(see instructions)       6.648,662       49.00         2005       Press through costs applicable to Program Inpatient routine services (from West. 0, sum of Parts 1 and 19.       0       51.00         21.00       Parts Through costs applicable to Program Inpatient ancillary services (from West. 0, sum of Parts 11 and 19.       0       51.00         21.00       Total Program excludence cost (sum of lines 50 and 51)       0       52.00       0         23.00       Total Program excludence cost (sum of lines 50 and 51)       0       52.00       0         23.01       Total Program excludence cost (sum of lines 50 and 51)       0       55.00       55.00         23.01       Total Program excludence cost (sum of lines 55, 50.11 and 56.02)       0       0       0         23.01       Target meanut (line 54 x sum of lines 55, 50.11 and 56.02)       0       0       0       0         23.00       Distribution towns in provement towns provement towns t	48.00							48.00	
NAST THROUGH COST ADJUSTMENTS           00         PASS THROUGH COST ADJUSTMENTS           011)         Pass through costs applicable to Program inpatient noutine services (from West. D. sum of Parts I and III)         0           010         Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts III)         0           010         Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts III)         0           010         Total Program excludable cost (sum of lines 50 and 51)         0         51.00           010         Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and end addition costs (line 49 end scharge         0         54.00           010         Torgat manual (line 54 end scharge         0.00         55.00         0         56.00           010         Torgat mount (line 54 es am of lines 55, 56.01 and 55.02)         0         0         0         58.00           010         Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)         0         58.00           010         Difference between adjusted inpatient operating cost and target amount (line 56 minus line 50)         0         60.00           010         Difference between adjusted inpatient costs inform prior year cost reporting period (scharge and cospopundes by the morter to basket)         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>column 1)</td> <td>-</td> <td>1</td>						column 1)	-	1	
111)       010       Pass through costs applicable to Program inputient ancillary services (from West. D. sum of Parts II and IV)       0       51.00         20       Total Program inputient operating octs and SI)       0       52.00         53.00       Program inputient operating octs and control octs (ine 49 minus line 52)       0       53.00         54.00       Program discharges       0       54.00         55.00       Target AutoMT Abb Lint ComPUTATION       0       55.00         56.00       Target AutoMT Abb Lint ComPUTATION       0.00       55.00         57.00       Target AutoMT Abb Lint ComPUTATION       0.00       55.01         58.01       Target AutoMT Abb Lint ComPUTATION       0.00       55.01         59.02       Target AutoMT Abb Lint ComPUTATION       0.00       55.01         50.03       Difference between adjusted inputient Solt and apdit and compounded by the market basket)       0.00       55.00         50.00       Trended costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0.00       60.00         61.00       Expected costs (lesser of lines 4.00) in the soft the amount by which operating costs (line 53 so 1) as incortive payment (see instructions)       0       62.00         62.00       Relief payment (see instructions)       0       62.00	49.00		41 through 48.C	(see mstruc	tions)		0, 048, 002	49.00	
51.00       Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II and Program inpatient costs (sum of lines 50 and 51)       0       51.00         52.00       Total Program inpatient coersting cost excluding capital related, non-physician anesthetist, and the program inpatient coersting cost excluding capital related, non-physician anesthetist, and the program instructions (sum of lines 55).       0       51.00         53.00       Total Program instructions (sum of lines 55, 55.01, and 55.02).       0       60.00       55.00         50.00       Torget amount (per discharge (contractor use only)       0.00       55.02       0       57.00         50.00       Torget amount (per discharge (contractor use only)       0.00       55.02       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       0       0.00       50.00       0 <td>50.00</td> <td></td> <td>atient routine</td> <td>services (from</td> <td>Wkst. D, sum</td> <td>of Parts I and</td> <td>0</td> <td>50.00</td>	50.00		atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00	
52.00       Total Program excludable cost (sum of lines 50 and 51)       0       52.00       Total Program excludable cost (sum of lines 50 and 51)       0       52.00         10       Total Program Inpatition Coervitation costs (line 49 minus line 52)       0       14         10       Total Program Inpatition Coervitation       0       14         10       Fordam of schempe       0       0         10       Fordam of schempe       0 <t< td=""><td>51.00</td><td>Pass through costs applicable to Program inpa</td><td>atient ancillar</td><td>ry services (fr</td><td>om Wkst. D, s</td><td>um of Parts II</td><td>0</td><td>51.00</td></t<>	51.00	Pass through costs applicable to Program inpa	atient ancillar	ry services (fr	om Wkst. D, s	um of Parts II	0	51.00	
medical education costs (illne 47 minus line 52)         0           TARGET ANOMET AND LINE TOWPLATION         0           54.00         Program discharges         0           54.01         Program discharges         0.000 55.00           55.01         Target amount per discharge (contractor use only)         0.000 55.00           56.02         Target amount per discharge (contractor use only)         0.000 55.00           56.03         Target amount per discharge (contractor use only)         0.000 55.00           56.04         Target amount per discharge (contractor use only)         0.000 55.00           57.00         Tranded costs (lesser of line 54, st or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)         0.000 59.00           60.00         Expected costs (lesser of line 53 + line 54, or line 55 from piror year cost report, updated by the market basket)         0.000 60.00           61.00         Continuous improvement bous payment (see instructions)         0         61.00           62.00         Relief payment (see instructions)         0         62.00           63.00         Allowable Ingutient costs pupyment (see instructions)         0         62.00           64.00         Medicare san ga-bed SNF inpatient routine costs through Becember 31 of the cost reporting period (See instructions) (tit RNII only).         64.00 <t< td=""><td></td><td>Total Program excludable cost (sum of lines</td><td></td><td></td><td></td><td></td><td>0</td><td></td></t<>		Total Program excludable cost (sum of lines					0		
TARGET AUGUNT AND LIMIT COMPUTATION           ALO         Program discharge         0         54.00           55.00         Target amount per discharge         0.00         55.00	53.00			elated, non-phy	sician anesth	etist, and	0	53.00	
55.00       Perment adjustment amount per discharge       0.00       55.00         55.01       Perment adjustment amount per discharge (contractor use only)       0.00       55.01         55.00       Target amount (ine 54 x sum of lines 55, 55.01, and 55.02)       0.00       55.01         57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55.00         59.00       Target amount (line 54 x sum of lines 55, 55.01, and 55.02)       0.00       58.00       0.00         60.00       updated and compounded by the merket baskel)       0.00       58.00       0.00       58.00       0.00       58.00       0.00       58.00       0.00       58.00       0.00       58.00       0.00       58.00       0.00       59.00       0.00       58.00       0.00       58.00       0.00       58.00       0.00       58.00       0.00       59.00       0.00       58.00       0.00       50.00       0.00       58.00       0.			52)						
55.01       Perfisionent anglustment amount per discharge (contractor use only)       0.00       55.02         50.02       Adjustment amount per discharge (contractor use only)       0.00       55.02         50.00       Terreferec between adjusted inpotention operating cost and target amount (line 56 minus line 53)       0.00       55.00         50.00       Difference between adjusted inpotention operating cost and target amount (line 56 minus line 53)       0.00       55.00         50.01       Difference between adjusted inpotention operating costs and target amount (line 56 minus line 53)       0.00       55.00         50.01       Difference between adjusted inpotention operating costs (line 57 mm prior year cost report, updated by the market basket)       0.00       0.00         60.01       Continuous improvement bonus payment (iff line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 57, or line 50, or line of the target amount (line 56), otherwise       0       61.00         61.00       Continuous improvement cost plus incentive payment (see instructions)       0       62.00       62.00       64.00         62.00       Relief payment (see instructions)       0       64.00       64.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       6									
55. 02       Adjustment amount her discharge (contractor use only)       0.00       55. 02         60. 0       Target amount (line 54 x sum of lines 55, 55. 01, and 55. 02)       0.00       55. 00         57. 00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       56. 00         59. 00       Trended costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0.00       60. 00         60. 00       Expected costs (lesser of line 53 + line 54, or line 56, is less than the lowest of line 55 plus 55. 01 or line 50, or line 60, enter the leaser of 508. of the amount which operating costs (line 55) us 55. 01 or line 50, or line 61, enter the leaser of 508. of the amount which operating costs (line 55) us 55. 01 or line 50, or line 61, enter the leaser of 508. of the amount which operating costs (line 50)       0       61.00         63. 00       POOGEM IMMENTINE THOUSE SH ME 60 DOST       0       62. 00       0       63. 00         64. 00       Medicare swing-bed SNF inpatient routine costs fitre December 31 of the cost reporting period (See instructions)       0       64. 00       66. 00         67. 00       Title V or XIX swing-bed NF inpatient routine costs fitre December 31 of the cost reporting period (See instructions)       0       66. 00         67. 00       Title V or XIX swing-bed NF inpatient routine costs fitre December 31 of the cost reporting period (In (In 1 x Line 30))       0       67. 00									
57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       57.00         58.00       Borns payment (see instructions)       0       57.00         59.00       Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)       0.00       0.00         60.00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0.00       60.00         61.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus to state tasket)       0       61.00         62.00       Rel lef payment (see instructions)       0       62.00       62.00         63.00       Maromale Inpatient corts plus (see 100 ST)       0       62.00       62.00         64.00       Maromale Inpatient corts plus (See 10 ST)       0       63.00       64.00         64.00       Maromale SW inpatient routine costs through December 31 of the cost reporting period (See Instructions)       0       64.00         65.00       The at the 20       0       64.00       0       64.00         66.00       The X XI Swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions)       0       64.00         67.00       The X V S	55.02	Adjustment amount per discharge (contractor	5.					55.02	
58.00       Brows payment (see instructions)       0       58.00       Charled costs (lessor of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)       0       0.00					ino 56 minus	lino 52)		1	
updated and compounded by the market basket)       60.0			ing cost and ta	inger anount (in	The 50 million	TTHE 55)	-		
60.00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the neart basket)       0.00       60.00         61.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 53) are less than expected costs (line lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line s54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)       0       61.00         62.00       Relief payment (see instructions)       0       62.00         62.00       Relief payment (see instructions)       0       63.00         62.00       Relief payment (see instructions)       0       64.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       64.00         65.00       Finpatient routine costs through December 31 of the cost reporting period (See (line 12 x line 19)       65.00         60.00       Total Indel care swing-bed NF inpatient routine costs (line 67 + line 68)       0       67.00         61.00       Routine data in patient routine costs (line 7 + line 2)       70.00       70.00         70.00       Routine data in patient routine service cost (line 7 + line 2)       70.00       70.00         70.00       Routine data in patient routine service cost (line 7 + line 2)       70.00       70.00 <td>59.00</td> <td colspan="8">59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,</td>	59.00	59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,							
61.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus solution of the set of the lesser of 50% of the anount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)       0       61.00         62.00       Relief payment (see instructions)       0       62.00       Relief payment (see instructions)       0       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(tile XNII only)       0       64.00         65.00       Instructions (tile XNII only)       0       65.00       66.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tile XVIII only): for CAH, see instructions       0       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       0       67.00         68.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0       68.00         70.00       Skilled nursing facility/other nursing facility/CF/ID routine service cost (line 37)       70.00       70.00         70.00       Kate Service cost (line 9 x line 71)       70.00       70.00       70.00       70.00         70.00       Kate Se	60.00	60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the							
62.00       Relief payment (see instructions)       0       62.00         63.00       Allowable inpatient cost plus incentive payment (see instructions)       0       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tilt & XVIII only)       0       64.00         65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tilt & XVIII only)       0       65.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(tilt a XVIII only): for CAH, see instructions       0       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       0       67.00         68.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69.00         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69.00         70.00       Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)       70.00         71.00       Adjusted general inpatient routine service costs (from Yorkine S)       70.00         71.00       Adjusted general inpatient routine service costs (from Yorkine S)       70.00         72.00       Total title V or XIX swing-bed NF inpatient	61.00	61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line							
63.00       Allowable Inpatient cost plus incentive payment (see instructions)       0       63.00         PROGRAM INPATIER TRUTINE WING BED COST       64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)       64.00       64.00         66.00       Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)       65.00       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (ine 12 x Line 19)       66.00         68.00       Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (ine 12 x Line 19)       67.00         68.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 7 + line 68)       0         70.00       Title V or XIX swing-bed NF inpatient routine service cost (line 7 + line 68)       0         70.00       Title V or XIX swing-bed NF inpatient routine service cost (line 7 + line 68)       0         70.00       Title V or XIX swing-bed NF inpatient routine service cost (line 7 + line 73)       70.00         70.00       Title STOTING PARENKING FACILITY, AMP ICF/IID ONLY       71.00         70.00       Capital -related cost (line 9 x line 7	62 00		0	62 00					
64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tit e XVIII only)       64.00         65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tit e XVIII only)       65.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 13 x line 20)       66.00         68.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       00         69.00       Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2)       70.00         70.00       Skilled nursing facility/other nursing facility/CF/IID routine service cost (line 37)       71.00         71.00       Agiusted general inpatient routine service costs (line 74 + line 35)       73.00         74.00       Total Program general inpatient routine service costs (line 72 + line 73)       76.00         75.00       Capit al -related costs (line 75 + line 2)       76.00         76.00       Program capit al -related costs (line 75 + line 2)       76.00         77.00       Regram routine service cost for comparison to the cost limitation (line 78 minus line 79)       78.00         76.00       P		Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)					
65.00Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)66.0065.0066.00Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions066.0070.01Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)068.0068.00Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)068.0069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.0070.01PART III - SkILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY70.0071.02Program routine service cost (line 9 x line 71)71.0072.00Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)73.0073.00Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)83.0080.00Inpatient routine service cost (line 9 x line 70)79.0079.00Reasnable inpatient routine service sce instructions)84.0079.00Reasnable inpatient routine service cost (from provider records)83.0079.00Reagregate charges to beneficiaries for excess costs (from provider records)83	64.00		ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64.00	
instructions)(itile XVIII only)66.0067.0066.0067.0066.0067.00Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions066.0067.00Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)067.0068.00Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)068.0069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.0070.00Skilled nursing facility/torben runsing facility/to	65 00		ts after Decemb	per 31 of the c	ost reporting	period (See	0	65 00	
CAH, see instructionsCAH, see instructions67.00Cille V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)67.0068.00Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)68.0069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.00PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY70.0070.00Killed nursing facility/ICF/IID routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)70.0072.00Program routine service cost (line 9 x line 71)70.0073.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related costs (line 75 + line 2)76.0076.00Program copital -related costs (line 75 + line 2)76.0076.00Program routine service cost from provider records)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0079.00Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)81.0081.00Inpatient routine service cost (see instructions)83.0079.00Program inpatient ancillary services (see instructions)83.0079.00Program inpatient ancillary services (see instructions)83.00 <tr< td=""><td></td><td>instructions)(title XVIII only)</td><td></td><td></td><td></td><td>•</td><td></td><td></td></tr<>		instructions)(title XVIII only)				•			
(line 12 x line 19)66677668.00Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period0666069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)0069.00PART 111 - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY0069.0070.00Skilled nursing facility/other nursing facility/ICF/ID routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)72.0072.00Program routine service cost (line 9 x line 71)73.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related costs (line 75 + line 2)77.0076.00Per diem capital-related costs (line 75 + line 2)77.0077.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0079.00Lagregare routine service cost (line 74 minus line 77)79.0079.00Inpatient routine service costs (see instructions)81.0081.00Inpatient routine service cost (see instructions)81.0082.00Inpatient routine service costs (see instructions)83.0083.00Program inpatient ancillary services (see instructions)84.0084.00Utilization review - physician compensation (see instructions)85.00<	67.00	CAH, see instructions				•	0	67.00	
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PART 111 - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY70.00Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)71.0072.00Program routine service cost (line 9 x line 71)72.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital-related costs (line 75 + line 2)76.0077.00Program routine service cost (line 74 minus line 77)76.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service cost s (ine 9 x line 81)80.0081.00Inpatient routine service cost (see instructions)81.0082.00Inpatient routine service cost (see instructions)83.0084.00Program inpatient operating costs (sum of lines 83 through 85)86.00PART 11 - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,471.2888.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,471.28		(line 13 x line 20)					0		
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84.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,37787.00Total observation bed days (see instructions)1,37788.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,471.28				· .					
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PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.00Total observation bed days (see instructions)1, 37787.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 471.2888.00			•						
87.00         Total observation bed days (see instructions)         1,377         87.00           88.00         Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)         1,471.28         88.00	ou. UU						1		
			•						

Health Financial Systems INC	ANA UNIVERSITY	Y HEALTH BEDFOR	D	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
				To 12/31/2023	Date/Time Pre 5/29/2024 2:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	454, 953	9, 750, 147	0. 04666	1 2, 025, 953	94, 533	90.00
91.00 Nursing Program cost	0	9, 750, 147	0.00000	2, 025, 953	0	91.00
92.00 Allied health cost	0	9, 750, 147	0.00000	2, 025, 953	0	92.00
93.00 All other Medical Education	0	9, 750, 147	0.00000	2, 025, 953	0	93.00

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Heal th	Financial Systems INDIANA UNIVERSITY H	HEALTH BEDFORD	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Peri od:	Worksheet D-1	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			10 12/01/2020	5/29/2024 2:1	
		Title XIX	Hospi tal	PPS	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	rs. excluding newborn)		6, 627	1.00
2.00	Inpatient days (including private room days, excluding swing-			6, 627	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ıys). 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 b			5, 250	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	nom davs) after December	31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becenber	ST OF THE COST	0	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the Program (excluding	swing-bed and	111	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	nom davs)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	•		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
40.00	through December 31 of the cost reporting period	V I Z I I I I I		0	10.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
	Total nursery days (title V or XIX only)	an (one aaring oning boa	uu jo)	0	15.00
	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost		17.00
	reporting period				10.00
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19.00
17.00	reporting period			0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			9, 750, 147	
22.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost report	ing period (line	0	22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23.00
20.00	x line 18)		ig period (inne o	Ū	20.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26 00	x line 20) Total swing-bed cost (see instructions)			0	26 00
26.00 27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 9, 750, 147	26.00 27.00
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nue line 33) (coo instruc	tions)	0.00 0.00	1
34.00 35.00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	9, 750, 147	
	27 minus line 36)	•			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			1, 471. 28	
39.00	Program general inpatient routine service cost (line 9 x line Medically perseary private room cost applicable to the Progr			163, 312	
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	. ,		0 163, 312	40.00
	1. Star i ogram gonorar ripatront roatine service cost (THE 37			105, 512	1 11.00

	ATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-1328	Period: From 01/01/2023	Worksheet D-1	2552-1
					To 12/31/2023		
	Cast Captor Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	Cost Center Description		Inpatient Days			(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)						42.00
3.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	4, 188, 572	1, 485	2, 820. 5	59 37	104, 362	43.00
4.00	CORONARY CARE UNIT	1,100,072	1, 100	2,020.0		101,002	44.0
5.00	BURN INTENSIVE CARE UNIT						45.0
6.00	SURGI CAL INTENSI VE CARE UNI T						46.0
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
	· ·					1.00	
8.00	Program inpatient ancillary service cost (Wk					160, 506	
8. 01 9. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 428, 180	
7.00	PASS THROUGH COST ADJUSTMENTS	41 through 48.0				428, 180	49.0
0. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sun	n of Parts I and	11, 188	50.0
1.00	<pre>III) Dass through costs applicable to Drogram inp</pre>	ationt ancillar	w convigos (fr	om Wkat Da	sum of Dorte II	3, 520	51.0
1.00	Pass through costs applicable to Program inp. and IV)		y services (II	UNI WKSL. D, S	Sum OF Parts II	3, 520	51.00
2.00	Total Program excludable cost (sum of lines					14, 708	52.0
3.00	Total Program inpatient operating cost exclu	5 1	lated, non-phy	si ci an anesth	netist, and	413, 472	53.0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4.00	Program di scharges					0	54.0
5.00	Target amount per discharge					0.00	
5.01	Permanent adjustment amount per discharge					0.00	
5. 02 6. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	
7.00	Difference between adjusted inpatient operat			ine 56 minus	line 53)	0	
8.00	Bonus payment (see instructions)	-	-			0	
9.00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market backet)		the cost repo	rting period	endi ng 1996,	0.00	59.0
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		m prior vear c	ost report, u	updated by the	0.00	60. C
	market basket)		. 5	·			
01.00	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise					0	61.0
2.00	enter zero. (see instructions) Relief payment (see instructions)					0	62.0
3.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	63.0
4.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.0
	instructions)(title XVIII only)	Ū.			0 1		
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	g period (See	0	65.0
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only); for	0	66.0
	CAH, see instructions					_	
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost re	eporting period	0	67.0
8. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	0	68.0
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino coste (	lino 67 Lino	60)		0	69.0
9.00	PART III - SKILLED NURSING FACILITY, OTHER N					0	09.0
0. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service c	ost (line 37)			70.0
1.00 2.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ıne 70 ÷ line	2)			71.0
2.00	Medically necessary private room cost applic.	,	ı(line 14 x li	ne 35)			73.0
4.00	Total Program general inpatient routine serv	0	•				74.0
5.00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	Part II, column		75.0
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
7.00	Program capital -related costs (line 9 x line						77.0
8.00	Inpatient routine service cost (line 74 minus line 77)						78.0
9.00 0.00							79.0
1.00	Inpatient routine service costs for comp				103 IIIC /7)		80.0
2.00	Inpatient routine service cost limitation (I	ine 9 x line 81					82.0
3.00	0 Reasonable inpatient routine service costs (see instructions)						83.0
84.00 85.00							84.0 85.0
6. 00	Total Program inpatient operating costs (sum						85.0
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u> </u>				
7.00 8.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2			1, 377 1, 471. 28	

Health Financial Systems IND	IANA UNIVERSITY HEALTH BEDFORD			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
				To 12/31/2023	Date/Time Pre 5/29/2024 2:1	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	454, 953	9, 750, 147	0. 04666	2, 025, 953	94, 533	90.00
91.00 Nursing Program cost	0	9, 750, 147	0.00000	2, 025, 953	0	91.00
92.00 Allied health cost	0	9, 750, 147	0.00000	2, 025, 953	0	92.00
93.00 All other Medical Education	0	9, 750, 147	0.00000	2, 025, 953	0	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONM	NT Drovidor (	CCN: 15-1328	Peri od:	u of Form CMS-2 Worksheet D-3	
NPATIENT ANCILLARY SERVICE CUST APPORTIONM	Provider (	UN: 15-1328	From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				5/29/2024 2:1	8 pm
	liti	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	5	Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2.00	3.00	-
INPATIENT ROUTINE SERVICE COST CENTER		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			4, 764, 743		30.00
31. 00 03100 I NTENSI VE CARE UNI T			3, 737, 627		31.00
ANCI LLARY SERVICE COST CENTERS		_1			1
50. 00 05000 OPERATI NG ROOM		0. 1095	98 756, 360	82, 896	50.00
51.00 05100 RECOVERY ROOM		0. 1082			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1750	33 493, 309	86, 345	54.00
56. 00 05600 RADI 0I SOTOPE		0. 0781	60 134, 445	10, 508	56.00
57.00 05700 CT SCAN		0. 0546	08 318, 575	17, 397	57.00
58. 00 05800 MRI		0. 1620	63 137, 866		
50. 00 06000 LABORATORY		0. 1995			
55. 00 06500 RESPI RATORY THERAPY		0. 2527		155, 802	65.00
56. 00 06600 PHYSI CAL THERAPY		0. 4252			
57.00 06700 OCCUPATIONAL THERAPY		0. 2721			
58.00 06800 SPEECH PATHOLOGY		0. 4298			
59. 00 06900 ELECTROCARDI OLOGY		0. 1407			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	ENT	0. 3434			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3713			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2291			
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0898		-	
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000		-	
78.00 07800 CAR T-CELL I MMUNOTHERAPY		0.0000	00 0	0	78.00
OUTPATIENT SERVICE COST CENTERS		0.1/52	95 0	0	
20.00 09000 CLINIC 20.01 09001 CLINIC - DIABETES		0. 1652		-	
20. 01 09001 CLINIC - DIABETES 21. 00 09100 EMERGENCY		0. 0000 0. 2184		°	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	ΛΡΤ	0. 2184			91.0
200.00 Total (sum of lines 50 through		0. 2492	9, 158, 303		
	ces-Program only charges (line 61)		9, 156, 505		200.00
		1	0	1	1201.01

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1328	Period: From 01/01/2023	Worksheet D-3	5
	Component	CCN: 15-Z328	To 12/31/2023		
	Title	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	-	I	
0.00 03000 ADULTS & PEDIATRICS					30.
1.00 03100 I NTENSI VE CARE UNI T					31.
ANCI LLARY SERVI CE COST CENTERS		1		1	
0.00 05000 OPERATING ROOM		0. 1095			
1.00 05100 RECOVERY ROOM		0. 1082		-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1750		0	
6. 00 05600 RADI 0I SOTOPE		0. 0781		0	
7. 00 05700 CT SCAN		0. 0546		0	
8. 00 05800 MRI		0. 1620		0	
0. 00 06000 LABORATORY		0. 1995		0	
5. 00 06500 RESPI RATORY THERAPY		0. 2527		0	
6. 00 06600 PHYSI CAL THERAPY		0. 4252	76 0	0	66.
7. 00 06700 OCCUPATI ONAL THERAPY		0. 2721	26 0	0	67.
8.00 06800 SPEECH PATHOLOGY		0. 4298	83 0	0	68.
9. 00 06900 ELECTROCARDI OLOGY		0. 1407	00 0	0	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.3434	92 0	0	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.3713	43 0	0	72.
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 2291	33 0	0	73.
6. 97 07697 CARDI AC REHABI LI TATI ON		0. 0898	89 0	0	76.
7.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 0	0	77.
8.00 07800 CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	78.
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC		0. 1652	95 0	0	90.
0. 01 09001 CLINIC - DIABETES		0.0000		0	90.
1.00 09100 EMERGENCY		0. 2184		0	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2492		0	92.
00.00 Total (sum of lines 50 through 94 and 96 through 9	8)		0	0	200.
01.00 Less PBP Clinic Laboratory Services-Program only c			0		201.
02.00 Net charges (line 200 minus line 201)	. <u>312</u> ( 01)		0		202.

Health Financial Systems INDIANA UNIVERSITY I	HEALTH BEDFOR	RD	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 2:1	pared:
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			241, 426		30.00
31.00 03100 I NTENSI VE CARE UNI T			240, 589		31.00
ANCI LLARY SERVI CE COST CENTERS				1	
50.00 05000 OPERATING ROOM		0. 1095	98 8, 140	892	50.00
51.00 05100 RECOVERY ROOM		0. 1082	47 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1750	33 19, 634	3, 437	54.00
56. 00 05600 RADI 0I SOTOPE		0. 0781	50 4, 308	337	56.00
57.00 05700 CT SCAN		0.0546			57.00
58. 00 05800 MRI		0. 1620			
60. 00 06000 LABORATORY		0. 1995		27, 348	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 2527			
66. 00 06600 PHYSI CAL THERAPY		0. 4252			
67.00 06700 OCCUPATI ONAL THERAPY		0. 2721			67.00
68.00 06800 SPEECH PATHOLOGY		0. 4298			
69. 00 06900 ELECTROCARDI OLOGY		0. 1407			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3434		2, 414	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3713		, o	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2291		53, 365	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 0898		0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000		0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0.0000	0 00	0	78.00
OUTPATI ENT SERVICE COST CENTERS		1			
90. 00 09000 CLINIC		0. 1652			
90. 01 09001 CLINIC - DIABETES		0.0000		0	90.01
91.00 09100 EMERGENCY		0. 2184			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2492		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			768, 368	160, 506	•
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	768, 368	I	202.00

I NPATI EN	IT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1328	Period: From 01/01/2023	Worksheet D-3	
	·	Component	CCN: 15-Z328	To 12/31/2023		
		Ti tl	e XIX	Swing Beds - SNF		
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1		1	-
	3000 ADULTS & PEDI ATRI CS					30.
	3100 I NTENSI VE CARE UNI T					31.
	NCI LLARY SERVI CE COST CENTERS		0.1005	<u></u>		1 - 0
	5000 OPERATING ROOM		0. 1095			
	5100 RECOVERY ROOM		0. 1082		-	
	5400 RADI OLOGY-DI AGNOSTI C		0. 1750		0	
	5600 RADI OI SOTOPE		0.0781		0	
	5700 CT SCAN		0.0546		0	
			0. 1620		0	
	6000 LABORATORY		0. 1995		0	
	5500 RESPI RATORY THERAPY		0. 2527		0	
	6600 PHYSI CAL THERAPY		0. 4252		0	
	5700 OCCUPATI ONAL THERAPY		0. 2721		0	
	5800 SPEECH PATHOLOGY		0. 4298		0	
	5900 ELECTROCARDI OLOGY		0. 1407		0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3434		0	1
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 3713		0	1
	7300 DRUGS CHARGED TO PATIENTS		0. 2291		0	
	7697 CARDI AC REHABI LI TATI ON		0. 0898		0	
	7700 ALLOGENEIC HSCT ACQUISITION		0.0000			1
	7800 CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	78.
	JTPATIENT SERVICE COST CENTERS					
	9000 CLI NI C		0. 1652			
	9001 CLINIC - DIABETES		0.0000		0	
	9100 EMERGENCY		0. 2184		0	
	9200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0. 2492	82 0	0	1
200.00	Total (sum of lines 50 through 94 and 96 through 98)			0		200.
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
202.00	Net charges (line 200 minus line 201)			0		202.

	Financial Systems INDIANA UNIVERSITY H ATION OF REIMBURSEMENT SETTLEMENT	EALTH BEDFORD Provider CCN: 15-1328 Title XVIII	In Lie Period: From 01/01/2023 To 12/31/2023 Hospital		pared:
			nospi tui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			16, 635, 838	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	tions)		0	2.00
3.00	OPPS or REH payments			0	
4.00	Outlier payment (see instructions)			0	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	4.01 5.00
6.00	Line 2 times line 5			0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs including REH direct	ct graduate medical educ	cation costs from	0	9.00
10.00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			16, 635, 838	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ing (0)		0	
13.00 14.00	Total reasonable charges (sum of lines 12 and 13)	The 69)		0	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p			0	15.00
16.00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17 00
18.00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds li	ne 11) (see	0	19.00
20.00	instructions)		10) (	0	20.00
20.00	Excess of reasonable cost over customary charges (complete onl instructions)	Ty IT TThe IT exceeds IT	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			16, 802, 196	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		120, 820	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see inst	ructions)	15, 292, 109	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 2	2 and 23] (see	1, 389, 267	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	28.00
28.50	REH facility payment amount (see instructions)				28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			1, 389, 267	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			85 1, 389, 182	
52.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)		1, 307, 102	52.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			1, 293, 657	34.00
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		840, 877 1, 032, 791	
37.00	Subtotal (see instructions)			2, 230, 059	
38.00	MSP-LCC reconciliation amount from PS&R			0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions	s)		-	39.50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	39.75 39.97
39.97 39.98	Partial or full credits received from manufacturers for replace	ced devices (see instru	ctions)	0	39.97
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			2, 230, 059	40.00
40.01	Sequestration adjustment (see instructions)			44, 601	40.01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
40.03	Interim payments			2, 065, 878	
41.01	Interim payments-PARHM				41.01
42.00	Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)			110 500	42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			119, 580	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	1, 303, 668	
	§115. 2	· · · · · · · · · · · · · · · · · · ·			
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFORD	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Peri od:	Worksheet E Part B	
		From 01/01/2023 To 12/31/2023		
	Title XVIII	Hospi tal	Cost	
			1.00	
94.00 Total (sum of lines 91 and 93)			0	94.00
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6, 407, 99	1	2, 065, 878	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	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
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/29/2023	182, 00	0	0	3.0
3.02		0772772023		0	0	3.02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program			_1		
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50 3.5
3.51				0	0	3.5 3.52
3.53				0	0	3. 53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		182, 00	0	0	3.99
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		6, 589, 99	1	2, 065, 878	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		0, 307, 77		2,000,070	4.00
	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					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program	1				
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51 5.52				0	0	5.52
5.92	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)				-	
6.00	Determined net settlement amount (balance due) based on					6.00
4 01	the cost report. (1)				110 500	1.00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		782, 37	0	119, 580 0	6. 0' 6. 02
6.02 7.00	Total Medicare program liability (see instructions)		782, 37 5, 807, 61		2, 185, 458	7.0
			3, 337, 01	Contractor	NPR Date	,
				Number	(Mo/Day/Yr)	
			)	1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component (	CN: 15-1328 CCN: 15-Z328		riod: om 01/01/2023 12/31/2023	Worksheet E- Part I Date/Time Pr	гера	ared:
						5/29/2024 2:	18	pm
			XVIII	Sw	ing Beds - SNF	Cost t B		
		inpatien	t Part A		Par	ιв		
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount		
		1.00	2.00		3.00	4.00		
1.00	Total interim payments paid to provider			0			0	1.00
2.00	Interim payments payable on individual bills, either			0			0	2.00
	submitted or to be submitted to the contractor for							
	services rendered in the cost reporting period. If none,							
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment							3.00
3.00	amount based on subsequent revision of the interim rate							3.00
	for the cost reporting period. Also show date of each							
	payment. If none, write "NONE" or enter a zero. (1)							
	Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER			0			0	3. 01
3.02				0			0	3. 02
3.03				0			0	3.03
3.04				0			0	3.04
3.05	Description to Description			0			0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0			0	3.50
3.50	ADJUSTMENTS TU PRUGRAM			0			0	3.50
3.52				0			0	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			0			0	3.99
	3. 50-3. 98)							
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0			0	4. OC
	(transfer to Wkst. E or Wkst. E-3, line and column as							
	appropriate) TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after							5. OC
0.00	desk review. Also show date of each payment. If none,							0.00
	write "NONE" or enter a zero. (1)							
	Program to Provider							
5.01	TENTATI VE TO PROVIDER			0			0	5.01
5.02				0			0	5.02
5.03	Dravidar to Dragram			0			0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0			0	5. 5C
5.50				0			0	5.50
5.52				õ			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	Determined net settlement amount (balance due) based on							6. OC
	the cost report. (1)							, -
6.01	SETTLEMENT TO PROVIDER			0			0	6.01
6.02	SETTLEMENT TO PROGRAM			0			0	6.02
7.00	Total Medicare program liability (see instructions)		L	0	Contractor	NPR Date	0	7.00
					Number	(Mo/Day/Yr)		
		(	)		1.00	2.00		
8.00	Name of Contractor							8.00

Heal th	Financial Systems INDIANA UNIVERSITY	HEALTH BEDFORD	In Lie	u of Form CMS-	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1328	Peri od:	Worksheet E-	
			From 01/01/2023 To 12/31/2023		parad
			10 12/31/2023	Date/Time Pre 5/29/2024 2: 2	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	:. S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00

	Financial Systems INDIANA UNIVERSITY HEAL TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS PI	rovider CCN: 15-1328	Peri od:	u of Form CMS-2 Worksheet E-2	
	C	omponent CCN: 15-Z328	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 2:13	
		Title XVIII	Swing Beds - SNF	Cost	o p
			Part A 1.00	<u>Part B</u> 2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.0
. 00	Inpatient routine services - swing bed-NF (see instructions)				2.0
. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A	, and sum of Wkst. D,	0	0	3. C
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-	bed pass-through, see			
	instructions)				
1	Nursing and allied health payment-PARHM (see instructions)			0.00	3.0
	Per diem cost for interns and residents not in approved teaching instructions)	program (see		0.00	4.0
1	Program days		0	0	5.0
	Interns and residents not in approved teaching program (see inst	ructions)	Ŭ	0	
	Utilization review - physician compensation - SNF optional metho		0	-	7.0
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	5	0	0	8.0
. 00	Primary payer payments (see instructions)		0	0	9.0
0.00	Subtotal (line 8 minus line 9)		0	0	10.0
	Deductibles billed to program patients (exclude amounts applicab	le to physician	0	0	11. (
	professional services)			_	
	Subtotal (line 10 minus line 11)		0	0	
	Coinsurance billed to program patients (from provider records) (	exclude coinsurance	0	0	13.0
	for physician professional services)			0	14.0
	80% of Part B costs (line 12 x 80%) Subtotal (see instructions)		0	0	14.0
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.5
	Rural community hospital demonstration project (§410A Demonstrat	ion) payment	0		16.5
	adjustment (see instructions)		-		
	Demonstration payment adjustment amount before sequestration		0	0	16. 9
7.00	Allowable bad debts (see instructions)		0	0	17.0
7.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.0
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	
	Total (see instructions)		0	0	
	Sequestration adjustment (see instructions)		0	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
1	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)		0	0	19.0 19.2
	Interim payments		0	0	
	Interim payments-PARHM		Ŭ	0	20.0
	Tentative settlement (for contractor use only)		0	0	
1	Tentative settlement-PARHM (for contractor use only)				21.0
2.00	Balance due provider/program (line 19 minus lines 19.01, 19.02,	19.25, 20, and 21)	0	0	22.0
	Balance due provider/program-PARHM (see instructions)				22.0
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23.0
	chapter 1, §115.2	:> A-I:+			
	Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration peric				200. 0
	Century Cures Act? Enter "Y" for yes or "N" for no.				200.0
	Cost Reimbursement				1
01.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	t. D-1, Pt. II, line			201.0
	66 (title XVIII hospital))				
	Medicare swing-bed SNF inpatient ancillary service costs (from W	kst. D-3, col. 3, lin	e		202.0
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.0
	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi	ret year of the curre	nt E voar domonat	ration	204. (
	period)	ist year of the curre	int 5-year demonst	Tation	
	Medicare swing-bed SNF target amount				205.0
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time	s line 204)			206.0
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem				1
	Program reimbursement under the §410A Demonstration (see instruc				207.0
08.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1		208. 0
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209. 0
	Reserved for future use				210. 0
	Comparision of PPS versus Cost Reimbursement				045 -
15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 instructions)	pius line 210) (see			215. (

ALCULA		BEDFORD ider CCN: 15-1328	Peri od:	Worksheet E	8-2552 -2
	Comp	oonent CCN: 15-Z328	From 01/01/2023 To 12/31/2023	Date/Time Pi 5/29/2024 2:	
		Title XIX	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	_
	COMPUTATION OF NET COST OF COVERED SERVICES		0		1.
	npatient routine services - swing bed-SNF (see instructions) npatient routine services - swing bed-NF (see instructions)		0		2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,	and sum of Wkst D	0		3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-be		-		J 3.
	nstructions)	1 3			
	Nursing and allied health payment-PARHM (see instructions)				3.
	Per diem cost for interns and residents not in approved teaching p	rogram (see	0.00		4.
1	nstructions)		0		-
	Program days nterns and residents not in approved teaching program (see instru	ctions)	0		5
	Itilization review - physician compensation - SNF optional method		0		7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	on y	0		8
	Primary payer payments (see instructions)		0		9
	Subtotal (line 8 minus line 9)		0		10
	Deductibles billed to program patients (exclude amounts applicable	to physician	0		11
	professional services)				
	Subtotal (line 10 minus line 11)		0		12
	Coinsurance billed to program patients (from provider records) (ex for physician professional services)	ci ude coi nsurance	0		13
	30% of Part B costs (line 12 x 80%)		0		14
	Subtotal (see instructions)		0		15
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16
.50 F	Pioneer ACO demonstration payment adjustment (see instructions)				16
.55 F	Rural community hospital demonstration project (§410A Demonstratio	n) payment			16
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0		16
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0		17
	Allowable bad debts for dual eligible beneficiaries (see instructi	anc)	0		18
	Fotal (see instructions)	51137	0		19
	Sequestration adjustment (see instructions)		0		19
. 02 [	Demonstration payment adjustment amount after sequestration)		0		19
. 03   5	Sequestration adjustment-PARHM pass-throughs				19
	Sequestration for non-claims based amounts (see instructions)		0		19
1	nterim payments		0		20
	nterim payments-PARHM				20
	Fentative settlement (for contractor use only) Fentative settlement-PARHM (for contractor use only)		0		21
	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19	25 20 and 21)	0		21
	Balance due provider/program-PARHM (see instructions)	. 20, 20, and 21)	Ŭ		22
	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub. 15-2,	0		23
c	chapter 1, §115.2				
	ural Community Hospital Demonstration Project (§410A Demonstration				
	s this the first year of the current 5-year demonstration period	under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Medicare swing-bed SNF inpatient routine service costs (from Wkst.	D-1 Pt II line			201
	56 (title XVIII hospital))	5 1, 10 11, 1110			
	Medicare swing-bed SNF inpatient ancillary service costs (from Wks	t. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF))				
	Fotal (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions) computation of Demonstration Target Amount Limitation (N/A in firs	t year of the ourre	nt E voor demonst	ration	204
	eriod)	t year of the curre	int b-year demonst	1411011	
	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursemen				
7.00 F	Program reimbursement under the §410A Demonstration (see instructi	ons)			207
	<i>N</i> edicare swing-bed SNF inpatient service costs (from Wkst. E-2, co	I. 1, sum of lines	1		208
	and 3)				000
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	5)			209 210
	Reserved for future use cost Reimbursement				$-1^{210}$
	Fotal adjustment to Medicare swing-bed SNF PPS payment (line 209 p				215

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2023	Worksheet E-3 Part V	
			To 12/31/2023		
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - COST	REIMBURSEMENT		
. 00	Inpatient services	+:)		6, 648, 662	
2.00 3.00	Nursing and Allied Health Managed Care payment (see instruct Organ acquisition	tions)		0	2. 3.
. 00	Cellular therapy acquisition cost (see instructions)			0	3.
. 00	Subtotal (sum of lines 1 through 3.01)			6, 648, 662	
. 00	Primary payer payments			272	5.
. 00	Total cost (line 4 less line 5). For CAH (see instructions)			6, 714, 877	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable charges			0	- 1
. 00 . 00	Routine service charges Ancillary service charges			0	7. 8.
. 00	Organ acquisition charges, net of revenue			0	
	Total reasonable charges			0	10.
	Customary charges				
	Aggregate amount actually collected from patients liable for	1 3	Ū	0	
2.00	Amounts that would have been realized from patients liable f		on a charge basis	0	12.
2 00	had such payment been made in accordance with 42 CFR 413.13(	(e)		0,000000	12
3.00 4.00	Ratio of line 11 to line 12 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	13
	Excess of customary charges over reasonable cost (complete o	only if line 14 exceeds li	ne 6) (see	0	
0.00	instructions)		10 0) (000	0	
6.00	Excess of reasonable cost over customary charges (complete o	only if line 6 exceeds lin	ne 14) (see	0	16
	instructions)				
7.00	Cost of physicians' services in a teaching hospital (see ins COMPUTATION OF REIMBURSEMENT SETTLEMENT	structions)		0	17.
8 00	Direct graduate medical education payments (from Worksheet E	-4 line 49)		0	18.
	Cost of covered services (sum of lines 6, 17 and 18)	,		6, 714, 877	
0. 00	Deductibles (exclude professional component)			796, 404	20
1.00	Excess reasonable cost (from line 16)			0	21
	Subtotal (line 19 minus line 20 and 21)			5, 918, 473	
				16, 800	
	Subtotal (line 22 minus line 23)	(acc) (acc instructions)		5, 901, 673	
	Allowable bad debts (exclude bad debts for professional serv Adjusted reimbursable bad debts (see instructions)	vices) (see finstructions)		37, 634 24, 462	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		11, 200	
	Subtotal (sum of lines 24 and 25, or line 26)			5, 926, 135	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
9.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29
9. 98	Recovery of accelerated depreciation.			0	29
9. 99	Demonstration payment adjustment amount before sequestration	ו		0	
0.00	Subtotal (see instructions)			5, 926, 135	
). 01 ). 02	Sequestration adjustment (see instructions)			118, 523 0	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM			0	30
. 00	Interim payments			6, 589, 991	31
1.01	Interim payments-PARHM			2,007,771	31
2.00	Tentative settlement (for contractor use only)			0	
2. 01	Tentative settlement-PARHM (for contractor use only)				32
3.00	Balance due provider/program (line 30 minus lines 30.01, 30.			-782, 379	
3.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26,				33
4.00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	chapter 1,	488, 826	34

	Financial Systems INDIANA UNIVERSITY E SHEET (If you are nonproprietary and do not maintain when accounting accounts account of the Canada Summers	Provider C		Period: From 01/01/2023	u of Form CMS-2 Worksheet G	
una-t nl y)	ype accounting records, complete the General Fund column			To 12/31/2023	Date/Time Pre 5/29/2024 2:1	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	-
00	CURRENT ASSETS Cash on hand in banks	139, 182, 409	(	0	0	1 1.
00	Temporary investments	0 137, 102, 407		-	0	
00	Notes receivable	0		-	0	
00	Accounts receivable	10, 033, 585			0	
00	Other receivable	617, 452		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	0	(	0	0	
00	Inventory	1, 842, 096	(	0 0	0	7
00	Prepai d expenses	198, 445		0 0	0	8
00	Other current assets	0		0 0	0	9
0. 00	Due from other funds	0	(	0 0	0	10
I. 00	Total current assets (sum of lines 1-10)	151, 873, 987	(	0 0	0	11
	FIXED ASSETS		_			
2.00	Land	1, 034, 321	(	0 0	0	12
3.00	Land improvements	1, 093, 347	(	0 0	0	13
4.00	Accumulated depreciation	-1, 082, 052	(	0 0	0	14
	Bui I di ngs	20, 660, 864	(		0	
6.00	Accumulated depreciation	-14, 296, 295	(	-	0	
	Leasehold improvements	0	(		0	
8.00	Accumulated depreciation	0	(	-	0	
	Fixed equipment	0	(		0	
	Accumulated depreciation	0	(	-	0	
	Automobiles and trucks	266, 329			0	
	Accumulated depreciation	220, 520- 20, 995, 164		-	0	
3.00 4.00	Major movable equipment			-	0	
	Accumulated depreciation Minor equipment depreciable	-14, 512, 297		-	0	
	Accumulated depreciation	0		-	0	
	HIT designated Assets				0	
8.00	Accumulated depreciation	0		-	0	
	Mi nor equi pment-nondepreci abl e	0		-	0	
	Total fixed assets (sum of lines 12-29)	13, 938, 861		-	0	
	OTHER ASSETS	,			-	
1.00	Investments	0	(	0 0	0	31
2.00	Deposits on Leases	0	(	0 0	0	32
3.00	Due from owners/officers	0	(	0 0	0	33
4.00	Other assets	6, 088, 016		0 0	0	34
5.00	Total other assets (sum of lines 31-34)	6, 088, 016	(	0 0	0	35
6.00	Total assets (sum of lines 11, 30, and 35)	171, 900, 864	(	0 0	0	36
	CURRENT LIABILITIES					
	Accounts payable	9, 672, 638			0	
	Salaries, wages, and fees payable	133, 642			0	
9.00	Payroll taxes payable	1, 224, 796			0	
0.00		65, 337		0	0	
	Deferred income	0	(	0 0	0	
2.00	Accel erated payments	0				42
	Due to other funds			-	0	
	Other current liabilities	3, 683, 910		-	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	14, 780, 323	(	0 0	0	45
6. 00	LONG TERM LIABILITIES Mortgage payable	0	(	) 0	0	46
7.00	Notes payable	0			0	
8.00	Unsecured Loans				0	
	Other long term liabilities	114, 929			0	
	Total long term liabilities (sum of lines 46 thru 49)	114, 929		-	0	
	Total liabilities (sum of lines 45 and 50)	14, 895, 252		-	0	
	CAPITAL ACCOUNTS	., 2.0, 202				1 '
2.00	General fund balance	157, 005, 612				1 52
3.00	Specific purpose fund		(			53
4.00	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
6. 00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
8.00			1	1		1
8. 00	replacement, and expansion					1
8. 00 9. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	157, 005, 612	(	o o	0	59

		I ANA UNI VERSI TY			_		u of Form CMS-	
STATEMENT OF CHANGES IN FUND BALANCES			Provider CCN: 15-1328 Period: From 01/01/20 To 12/31/20		om 01/01/2023			
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	132, 961, 604 24, 044, 000 157, 005, 604 8 157, 005, 612 0 157, 005, 612		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0		5.00         6.00         7.00         8.00         9.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00
		Endowment Fund	PI ant					
1.00	Fund halances at had aning of pariod	6.00	7.00	8.00	0			1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-1328		d: 01/01/2023 12/31/2023	Worksheet G-2 Parts I & II Date/Time Pre 5/29/2024 2:	epared:
	Cost Center Description		Inpati ent	Ou	tpati ent	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						_
	General Inpatient Routine Services						_
1.00	Hospi tal		11, 955, 7	41		11, 955, 741	
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF		33, 5			33, 587	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE		44 000 0	~~		11 000 000	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		11, 989, 3	28		11, 989, 328	3 10.00
11 00	Intensive Care Type Inpatient Hospital Services		10 004 0			10 004 25	1 11 00
11.00	INTENSIVE CARE UNIT CORONARY CARE UNIT		10, 084, 3	57		10, 084, 357	
12.00							12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	Linco	10 004 2	E 7		10 004 25	
16.00	Total intensive care type inpatient hospital services (sum of 11-15)	Tines	10, 084, 3	57		10, 084, 357	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16	、 · · · · ·	22,073,6	OE		22, 073, 685	5 17.00
18.00	Ancillary services	,	26, 218, 1		19, 699, 246	245, 917, 352	
19.00	Outpatient services		20, 218, 1		19, 099, 240 89, 456, 774	91, 755, 252	
20.00	RURAL HEALTH CLINIC		2, 270, 4	0	09,450,774	91, 755, 252	
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	(	
22.00	HOME HEALTH AGENCY	·		U	0		22.00
23.00	AMBULANCE SERVICES						23.00
24.00	CMHC						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )						25.00
26.00	HOSPICE						26.00
27.00	PHYSI CI AN REVENUE			0	2, 994, 946	2, 994, 946	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	50, 590, 2	-	12, 150, 966	362, 741, 235	
	G-3. Line 1)			-		, ,	
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				83, 209, 949		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 (SPECI FY)			0			37.00
38.00				0			38.00
39. 00				0			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	2)(transfer		1 1	83, 209, 949		43.00

					u of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1328 Period: From 01/01/2023				Worksheet G-3			
	3 3 Date/Time Prepare						
	5/29/2024 2:1						
				1.00			
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			362, 741, 235			
2.00	Less contractual allowances and discounts on patients' account	its		264, 026, 307			
3.00	Net patient revenues (line 1 minus line 2)			98, 714, 928			
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		83, 209, 949			
5.00	Net income from service to patients (line 3 minus line 4)			15, 504, 979	5.00		
( 00	OTHER INCOME			0	6 00		
6.00 7.00	Contributions, donations, bequests, etc Income from investments			0	6.00 7.00		
7.00 8.00	Revenues from telephone and other miscellaneous communication			0			
8.00 9.00	Revenue from television and radio service	Services		0			
9.00 10.00	Purchase di scounts			0			
11.00	Rebates and refunds of expenses			0			
12.00	Parking lot receipts			0			
12.00	Revenue from Laundry and Linen service			0			
	Revenue from meals sold to employees and quests			0			
	Revenue from rental of living quarters			0			
	Revenue from sale of medical and surgical supplies to other t	han patients		0			
	Revenue from sale of drugs to other than patients			0			
	Revenue from sale of medical records and abstracts			0			
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00		
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00		
21.00	Rental of vending machines			0	21.00		
22.00	Rental of hospital space			0	22.00		
23.00	Governmental appropriations			0	23.00		
24.00	MI SCELLANEOUS I NCOME			8, 539, 021	24.00		
24.50	COVI D-19 PHE Fundi ng			0	24.50		
25.00	Total other income (sum of lines 6-24)			8, 539, 021	25.00		
26.00	Total (line 5 plus line 25)			24, 044, 000	26.00		
27.00	OTHER EXPENSES (SPECIFY)			0			
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00		
29.00	Net income (or loss) for the period (line 26 minus line 28)			24, 044, 000	29.00		