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: 15-0051 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2024 1:53 pm use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLOOMINGTON HOSPITAL (15-0051) for the cost reporting period beginning 01/01/2023 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Mic	hael Craig	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Mi chael Crai g			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
HOSPI TAL	0	348, 201	1, 930	0	0	1. 00
SUBPROVI DER - I PF	0	0	0		0	2. 00
SUBPROVI DER - I RF	0	0	0		0	3. 00
SUBPROVI DER (OTHER)						4. 00
SWING BED - SNF	0	0	0		0	5. 00
SWING BED - NF	0				0	6. 00
HOME HEALTH AGENCY I	0	0	0		0	9. 00
TOTAL	0	348, 201	1, 930	0	0	200. 00
	HOSPI TAL SUBPROVI DER - I PF SUBPROVI DER - I RF SUBPROVI DER (OTHER) SWI NG BED - SNF SWI NG BED - NF	1.00	Title V Part A 1.00 2.00	1.00 2.00 3.00	Title V	Title V

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, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I	IU HEALTH BLOOMI DENTIFICATION DATA			CN: 1		lı Period: From 01/01/		of For Workshe Part I		2552-10
							To 12/31/		Date/Ti 5/29/20		
	1.00	2.00		3. 00			4	4. 00	5/2//20	724 1.5	J piii
1. 00	Hospital and Hospital Health Care Co Street: 601 WEST SECOND STREET	PO Box: 1149									1. 00
2.00	Ci ty: BLOOMINGTON	State: IN	Zi p Cod	_			y: MONROE	D	-1 01	(D	2. 00
		Component Name	CCN Number	CB:		Provi der Type	Date Certified		nt Syst 0, or		
		1.00	2.00	3.	00	4.00	5. 00	V 6. 00	7. 00		
	Hospital and Hospital-Based Componen		2.00	3.	00	4.00	5.00	0.00	7.00	0.00	
3. 00	Hospi tal	IU HEALTH BLOOMINGTON HOSPITAL	150051	140	020	1	07/01/1966	N	Р	P	3. 00
4.00	Subprovider - IPF	IIIOSI I TAL									4. 00
5. 00 6. 00	Subprovi der - IRF Subprovi der - (Other)										5. 00 6. 00
7. 00	Swing Beds - SNF										7. 00
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF										8. 00 9. 00
10.00	Hospi tal -Based NF										10.00
11.00	Hospi tal -Based OLTC										11.00
12. 00 13. 00	· ·										12. 00 13. 00
14. 00	Hospi tal -Based Hospi ce										14. 00
15. 00 16. 00											15. 00 16. 00
17. 00											17. 00
18.00	1										18.00
19. 00	Other						From:		To):	19. 00
							1.00		2. (
20. 00 21. 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/2	023	12/31	/2023	20.00
	· · · · · · · · · · · · · · · · · · ·					4 00					
	Inpatient PPS Information					1. 00	2. 00		3. (JU	
22. 00	Does this facility qualify and is it					Υ	N				22. 00
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			₹							
	facility subject to 42 CFR Section §	412. 106(c)(2)(Pickle am									
22. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC		tal UCPs.	for		Υ	Υ				22. 01
	this cost reporting period? Enter in	column 1, "Y" for yes	or "N" for	no no							
	for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or										
	cost reporting period occurring on o			.0							
22. 02	instructions) Is this a newly merged hospital that	requires a final IICP to	n he			N	N				22. 02
22.02	determined at cost report settlement			umn		.,					22.02
	1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in			no							
	for the portion of the cost reportin			110,							
22. 03						N	N		N		22. 03
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reportin			er							
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft										
	Does this hospital contain at least		•								
	counted in accordance with 42 CFR 41 yes or "N" for no.	2.105)? Enter in column	3, "Y" fo	or							
22. 04	Did this hospital receive a geograph										22. 04
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reportin	g period prior to Octob	er 1. Ente								
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft										
	Does this hospital contain at least			as							
	counted in accordance with 42 CFR 41 yes or "N" for no.	2.105)? Enter in column	n 3, "Y" f	for							
23. 00	-	dicaid days on lines 24	and/or 25	5			3 N				23. 00
	below? In column 1, enter 1 if date	of admission, 2 if cens	us days, d	or 3							
	if date of discharge. Is the method reporting period different from the			.US (
	reporting period? In column 2, ente	r "Y" for yes or "N" fo	r no.								

		V	XVIII	XI X	
		1. 00	2. 00	3.00	
	Prospective Payment System (PPS)-Capital				
	Does this facility qualify and receive Capital payment for disproportionate share in accordance	N	Y	N	45. 00
	with 42 CFR Section §412.320? (see instructions)				47.00
	Is this facility eligible for additional payment exception for extraordinary circumstances	N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.				
	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47. 00
	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48. 00
40.00	Teaching Hospitals	l IA	IN	IN	40.00
56 00	Is this a hospital involved in training residents in approved GME programs? For cost reporting	N			56. 00
30. 00	periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For	''			30.00
	cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see				
	the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was				
	involved in training residents in approved GME programs in the prior year or penultimate year,				
	and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter				
	"Y" for yes; otherwise, enter "N" for no in column 2.				
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes,				57.00
	is this the first cost reporting period during which residents in approved GME programs trained				
	at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did				
	residents start training in the first month of this cost reporting period? Enter "Y" for yes or				
	"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N",				
	complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods				
	beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of				
	which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y"				
	for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				F0 00
	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as				58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				

61. 05	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. 05	
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61. 06	
	care or general surgery. (see instructions)							
		Pr	ogram Name	Program Code	Unweighted IME	Unwei ghted		
					FTE Count	Direct GME FTE		
						Count		
			1. 00	2. 00	3. 00	4. 00		
	Of the FTEs in line 61.05, specify each new program 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				0. 00		61. 10	
	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.					1.00		
	ACA Provisions Affecting the Health Resources and Ser							
62. 00	Enter the number of FTE residents that your hospital		d in this cost	reporting peri	od for which	0.00	62. 00	
(2.01	your hospital received HRSA PCRE funding (see instruc		!!! +!- ^	(TUC) :		0.00	(2.01	
62.01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC productions.				your nospi tai	0.00	62. 01	
				15)				
63. 00	Teaching Hospitals that Claim Residents in Nonprovider Settings 3.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)							

Heal th	n Financial Systems	IU HFALTH	BLOOMI NGT	ON HOSPITAL		In Lie	eu of Form CMS	2552-10
	TAL AND HOSPITAL HEALTH CARE COMP			Provi der Co		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I	pared:
					Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Yea	ur ETE Residents in N	onprovi der	Settings	1.00 This base yea	2.00	3.00	
64. 00	period that begins on or after of Enter in column 1, if line 63 is in the base year period, the numeresident FTEs attributable to resettings. Enter in column 2 the	luly 1, 2009 and befo yes, or your faciliaber of unweighted non tations occurring in	re June 30 ty trained n-primary all nonpr	resi dents care ovi der	0.			64.00
	resident FTEs that trained in your of (column 1 divided by (column							
	joi (corumni i di vi ded by (corumni	Program Name		am Code	Unwei ghted FTEs Nonprovi der	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	(
		1. 00	2	. 00	3. 00	4.00	5.00	1
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				Unwei ghted	Unwei ghted	Ratio (col. 1/	
					FTEs Nonprovi der Si te	·	(col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovi	der Settina	1.00 sEffective	2.00 for cost report	3.00 ina periods	
// 00	beginning on or after July 1, 20)10						
66.00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpounce unweighted non-priman al. Enter in column (rovider se ry care re 3 the rati	ttings. sident o of	0.	0.0	0. 000000	66.00
		Program Name	Progr	am Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	,
67 00	Enter in column 1, the program	1. 00	2	. 00	3. 00	4. 00 00 0. 0	5. 00 0. 000000	67 00
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							

	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti		column 2 for			
98. 02	title XIX. 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. 02
98. 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	N	98. 03
98. 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 ir			N	N	98. 04
8. 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			N	Y	98. 05
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 columr column 2 for title XIX.			N	Y	98. 06
Ī	Rural Providers					
06.00	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 met	hod of payment	N		105. 00 106. 00
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 approved medical education program in the CAH's excluded IF	n 1. (see ins you train I&R PF and/or IRF	tructions) s in an			107. 00
07. 01	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 of instructions)	t elígible for				107. 01
	Is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 42	N		108. 00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				Respi ratory	
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupational	Speech 3 00		-
109. 00	CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 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.	Physi cal 1.00	Occupati onal 2.00	Speech 3. 00	4.00	109. 00
109. 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.	1.00	2.00	3.00	4.00	109.00
109. 00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1.00 al Demonstrati 'Y" for yes or	2.00 on project (§41 "N" for no. If	3. 00 0A yes,	4.00	
109. 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. 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	1.00 al Demonstrati 'Y" for yes or	2.00 on project (§41 "N" for no. If	3.00 0A yes, h 215, as	4. 00 1. 00 N	
110.00	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. 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	1.00 al Demonstrati 'Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	on project (§41 "N" for no. If ines 200 throug ommunity period? Enter enter the column 2.	3. 00 0A yes,	4.00	110. 00
110.00	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. 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 Worapplicable. If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this come "Y" for yes or "N" for no in column 1. If the response to continue in the call that apply: "A" for Ambulance services; "B" for accompliance in the call that apply: "A" for Ambulance services; "B" for accompliance in the complex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuation in the call that apply: "A" for Ambulance services; "B" for accomplex continuatio	1.00 al Demonstrati 'Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	on project (§41 "N" for no. If ines 200 throug ommunity period? Enter enter the column 2.	3. 00 OA yes, h 215, as	4. 00 1. 00 N	110. 00
11.00	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. 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 the Health Integration Project (FCHIP) demonstration for this complete that apply in the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for according to the 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 comparing the pennsylvania cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the pennsylvania cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the pennsylvania cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the pennsylvania cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the pennsylvania cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the pennsylvania cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the pennsylvania cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparing the pennsylvania cost reportion of the current "Y" for yes or "N" for no in column 1 in the demonstration, if applicable.	al Demonstrati 'Y" for yes or 'ksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is oating in the	on project (§41 "N" for no. If ines 200 throug ommunity period? Enter enter the column 2. ; and/or "C"	3.00 0A yes, h 215, as	1. 00 N	110.00
1109. 00 1110. 00 1112. 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. Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this complete that apply in the FCHIP demoin which this CAH is participate in the response to complete that apply: "A" for Ambulance services; "B" for action 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 complete the hospital began participate in the date the hospital ceaparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "Gor short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider).	al Demonstrati 'Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is oating in the ased r "N" for no 3, or E only) 93" percent (includes	on project (§41 "N" for no. If ines 200 throug ommunity period? Enter enter the column 2. ; and/or "C"	3.00 0A yes, h 215, as	4.00 1.00 N	111.00
10. 00 11. 00 12. 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. Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this con "Y" for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demoning which this CAH is participate all that apply: "A" for Ambulance services; "B" for action for tele-health services. Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost respectively. The period? Enter "Y" for yes or "N" for no in column 1. If concept and the demonstration in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G 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. Is this facility classified as a referral center? Enter "Y"	al Demonstrati 'Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is oating in the ased "N" for no 3, or E only) 93" percent (includes rs) based on	on project (§41 "N" for no. If ines 200 throug ommunity period? Enter enter the column 2. ; and/or "C"	3.00 0A yes, h 215, as	4.00 1.00 N	111.00
1109. 00 1110. 00 1112. 00 1115. 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. Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this complete that a property in the property of the FCHIP demonstration for this complete and the property of the FCHIP demonstration for the 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 complete the hospital began participated participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 2 is "E", enter in column 3 either "Sychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	al Demonstrati 'Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is oating in the ased "N" for no 3, or E only) 93" percent (includes rs) based on for yes or	on project (§41 "N" for no. If i nes 200 throug ommunity period? Enter enter the column 2. ; and/or "C"	3.00 0A yes, h 215, as	4.00 1.00 N	1109. 00 1110. 00 1112. 00 1115. 00 1116. 00 117. 00

		1.00	
144.00 Are provider based physicians' costs included in Worksheet A?		Υ	144. 00
	1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for	Y		145. 00
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is			
no, does the dialysis facility include Medicare utilization for this cost reporting			
period? Enter "Y" for yes or "N" for no in column 2.			
146.00 Has the cost allocation methodology changed from the previously filed cost report?	N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If			
yes, enter the approval date (mm/dd/yyyy) in column 2.			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der C	CN: 15-0051		1/01/2023 2/31/2023		repared:
						1.00	_
147.00 Was there a change in the statisti	cal basis? Enter "Y" fo	or yes or "N" for	no.			N N	147. 00
148.00 Was there a change in the order of	allocation? Enter "Y"	for yes or "N" f	or no.			N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method	? Enter "Y" for y	es or "N" f			N	149. 00
		Part A	Part B	T	itle V	Title XIX	
		1.00	2.00		3. 00	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or '	N for no for each com	ponent for Part P	and Part B	5. (See 42	2 CFR 9413 N	3. 13) N	155. 00
156. 00 Subprovi der – TPF		N N	N N		N	N N	156. 00
157. 00 Subprovider - TRF		N N	N N		N	N N	157. 00
158. OO SUBPROVI DER		IN .	l IV		IV	IN IN	158. 00
159. 00 SNF		N	l N		N	N	159. 00
160.00HOME HEALTH AGENCY		N N	N N		N	N N	160.00
161. 00 CMHC			l N		N	N N	161. 00
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multica	mpus hospital that has	one or more camp	uses in dif	ferent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.							
	Name	County		Zip Code	CBSA	FTE/Campus	
1// 00 6 1: 1/5 : 6	0	1. 00	2. 00	3. 00	4. 00	5. 00	00 166. 00
166.00 f line 165 is yes, for each 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						0.1	50 166. 00
column 5 (see instructions)							
						1.00	
Health Information Technology (HI				ent Act		T	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the h	05 is "Y") and is a mean	ningful user (lin		"), enter	the	Y	167. 00 168. 00
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)?	ot a meaningful user, o Enter "Y" for yes or '	does this provide "N" for no. (see	instruction	s)	·		168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction		and is not a CAH	(line 105 i	s "N"), e	enter the	9.	99169. 00
					gi nni ng 1. 00	Endi ng 2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and endi	ng date for the r	eporti ng		1.00	2.00	170. 00
					1. 00	2.00	
171.00 fline 167 is "Y", does this prov	ider have any days for	individuals enro	lled in		Y		33 171. 00
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, I mn 1. If column 1 is ye	Pt. I, line 2, co	I. 6? Enter		ı	1,0	55,171.00

Heal th	Financial Systems IU HEALTH BLOOMI	NGTON HOSPITAL		In lie	u of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0051	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre	epared:
				Y/N	5/29/2024 1:5 Date	53 pm
				1. 00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			r all dates in 1	the	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1. 00
	,		Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)					3. 00
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00 5. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4. 00
3.00	those on the filed financial statements? If yes, submit received		"			3.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?		s the provider			6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	Y N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
					Y/N 1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection provided 15 yes. Submit sony.			st reporting	Y N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurations.	ance amounts wa	nived? If yes,	see	N	14. 00
15. 00	Bed Complement Did total beds available change from the prior cost reporti				Υ	15. 00
			rt A		t B	
		1. 00	2. 00	Y/N 3. 00	Date 4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00
17. 00	instructions) 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		N		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		N		19. 00

	Financial Systems IU HEALTH BLOOM	INGTON HOSPITAL	<u>_</u>	In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (CCN: 15-0051	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time F 5/29/2024 1	repared:
			i pti on	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
		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 records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS I	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see		aala mada duu	ing the cost		22. 00 23. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made dur	rng the cost		23.00
24. 00	Were new leases and/or amendments to existing leases enter- lf yes, see instructions	porting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	'If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he cost report	ing period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cost	reporting		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service R	Reserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mate		debt? If yes	s, see		30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see		31. 00
	instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care se	rvices furnish	ed through co	ntractual		32. 00
33. 00	arrangements with suppliers of services? If yes, see instrict of line 32 is yes, were the requirements of Sec. 2135.2 app	uctions.	-			33. 00
	no, see instructions. Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-b	ased physicians?		34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreeme	nts with the	provi der-based		35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.		V (8)	5 .	
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
36.00	Were home office costs claimed on the cost report?					36. 00
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	·		37. 00
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of			-		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year enter line 36 is yes, did the provider render services to other			i,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00
	i nstructi ons.					
		1	. 00	2	00	
	Cost Report Preparer Contact Information			2,		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	I NDI ANA UNI VEI	RSLTY HEALTH			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	317-556-3910		RUTTER@I UHEALTI	H. ORG	43. 00
	report preparer in columns 1 and 2, respectively.	I		I		II

Heal th	n Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	In Lieu of Form CMS-2552-1			
HOSPI 7	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT (QUESTI ONNAI RE	Provi der CCN		Peri od:	Worksheet S-2			
					From 01/01/2023 o 12/31/2023	Date/Time Pre	pared:		
						5/29/2024 1:5			
			3. 0	0					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the ti	tle/position	DI RECTOR				41. 00		
	held by the cost report preparer in column	ns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the cos	st report					42. 00		
	preparer.								
43.00	Enter the telephone number and email addre						43.00		
	report preparer in columns 1 and 2, respec	cti vel y.							

Component Worksheet A No. of Beds Bed Days Available CAH/REH Hours Title V
Component Worksheet A No. of Beds Bed Days Available CAH/REH Hours Title V
Component Worksheet A No. of Beds Bed Days Available CAH/REH Hours Title V Line No. 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
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) 2.00
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 3.00 4.00 HM0 IPF Subprovider 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 16 5,840 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 16 5,840 0.00 0 8.00 9.00 CORONARY CARE UNIT 32.00 0 0 0 0 0 0 9.00 10.00 BURN INTENSIVE CARE UNIT
for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 10.00 BURN INTENSIVE CARE UNIT 12.00 3.00 4.00 4.00 5.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 6
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 13.00 10.00 BURN INTENSIVE CARE UNIT 2.00 3.00 4.00 5.00 6.00 7.00 0.00 0.00 0.00 0.00 0.00 0
3.00 4.00 HM0 I PF Subprovi der 4.00 Hospi tal Adul ts & Peds. Swi ng Bed SNF 6.00 Hospi tal Adul ts & Peds. Swi ng Bed NF 7.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8.00 INTENSI VE CARE UNIT 9.00 CORONARY CARE UNIT 31.00 16 5,840 0.00 0 8.00 9.00 BURN INTENSI VE CARE UNIT 10.00
4.00 HM0 I RF Subprovi der 5.00 Hospi tal Adul ts & Peds. Swing Bed SNF 6.00 Hospi tal Adul ts & Peds. Swing Bed NF 7.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8.00 INTENSI VE CARE UNIT 9.00 CORONARY CARE UNIT 31.00 16 5,840 0.00 0 8.00 9.00 CORONARY CARE UNIT 10.00 BURN INTENSI VE CARE UNIT
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 31.00 16 5,840 0.00 0 8.00 9.00 GORONARY CARE UNIT 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 O O O O O O O O O O O O O O O O O O
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 156 56,940 0.00 0 7.00 0 8.00 0 9.00
beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 16 5,840 0.00 0 8.00 9.00 CORONARY CARE UNIT 32.00 0 0 0.00 0 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00
8. 00 INTENSIVE CARE UNIT 31. 00 16 5, 840 0. 00 0 8. 00 9. 00 CORONARY CARE UNIT 32. 00 0 0 0. 00 0 9. 00 10. 00 BURN INTENSIVE CARE UNIT 10. 00
9.00 CORONARY CARE UNIT 32.00 0 0.00 0 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00
10.00 BURN INTENSIVE CARE UNIT
12.00 NEONATAL INTENSIVE CARE UNIT 35.00 18 6,570 0.00 0 12.00
13. 00 NURSERY 43. 00 0 13. 00
14.00 Total (see instructions) 190 69,350 0.00 0 14.00
15.00 CAH visits 0 15.00
15.10 REH hours and visits 0.00 0 15.10
16. 00 SUBPROVI DER - I PF 16. 00
17. 00 SUBPROVI DER - I RF 17. 00
18. 00 SUBPROVI DER 42. 00 0 0 18. 00
19.00 SKILLED NURSING FACILITY
20. 00 NURSING FACILITY 20. 00
21. 00 OTHER LONG TERM CARE 21. 00
22. 00 HOME HEALTH AGENCY 101. 00 22. 00
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 115. 00 23. 00 24. 00 25. 00 25. 00 26. 00
24. 00 HOSPICE 116. 00 0 0 24. 00 24. 10 HOSPICE (non-distinct part) 30. 00 24. 10
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 0 26. 25
27. 00 Total (sum of lines 14-26) 190 27. 00
28. 00 Observation Bed Days 0 28. 00
29. 00 Ambul ance Trips 29. 00
30.00 Employee discount days (see instruction)
31.00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions) 12 4,380 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 33.01
34.00 Temporary Expansi on COVI D-19 PHE Acute Care 30.00 0 0 0 34.00

 Heal th Financial
 Systems
 I U HEALTH

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 In Lieu of Form CMS-2552-10 IU HEALTH BLOOMINGTON HOSPITAL | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0051

				'	0 12/31/2023	5/29/2024 1:5	
		I/P Days	o/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	14, 853	1, 455	46, 608			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)	40.000	40.50/				
2.00	HMO and other (see instructions)	13, 020	13, 526				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	U	0	1			4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	۷	0	· -			5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation	14, 853	1, 455	ľ			7.00
7.00	beds) (see instructions)	14, 603	1, 400	40, 000			7.00
8.00	INTENSIVE CARE UNIT	1, 439	169	4, 747			8.00
9. 00	CORONARY CARE UNIT	1, 437	107	4, 747			9.00
10. 00	BURN INTENSIVE CARE UNIT	Ĭ	o o	Ĭ			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	ol	372	3, 576			12.00
13. 00	NURSERY	Ĭ	1, 499				13. 00
14. 00	Total (see instructions)	16, 292	3, 495			1, 663. 41	14. 00
15. 00	CAH visits	o	0	1		,	15. 00
15. 10	REH hours and visits	o	0	0			15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER		0	0	0.00	0.00	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0	0	0			
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0. 00		1
24. 00	HOSPI CE	0	0	·		0.00	1
24. 10	HOSPICE (non-distinct part)			84			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0	0		0.00	0.00	26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	U	0	0			•
28. 00	Total (sum of lines 14-26)		94	2, 464	0.00	1, 663. 41	28.00
29. 00	Observation Bed Days Ambulance Trips	0	94	2, 404			29.00
30.00	Employee discount days (see instruction)	٩		0			30.00
31.00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)	2	42	·			32.00
32. 01	Total ancillary labor & delivery room	-	72	1, 330			32. 01
52. 51	outpatient days (see instructions)			ĺ] 52.01
33. 00	LTCH non-covered days	ol					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	o	0	0			34. 00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 |
 Heal th Financial
 Systems
 I U HEALTH

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051

				10	0 12/31/2023	Date/IIMe Prep 5/29/2024 1:53	
		Full Time		Di sch	arges	072772021 1.00	Б
		Equi val ents		2. 55.	u. 900		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	r Production	Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	3, 033	287	10, 635	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, 092	2, 351		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY					40.405	13.00
14. 00	Total (see instructions)	0. 00	C	3, 033	287	10, 635	
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - I RF	0.00				0	17. 00
18.00	SUBPROVI DER	0. 00	C	'	0	U	18.00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY	+					19. 00 20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPICE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF				ļ		31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room				ļ		32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34. 00
		•		•	· ·		

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0051

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared:

					To	12/31/2023		
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	5 pili
		1. 00	2. 00	A-6) 3.00	3) 4.00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	0.00	
1 00	SALARI ES	200. 00	124 010 224	E/2 417	124 244 007	2 450 047 20	35. 91	1 00
1. 00	Total salaries (see instructions)	200.00	124, 810, 224	-563, 417	124, 246, 807	3, 459, 967. 30	35. 91	1. 00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0.00	3. 00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0		0	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related		0	0	О	0.00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	0	О	0	0.00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		8, 638, 384	2, 051, 305	10, 689, 689	293, 585. 51	36. 41	10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		11, 423, 586	0	11, 423, 586	100, 495. 00	113. 67	11. 00
12.00	Care							12.00
12. 00	Contract labor: Top level management and other management and administrative services		U	0	0	0.00	0.00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		1, 661, 285	0	1, 661, 285	21, 643. 19	76. 76	13. 00
14. 00	Home office and/or related organization salaries and		0	О	О	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		37, 359, 469	o	37, 359, 469	986, 008. 45	37. 89	14. 01
14. 02	Related organization salaries		0	0	0	0.00		
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A		0	0	0	0.00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	О	0	0.00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		28, 754, 017	0	28, 754, 017			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00	Excluded areas		2, 683, 911	0	2, 683, 911			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20. 00
21. 00	Non-physician anesthetist Part B		0	0	0			21.00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	0	0			24. 00 25. 00
25. 50	Home office wage-related (core)		10, 633, 403	0	10, 633, 403			25. 50
25. 51	Related organization wage-related (core)		0	0	О			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52
		'						

Provider CCN: 15-0051

					Т	o 12/31/2023	Date/Time Prep 5/29/2024 1:5	
	·	Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII			_	_			
26. 00	Employee Benefits Department	4. 00	0	0	0	0.00		
27. 00	Administrative & General	5. 00	5, 946, 353	1		,		
28. 00	Administrative & General under		2, 973, 443	0	2, 973, 443	26, 878. 15	110. 63	28. 00
	contract (see inst.)	, , ,						
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	2, 656, 953	-81, 759	2, 575, 194			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32. 00	Housekeepi ng	9. 00	2, 145, 615			i i		
33. 00	Housekeeping under contract (see instructions)		365, 996	0	365, 996	7, 165. 00	51. 08	33. 00
34.00	Di etary	10. 00	3, 213, 897	-1, 278, 708	1, 935, 189	88, 953. 47	21. 76	34. 00
35.00	Di etary under contract (see		325, 962	0	325, 962	6, 865. 60	47. 48	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	1, 271, 763	1, 271, 763	64, 512. 54	19. 71	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	9, 825, 310	-210, 175	9, 615, 135	236, 130. 94	40. 72	38. 00
39.00	Central Services and Supply	14. 00	27, 657	0	27, 657	1, 302. 86	21. 23	39. 00
40.00	Pharmacy	15. 00	6, 265, 377	-667, 166	5, 598, 211	112, 781. 70	49. 64	40. 00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41. 00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42. 00
43.00	Other General Service	18. 00	810, 159	-1, 596	808, 563	36, 409. 15	22. 21	43.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0051 Worksheet S-3 Peri od: From 01/01/2023 To 12/31/2023 Part III Date/Time Prepared: 5/29/2024 1:53 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 6.00 2.00 5.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 128, 475, 625 -563, 417 127, 912, 208 3, 500, 876. 05 1.00 36. 54 instructions) 2.00 8, 638, 384 2, 051, 305 10, 689, 689 293, 585. 51 2.00 Excluded area salaries (see 36.41 instructions) 3.00 Subtotal salaries (line 1 119, 837, 241 -2, 614, 722 117, 222, 519 3, 207, 290. 54 36.55 3.00 minus line 2)

50, 444, 340

39, 387, 420

207, 054, 279

32, 634, 114

C

-2, 614, 722

-1, 922, 608

1, 108, 146. 64

4, 315, 437. 18

870, 797. 53

0.00

45.52

33.60

47 98

37. 48

4.00

5.00

6.00

7.00

50, 444, 340

39, 387, 420

209, 669, 001

34, 556, 722

4.00

5.00

6.00

7.00

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

costs (see inst.)

(see inst.)

instructions)

	To 12/31/2023	Date/Time Prep 5/29/2024 1:53	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	4, 697, 338	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	o	6. 00
7.00	Employee Managed Care Program Administration Fees	o	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	o	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	16, 098, 212	8. 02
8. 03	Health Insurance (Purchased)	0	1
9.00	Prescription Drug Plan	o	9. 00
10.00	Dental, Hearing and Vision Plan	367, 587	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
	Accident Insurance (If employee is owner or beneficiary)	o	12. 00
	Disability Insurance (If employee is owner or beneficiary)	563, 417	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		603, 316	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		1
	TAXES		1
17.00	FICA-Employers Portion Only	9, 102, 656	17. 00
18. 00	Medicare Taxes - Employers Portion Only	O	18. 00
19. 00	Unemployment Insurance	o	19. 00
20.00	State or Federal Unemployment Taxes	o	20.00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22. 00	Day Care Cost and Allowances	o	22. 00
23.00	Tuition Reimbursement	5, 402	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	31, 437, 928	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
	•	'	

Health Financial Systems IU	HEALTH BLOOMINGTON HOSPITAL	In Lie	2552-10	
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0051 Pe Fr		Worksheet S-3 Part V Date/Time Prep 5/29/2024 1:53	pared:
Cost Center Description		Contract Labor 1.00	Benefit Cost 2.00	

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	11, 423, 586	31, 437, 928	1.00
2.00	Hospi tal	11, 423, 586	28, 754, 017	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I	0	0	12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18. 00	Other	0	2, 683, 911	18. 00

	Financial Systems I U HE AL UNCOMPENSATED AND INDIGENT CARE DATA	ALTH BLOOMINGTON HOSPI	TAL r CCN: 15-0051	In Lie	wof Form CMS-2 Worksheet S-1	
позетт	AL UNCOMPENSATED AND INDIGENT CARE DATA	Frovide	1 CCN. 15-0051	From 01/01/2023 To 12/31/2023	Parts I & II	pared:
					372972024 1.3	3 piii
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
	Uncompensated and Indigent Care Cost-to-Charge R	ati o				
1. 00	Cost to charge ratio (see instructions)				0. 193209	1.00
	Medicaid (see instructions for each line)				50 (40 550	
2.00	Net revenue from Medicaid				58, 613, 553	2. 00
3.00	Did you receive DSH or supplemental payments fro			. 10	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH an			ai d'?	Y	4. 00
5.00	If line 4 is no, then enter DSH and/or supplemen	ital payments from Medi	caid		0	5. 00
6.00	Medi cai d charges				373, 696, 538	
7.00	Medicaid cost (line 1 times line 6)				72, 201, 534	
8. 00	Difference between net revenue and costs for Med				13, 587, 981	8. 00
0 00	Children's Health Insurance Program (CHIP) (see	instructions for each	line)			0 00
9.00	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)	CIUD (i			0	11.00
12.00	Difference between net revenue and costs for sta			\	0	12.00
12 00	Other state or local government indigent care pr Net revenue from state or local indigent care pr				(702	13.00
					6, 703 57, 319	
	10)	3 1 3	am (Not Included	In Times 6 of	57, 319	14.00
	State or local indigent care program cost (line				11, 075	
16. 00	Difference between net revenue and costs for sta				4, 372	16. 00
	Grants, donations and total unreimbursed cost fo instructions for each line)			gent care progran	ns (see	
17.00	Private grants, donations, or endowment income r	estricted to funding of	charity care		0	17. 00
18. 00	Government grants, appropriations or transfers f	or support of hospital	operati ons		0	18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and 8, 12 and 16)	state and local indige	ent care program	s (sum of lines	13, 592, 353	19. 00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions for ea					ļ
	Charity care charges and uninsured discounts (se		22, 673, 4			
21. 00	Cost of patients approved for charity care and u instructions)	ni nsured di scounts (se	ee 4, 380, 7	23 1, 149, 297	5, 530, 020	21. 00
22. 00	Payments received from patients for amounts prev	iously written off as	15, 2	06 830	16, 036	22. 00
	charity care	•				
23.00	Cost of charity care (see instructions)		4, 365, 5	17 1, 148, 467	5, 513, 984	23.00

	Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL			eu of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der C		Period: From 01/01/2023 To 12/31/2023		pared:
					1.00	
	PART II - HOSPITAL DATA				1. 00	
	Uncompensated and Indigent Care Cost-to-C	Charge Ratio				i
	Cost to charge ratio (see instructions)	mar ge Rati e			0. 193209	1.00
	Medicaid (see instructions for each line)				0.170207	
2.00	Net revenue from Medicaid					2.00
3.00	Did you receive DSH or supplemental paymental	ents from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include al	DSH and/or supplemental payment	ts from Medicai	i d?		4.00
5.00	If line 4 is no, then enter DSH and/or s					5.00
6.00	Medi cai d charges					6.00
7.00	Medicaid cost (line 1 times line 6)					7.00
8.00	Difference between net revenue and costs					8. 00
	Children's Health Insurance Program (CHII	e) (see instructions for each lin	ne)			
9.00	Net revenue from stand-alone CHIP					9. 00
	Stand-alone CHIP charges					10.00
	Stand-alone CHIP cost (line 1 times line					11. 00
	Difference between net revenue and costs				<u> </u>	12. 00
	Other state or local government indigent			<u> </u>		10.00
	Net revenue from state or local indigent					13.00
14. 00	Charges for patients covered under state 10)	or rocal indigent care program ((Not included	in lines 6 or		14. 00
15 00	State or local indigent care program cos	t (ling 1 times ling 14)				15.00
	Difference between net revenue and costs		nrogram (see	instructions)		16.00
	Grants, donations and total unreimbursed				ns (see	10.00
	instructions for each line)	cost for moureard, only and star	to, roodi riidi gi	one can o program	.5 (555	
17. 00	Private grants, donations, or endowment	ncome restricted to funding char	rity care			17. 00
18.00	Government grants, appropriations or tra	nsfers for support of hospital op	perati ons			18.00
19.00	Total unreimbursed cost for Medicaid, Cl	HIP and state and local indigent	care programs	(sum of lines		19.00
	8, 12 and 16)		-			
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions		00 (70 40	1 0 (50 540	05 000 000	
	Charity care charges and uninsured disco		22, 673, 49			
21. 00	Cost of patients approved for charity calinstructions)	re and uninsured discounts (see	4, 380, 72	3 1, 149, 297	5, 530, 020	21.00
			1		1	1
22 00	Dayments received from nationts for amount	nte nraviouely writtan off ac	15 20	חכיט וא	16 026	1 22 00
22. 00	Payments received from patients for amount charity care	nts previously written off as	15, 20	6 830	16, 036	22. 00

		U HEALTH BLOOMIN	Provider C			u of Form CMS-2 Worksheet A	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (JF EXPENSES	Provider C	F	Period: From 01/01/2023		
				1	o 12/31/2023	Date/Time Pre 5/29/2024 1:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	DIII
				+ 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						
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	(, - , ,	11, 892, 447	1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0		21, 024, 899	21, 024, 899 0	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	O	1, 520, 662	1, 520, 662	21, 811, 529	23, 332, 191	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 946, 353	103, 953, 421			101, 493, 559	5. 00
7.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	2, 656, 953	27, 094, 887 190, 951			17, 162, 650 190, 944	7.00
8. 00 9. 00	00900 HOUSEKEEPING	0 2, 145, 615	3, 068, 490			4, 658, 959	8. 00 9. 00
10.00	01000 DI ETARY	3, 213, 897	1, 685, 551			2, 436, 102	10.00
11. 00	01100 CAFETERI A	0	0	(1, 742, 842	1, 742, 842	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	9, 825, 310	4, 437, 686			11, 322, 245	13.00
14. 00 15. 00	01500 PHARMACY	27, 657 6, 265, 377	6, 552, 558 40, 322, 780			15, 033, 690 7, 975, 050	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(0	16. 00
18. 00	01850 SOCIAL SERVICES	0	0	(0	0	18. 00
18. 01 23. 00	01851 CENTRAL STERILIZATION 02301 PARAMED ED PRGM-PHARMACY RESIDENCY	810, 159 136, 212	1, 564, 046 45, 341			1, 758, 232 400, 692	18. 01 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	130, 212	45, 341	161, 553	0 219, 139	400, 692	23.00
30. 00	03000 ADULTS & PEDIATRICS	20, 996, 201	32, 635, 360	53, 631, 561	-8, 140, 439	45, 491, 122	30. 00
31.00	03100 NTENSI VE CARE UNI T	4, 068, 873	3, 311, 299	7, 380, 172	-1, 491, 377	5, 888, 795	
32. 00 35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	2, 333, 007	0 2, 278, 328	4, 611, 335	0 5 -605, 160	0 4, 006, 175	32. 00 35. 00
42. 00	04200 SUBPROVI DER	2, 333, 007	2, 276, 326	4,011,335	0	4,000,173	42.00
43.00	04300 NURSERY	0	0	(968, 810	968, 810	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS		07 705 540	14 (0) 01	00.044.070	20 242 (22	F0 00
50. 00 50. 01	05000 OPERATING ROOM 05001 CV SURGERY	6, 901, 369	37, 785, 542	44, 686, 911	-22, 346, 273	22, 340, 638 0	50. 00 50. 01
51. 00	05100 RECOVERY ROOM	5, 032, 171	2, 257, 933	7, 290, 104	-1, 291, 406	5, 998, 698	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 776, 105	2, 679, 244	5, 455, 349	-1, 190, 163	4, 265, 186	52. 00
53.00	05300 ANESTHESI OLOGY	0	2 704 202	(012 451	0	0 F 701 350	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	3, 306, 069 2, 402, 113	2, 706, 382 4, 483, 850			5, 701, 350 4, 217, 301	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	0	0	(0	0	56. 00
57. 00	05700 CT SCAN	680, 864	2, 982, 754			2, 600, 266	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	719, 473	1, 964, 016			1, 288, 846	58. 00 59. 00
60.00	06000 LABORATORY	2, 139, 410 1, 466	16, 274, 396 19, 213, 863			2, 298, 902 19, 231, 720	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	3, 395, 214	1, 874, 638			3, 927, 213	65.00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	6, 987, 038 1, 204, 290	2, 621, 216 965, 434			7, 520, 887 1, 639, 856	66. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	442, 466	1, 796, 695			1, 881, 687	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		10, 818, 204	10, 818, 204	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(17, 056, 457	17, 056, 457	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07302 OP PHARMACY	556, 755	5, 458, 990	6, 015, 745	40, 316, 022 -103, 831	40, 316, 022 5, 911, 914	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS	0	1, 762, 171	1		1, 689, 957	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	510, 679	176, 706			574, 285	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		-	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	<u> </u>	0)l Ol	0	78. 00
90.00	09000 CLI NI C	1, 122, 766	354, 353	1, 477, 119	-256, 516	1, 220, 603	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	4, 667, 283	2, 794, 409			6, 035, 476	90. 01
90. 02 90. 03	09002 WOUND CARE CENTER 09003 PAIN CLINIC	647, 254 598, 837	482, 723 794, 041			768, 826 932, 826	90. 02 90. 03
90. 03	09004 0B CLINIC	2, 513, 217	874, 939			2, 776, 112	90.03
90. 05	09005 OP PSYCH CLINIC	810, 111	433, 287			1, 059, 723	90. 05
90. 06	09006 MULTI SPECIALTY CLINIC	2, 192, 648	1, 159, 677			2, 660, 886	90.06
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 279, 349	15, 064, 423	21, 343, 772	-2, 504, 686	18, 839, 086	91. 00 92. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 995, 491	5, 062, 977	7, 058, 468	-1, 441, 278	5, 617, 190	1
	OTHER REIMBURSABLE COST CENTERS	.,,	3/332/111	.,,	., ., ., ., _, .,	37 3 3 3 7 3 3 3	
	09400 HOME PROGRAM DI ALYSI S	0	0	(0	0	
	09500 AMBULANCE SERVICES 10000 I&R SERVICES-NOT APPRVD PRGM	0	0			0	95. 00 100. 00
	10000 Tak Services-NOT APPROD PROM		0				100.00
	10200 OPIOLD TREATMENT PROGRAM	Ö	0		-		102. 00
140 -	SPECIAL PURPOSE COST CENTERS					_	110 00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF	0	0				113. 00 114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00
		'			'		

Health Financial Systems	J HEALTH BLOOMIN	GTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		eri od:	Worksheet A	
				rom 01/01/2023 o 12/31/2023	Date/Time Pre	narod:
			'	0 12/31/2023	5/29/2024 1:53	
Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1, 00	2.00	2.00	4.00	col . 4)	
116. 00 11600 HOSPI CE	1.00	2.00	3.00	4. 00	5. 00	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	116, 308, 052	360, 686, 019	476, 994, 071	-1, 024, 550	475, 969, 521	
NONREI MBURSABLE COST CENTERS	110, 300, 032	300, 000, 017	470, 774, 071	- 1, 024, 330	473, 707, 321	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-1, 450	-270	-1, 720	95, 360	93, 640	190. 00
190. 01 19001 PROMPTCARE	2, 495, 588	1, 410, 733			3, 085, 374	190. 01
190. 02 19002 RENTAL PROPERTIES	o	o	C	o	0	190. 02
190. 03 19003 OLCOTT	0	0	C	0		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	C	0		190. 04
190. 05 19005 FOUNDATI ON	0	0	C	0		190. 05
190. 06 19006 MARKETI NG	0	0	C	0		190. 06
190. 07 19007 HME STORE	0	0	C	0		190. 07
190. 08 19008 UNUSED SPACE	0	0	C	0		190. 08
190. 09 19009 CLINI CAL TRIALS 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC	0	0	Ü	0		190. 09 190. 10
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	6, 003, 587	4, 807, 828	10, 811, 415	-7, 714, 104	3, 097, 311	
191. 00 19100 RESEARCH	0,003,567	4, 007, 020	10, 611, 413	-7, 714, 104		190. 11
191. 01 19101 RESEARCH		0	0			191. 00
191. 02 19102 OTHER SPONSORED ACTIVITIES		0	0	6, 259, 247	6, 259, 247	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	694	86, 123	86, 817		48, 217	
193. 00 19300 NONPALD WORKERS	o	0	C	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	O	О	C	1, 074, 580	1, 074, 580	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	O	o	C	2, 039, 615	2, 039, 615	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	C	0	0	194. 02
194.03 07953 IU HEALTH SIP	3, 753	1, 093	4, 846	129, 399	134, 245	
194.04 07954 HOME CARE	0	0	C	0		194. 04
194. 05 07955 H0SPI CE	0	1, 775	·	I I		194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	124, 810, 224	366, 993, 301	491, 803, 525	이	491, 803, 525	200. 00

Provider CCN: 15-0051

Peri od: From 01/01/2023 To 12/31/2023

In Lieu of Form CMS-2552-10
Worksheet A Date/Time Prepared: 5/29/2024 1:53 pm

			5/29/2024 1: 5	3 pm
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
CENEDAL CEDVICE COCT CENTEDS	6. 00	7. 00		
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT	1, 339, 093	13, 231, 540		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	1, 641, 559			2.00
3. 00 00300 OTHER CAP REL COSTS	1,041,337	22, 000, 430		3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-146, 616	_		4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-13, 321, 203			5. 00
7. 00 00700 OPERATION OF PLANT	-78, 860			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	-70,000			8.00
9. 00 00900 HOUSEKEEPI NG	-38,000			9. 00
10. 00 01000 DI ETARY	-41, 482	2, 394, 620		10.00
11. 00 01100 CAFETERI A	0	1, 742, 842		11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-96, 861	11, 225, 384		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	-70, 801	15, 033, 690		14. 00
15. 00 01500 PHARMACY	-244	7, 974, 806		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	7, 774, 600		16. 00
18. 00 01850 SOCIAL SERVICES	0	0		18. 00
18. 01 01851 CENTRAL STERILIZATION	0	1, 758, 232		18. 01
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY	49, 783	450, 475		23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	47, 703	430, 473		23.00
30. 00 03000 ADULTS & PEDIATRICS	-7, 146, 994	38, 344, 128		30.00
31. 00 03100 NTENSI VE CARE UNI T	0	5, 888, 795		31.00
32. 00 03200 CORONARY CARE UNIT	0	0,000,775		32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	-517, 524	3, 488, 651		35. 00
42. 00 04200 SUBPROVI DER	-517, 524	3, 466, 651		42.00
43. 00 04300 NURSERY	0	968, 810		43.00
ANCILLARY SERVICE COST CENTERS	U	700, 010		43.00
50. 00 05000 OPERATING ROOM	-4, 544, 647	17, 795, 991		50.00
50. 00 05000 0FERATTING ROOM 50. 01 05001 CV SURGERY	-4, 544, 047	0		50.00
51. 00 05100 RECOVERY ROOM	0	5, 998, 698		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	4, 265, 186		52.00
	0	4, 203, 100		1
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	-527, 147			53. 00 54. 00
		5, 174, 203		1
55. 00 05500 RADI OLOGY-THERAPEUTI C	-554, 289	3, 663, 012		55. 00
56. 00 05600 RADI 01 SOTOPE	0	0 (00 0)		56.00
57. 00 05700 CT SCAN	0	2, 600, 266		57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	1, 288, 846		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	2, 298, 902		59. 00
60. 00 06000 LABORATORY	-551, 794	18, 679, 926		60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00 06500 RESPI RATORY THERAPY	-1, 712			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	7, 520, 887		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 639, 856		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	-1, 360, 861	520, 826		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 818, 204		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	17, 056, 457		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	40, 316, 022		73. 00
73. 01 07302 OP PHARMACY	-350, 619	5, 561, 295		73. 01
74.00 07400 RENAL DIALYSIS	0	1, 689, 957		74.00
76. 97 07697 CARDIAC REHABILITATION	0	574, 285		76. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	o		78. 00
OUTPATIENT SERVICE COST CENTERS		- 1]
90. 00 09000 CLI NI C	-17, 880	1, 202, 723		90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	-459, 614	5, 575, 862		90. 01
90. 02 09002 WOUND CARE CENTER	-2, 314	766, 512		90. 02
90. 03 09003 PAIN CLINIC	-2, 314	930, 512		90. 03
90. 04 09004 OB CLINIC	0	2, 776, 112		90. 04
90. 05 09005 OP PSYCH CLINIC	0	1, 059, 723		90. 05
90.06 09006 MULTI SPECIALTY CLINIC	-43, 071	2, 617, 815		90.06
91. 00 09100 EMERGENCY	-1, 462, 923			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 102, 720	17,070,100		92.00
92. 01 09202 OBSERVATION BEDS (DISTINCT PART)	-152	5, 617, 038		92. 01
OTHER REIMBURSABLE COST CENTERS	- 132	5,017,030		1 /2.01
94. 00 09400 HOME PROGRAM DI ALYSI S	n	Λ		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	٥		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0		100.00
102.00 10200 OPLOLD TREATMENT PROGRAM	0	0		101.00
	U	u U		102.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115.00
116. 00 11600 HOSPI CE	20 224 404	147 722 025		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-28, 236, 686	447, 732, 835	l .	118. 00

Health FinancialSystemsIUHEALTH BLOWRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0051

			5/29/2024 1:53 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7. 00	
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	93, 640	190. 00
190. 01 19001 PROMPTCARE	-26, 850	3, 058, 524	190. 01
190. 02 19002 RENTAL PROPERTI ES	0	0	190. 02
190. 03 19003 OLCOTT	0	0	190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	190. 04
190. 05 19005 FOUNDATI ON	0	0	190. 05
190. 06 19006 MARKETI NG	0	0	190. 06
190. 07 19007 HME STORE	0	0	190. 07
190. 08 19008 UNUSED SPACE	0	0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	3, 097, 311	190. 11
191. 00 19100 RESEARCH	0	0	191. 00
191. 01 19101 RESEARCH	0	0	191. 01
191.02 19102 OTHER SPONSORED ACTIVITIES	0	6, 259, 247	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	48, 217	192. 00
193. 00 19300 NONPALD WORKERS	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	1, 074, 580	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	2, 039, 615	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	194. 02
194.03 07953 IU HEALTH SIP	0	134, 245	194. 03
194.04 07954 HOME CARE	0	0	194. 04
194. 05 07955 HOSPI CE	0	1, 775	194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	-28, 263, 536	463, 539, 989	200.00

IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/29/2024 1:53 pm

					5/29/2024 1:	53 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5 00		
	2.00	3. 00	4. 00	5. 00		
1 00	A - BENEFITS	4.00	ol	21 015 021		1. 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT PHYSICIANS' PRIVATE OFFICES	192.00	0	21, 915, 821 1, 993		2.00
3.00	PHISICIANS PRIVATE OFFICES	0.00	0	1, 993		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	o	0		5. 00
6. 00		0.00	o	o		6. 00
7. 00		0.00	o	O		7. 00
8.00		0.00	o	Ö		8. 00
9. 00		0.00	o	0		9. 00
10.00		0.00	О	0		10.00
11.00		0.00	o	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14. 00		0. 00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00 19. 00		0. 00 0. 00	0	0 0		18. 00 19. 00
20. 00		0.00	0	0		20. 00
21. 00		0.00	0	o		21. 00
22. 00		0.00	o	0		22. 00
23. 00		0.00	o	O		23. 00
24. 00		0.00	o	Ō		24. 00
25.00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27.00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31. 00
32. 00 33. 00		0. 00 0. 00	0	0		32. 00 33. 00
34. 00		0.00	o	0		34. 00
35. 00		0.00	o	Ö		35. 00
36. 00		0.00	0	0		36. 00
37.00		0.00	О	0		37. 00
38. 00		0. 00	0	0		38. 00
39. 00	<u> </u>	0.00	•	0		39. 00
	O CARLEAL RELATER		0	21, 917, 814		-
1. 00	B - CAPITAL RELATED CAP REL COSTS-BLDG & FIXT	1.00	O	10, 514, 055		1. 00
2.00	CAP REL COSTS-BLDG & FIXT	2.00	0	20, 899, 351		2.00
3.00	IOAI KEE GOSTS WVBEE EQUIT	0.00	o	20, 077, 331		3. 00
4. 00		0.00	o	Ō		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0. 00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		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		0.00	o	0		15. 00
16. 00		0.00	o	Ö		16. 00
17. 00		0.00	o	O		17. 00
18. 00		0.00	o	0		18. 00
19.00		0.00	O	0		19. 00
20.00		0.00	0	0		20. 00
21.00		0.00	О	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00 27. 00		0. 00 0. 00	0	0 0		26. 00 27. 00
27. 00 28. 00		0.00	0	0		28.00
29. 00		0.00	0	0		29. 00
30. 00		0.00	o	0		30. 00
31. 00		0.00	o	0		31. 00
32. 00	<u> </u>	0. 00	0	0		32. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm Provider CCN: 15-0051

					10 12/31/2023	5/29/2024 1:53 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
22.00	2. 00	3.00	4.00	5.00		22.00
33. 00 34. 00		0. 00 0. 00	0	0		33. 00 34. 00
35. 00		0.00	0			35. 00
36. 00		0.00	0			36. 00
37. 00		0.00	0			37. 00
38. 00		0.00	0	0		38. 00
39. 00		0.00	0			39.00
	0		0	31, 413, 406		
1 00	C - BILLABLE MEDICAL SUPPLIES		0	10 010 204		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	U	10, 818, 204		1. 00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	5		2. 00
3. 00	ADMINISTRATIVE & GENERAL	5. 00	0			3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 273		4. 00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	67		5. 00
6.00		0.00	0			6. 00
7.00		0.00	0			7. 00
8. 00 9. 00		0. 00 0. 00	0			8. 00 9. 00
10. 00		0.00	0			10.00
11. 00		0.00	Ö	- 1		11. 00
12.00		0.00	O			12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0			14. 00
15. 00		0.00	0			15. 00
16.00		0.00	0	1		16.00
17. 00 18. 00		0. 00 0. 00	0			17. 00
19. 00		0.00	0			18. 00 19. 00
20. 00		0.00	0	1		20.00
21. 00		0.00	Ö			21. 00
22. 00		0.00	O	l l		22. 00
23.00		0.00	0	0		23. 00
24.00		0.00	0	1		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0			26. 00
27. 00 28. 00		0. 00 0. 00	0	1		27. 00 28. 00
29. 00		0.00	0			29. 00
27.00	<u> </u>					27.88
	D - NONBILLABLE MEDICAL SUPPL					
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	,		1. 00
2. 00 3. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0			2.00
4.00	OPERATION OF PLANT	7. 00	0			3. 00 4. 00
5. 00	HOUSEKEEPI NG	9. 00	Ö			5. 00
6.00	DI ETARY	10.00	0	741		6. 00
7.00	PARAMED ED PRGM-PHARMACY	23. 00	0	17		7. 00
	RESI DENCY					
8. 00 9. 00	PHYSI CAL THERAPY	66. 00 69. 00	0	· ·		8. 00 9. 00
10. 00	ELECTROCARDI OLOGY CARDI AC REHABI LI TATI ON	76. 97	0			10. 00
11. 00	CLINIC	90.00	Ö			11. 00
12. 00	OP PSYCH CLINIC	90. 05	0			12. 00
13.00		0.00	0			13. 00
14.00		0.00	0			14. 00
15. 00		0.00	0			15. 00
16.00		0.00	0	1		16.00
17. 00 18. 00		0. 00 0. 00	0			17. 00 18. 00
19. 00		0.00	0	- 1		19. 00
20. 00		0.00	0			20.00
21. 00		0.00	0			21. 00
22. 00		0.00	0			22. 00
23. 00		0.00	0			23. 00
24. 00		0.00	0			24. 00
25. 00		0.00	0	-		25. 00
26. 00 27. 00		0. 00 0. 00	0			26. 00 27. 00
28. 00		0.00	0			28. 00
29. 00	L	0.00	0	0		29. 00
	<u> </u>	_ _		11, 904, 831		

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/29/2024 1:53 pm

						5/29/2024 1:	53 pm
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3. 00	4. 00	5. 00		 	
	E - IMPLANTS SUPPLIES	70.00	ا م	17.05/ 157	ı		
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	17, 056, 457			1. 00
2. 00	PATIENTS MULTI SPECIALTY CLINIC	90. 06	0	664			2.00
	MULTI SPECIALLY CLINIC	0.00	0	004			2.00
3.00		0.00	0	0			3. 00 4. 00
4. 00 5. 00		0.00	0	0			5. 00
6. 00		0.00	0	0			6. 00
7. 00		0.00	o	0			7. 00
8. 00		0.00	0	0			8. 00
9. 00		0.00	o	0			9. 00
10. 00		0.00	0	0			10.00
11. 00		0.00	0	0			11.00
12. 00		0.00	0	0			12.00
13. 00		0.00	0	0			13. 00
13.00			— — —	17, 057, 121			13.00
	F - LEASE EXPENSE		<u> </u>	17,037,121			
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	1, 506, 047			1. 00
2. 00	CENTRAL SERVICES & SUPPLY	14.00	0	4, 022			2. 00
3. 00	CENTIAL SERVICES & SOITE	0.00	o	0			3. 00
4. 00		0.00	o	0			4. 00
5. 00		0.00	0	0			5. 00
6. 00		0.00	o	0			6. 00
7. 00		0.00	0	0			7. 00
8. 00		0.00	0	0			8. 00
9. 00		0.00	0	0			9. 00
10. 00		0.00	0	0			10.00
11. 00		0.00	0	0			11.00
12. 00		0.00	0	0			12.00
				-			
13.00		0.00	0	0			13.00
14.00		0.00	0	-			14.00
15. 00		0.00	0	0			15. 00
16. 00			0	0			16. 00
	O G - BI LLABLE DRUGS		U	1, 510, 069			
1 00	DRUGS CHARGED TO PATIENTS	72.00	٥	40 217 022			1 00
1.00		73.00	0	40, 316, 022			1.00
2.00	OP PHARMACY	73. 01	0	1, 504			2.00
3.00	NURSING ADMINISTRATION	13.00	0	1, 853			3. 00
4.00		0.00	0	0			4. 00
5.00		0.00	0	0			5. 00
6. 00		0.00	0	0			6. 00
7.00		0.00	0	0			7. 00
8.00		0.00	0	0			8. 00
9. 00		0.00	0	0			9. 00
10.00		0.00	0	0			10.00
11. 00		0.00	0	0			11. 00
12. 00		0.00	0	0			12. 00
13. 00		0.00	0	0			13. 00
14. 00		0. 00	0	0			14. 00
15. 00		0. 00	0	0			15. 00
16. 00		0.00	0	0			16. 00
17. 00		0.00	0	0			17. 00
18. 00		0. 00	0	0			18. 00
19. 00		0.00	0	0			19. 00
20. 00		0. 00	0	0			20. 00
21. 00		0.00	0	0			21. 00
22. 00		0. 00	0	0			22. 00
23. 00		0. 00	0	0			23. 00
24. 00		0. 00	0	0			24. 00
25. 00		0. 00	0	0			25. 00
26. 00		0.00	0	0			26. 00
27. 00		0.00	0	0			27. 00
28. 00		0.00	0	0			28. 00
29. 00		0.00	0	0			29. 00
30.00		0.00	0	0			30. 00
31. 00		0.00	0	0			31. 00
	0		0	40, 319, 379			_
	H - NON-BILLABLE DRUGS				I		
1.00	PHARMACY	15. 00	0	1, 655, 375			1.00
2. 00	OP PHARMACY	73. 01	0	2, 628			2. 00
3.00		0.00	0	0			3. 00
4.00		0.00	0	0			4. 00
5. 00		0.00	0	0			5. 00
6. 00		0.00	0	0	<u> </u>	 	6. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0051

					To 12/31/2023 Date/Time Pr 5/29/2024 1:	
		Increases				
	Cost Center	Li ne #	Salary	0ther		
7. 00	2. 00	3. 00	4.00	5. 00		7. 00
7. 00 8. 00		0.00	0	0		8.00
9. 00		0.00	Ö	Ö		9. 00
10.00		0.00	O	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	o	Ö		16. 00
17.00		0.00	О	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19.00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	o	Ö		22. 00
23.00		0.00	О	0		23. 00
24. 00		0.00	•	0		24. 00
	O LINTEDEST EXPENSE		0	1, 658, 003		
1. 00	J - INTEREST EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	0	74		1.00
1.00	0		— — ў			1.00
	K - PHARMACY RESIDENCY					
1.00	PARAMED ED PRGM-PHARMACY	23. 00	226, 600	17, 335		1. 00
2.00	RESI DENCY	0.00		0		2.00
2. 00			226, 600	<u>0</u> 17, 335		2. 00
	L - PSYCH ADMIN		220,000	17,000		
1.00	OP_PSYCH_CLINIC	90.05	68, 284	111, 183		1. 00
	0		68, 284	111, 183		
1 00	M - SOFTWARE LICENSE	2.00		120 222		1 00
1. 00 2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	129, 223 0		1. 00 2. 00
3. 00		0.00	0	0		3. 00
4. 00		0.00	O	Ö		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	o	Ö		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
	N - CAFETERIA		0	129, 223		
1. 00	CAFETERI A	11. 00	1, 271, 763	471, 079		1. 00
2.00	GIFT, FLOWER, COFFEE SHOP &	190.00	1, 450	93, 910		2. 00
	CANTEEN	+				
	O CHOPT TERM DICARLILITY/FIA	10	1, 273, 213	564, 989		
1. 00	O - SHORT TERM DISABILITY/FLN ADMINISTRATIVE & GENERAL	5. 00		1, 424		1. 00
2. 00	OPERATION OF PLANT	7. 00		7, 837		2. 00
3.00	HOUSEKEEPI NG	9. 00		11, 021		3. 00
4.00	DI ETARY	10.00		5, 495		4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00		57, 958		5. 00
6. 00 7. 00	PHARMACY CENTRAL STERILIZATION	15. 00 18. 01		91, 556 1, 596		6. 00 7. 00
8. 00	ADULTS & PEDIATRICS	30.00		89, 083		8. 00
9.00	INTENSIVE CARE UNIT	31.00		7, 727		9. 00
10.00	NEONATAL INTENSIVE CARE UNIT	35. 00		11, 427		10. 00
11. 00	OPERATING ROOM	50.00		27, 849		11.00
12. 00 13. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51. 00 52. 00		39, 618 43, 946		12. 00 13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54. 00		9, 816		14. 00
15. 00	RADI OLOGY-THERAPEUTI C	55. 00		925		15. 00
16.00	CT SCAN	57.00		1, 995		16. 00
17. 00	MAGNETIC RESONANCE IMAGING	58. 00		443		17. 00
18. 00	(MRI) CARDIAC CATHETERIZATION	59. 00		1, 043		18. 00
19. 00	RESPIRATORY THERAPY	65.00		1, 043		19.00
20. 00	PHYSI CAL THERAPY	66.00		23, 308		20. 00
21. 00	ELECTROCARDI OLOGY	69. 00		586		21. 00
22. 00	ELECTROENCEPHALOGRAPHY	70.00		1, 806		22. 00
23. 00	CARDIAC REHABILITATION	76. 97		2, 344		23. 00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 1:53 pm Provider CCN: 15-0051

Cost Center	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
2.00 3.00 4.00 5.00	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
24. 00	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
25. 00 OP ONCOLOGY INFUSION CENTER 90. 01 16, 212 26. 00 WOUND CARE CENTER 90. 02 4, 125 27. 00 PAIN CLINIC 90. 03 7, 219 28. 00 OB CLINIC 90. 04 20, 340 29. 00 OP PSYCH CLINIC 90. 05 502 30. 00 MULTI SPECIALTY CLINIC 90. 06 11, 414 31. 00 EMERGENCY 91. 00 14, 207 32. 00 OBSERVATION BEDS (DISTINCT 92. 01 9, 785 PART) 92. 01 9, 785 33. 00 PROMPTCARE 190. 01 2, 682 34. 00 COMMUNITY HEALTH SERVICES 190. 11 19, 269 0 0 563, 417 P - UTILITIES EXPENSE 1. 00 OPERATION OF PLANT 7. 00 0 304, 820	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
26. 00 WOUND CARE CENTER 90. 02 4, 125 27. 00 PAIN CLINIC 90. 03 7, 219 28. 00 0B CLINIC 90. 04 20, 340 29. 00 0P PSYCH CLINIC 90. 05 502 30. 00 MULTI SPECIALTY CLINIC 90. 06 11, 414 31. 00 EMERGENCY 91. 00 14, 207 32. 00 0BSERVATION BEDS (DISTINCT 92. 01 9, 785 PART) 33. 00 PROMPTCARE 190. 01 2, 682 34. 00 COMMUNITY HEALTH SERVICES 190. 11 1 19, 269 0 0 563, 417 P - UTILITIES EXPENSE 1. 00 OPERATION OF PLANT 7. 00 0 304, 820	26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
27. 00 PAIN CLINIC 90.03 7, 219 28. 00 0B CLINIC 90.04 20, 340 29. 00 0P PSYCH CLINIC 90.05 502 30. 00 MULTI SPECIALTY CLINIC 90.06 11, 414 31. 00 EMERGENCY 91. 00 14, 207 32. 00 0BSERVATION BEDS (DISTINCT 92. 01 9, 785 PART) 33. 00 PROMPTCARE 190. 01 2, 682 34. 00 COMMUNITY HEALTH SERVICES 190. 11 19, 269 0 0 563, 417 P - UTILITIES EXPENSE 1. 00 OPERATION OF PLANT 7. 00 0 304, 820	27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
28. 00	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
29. 00 OP PSYCH CLINIC 90. 05 502 30. 00 MULTI SPECIALTY CLINIC 90. 06 11, 414 31. 00 EMERGENCY 91. 00 14, 207 32. 00 OBSERVATION BEDS (DISTINCT 92. 01 9, 785 PART) 33. 00 PROMPTCARE 190. 01 2, 682 34. 00 COMMUNITY HEALTH SERVICES 190. 11 19, 269 0 0 563, 417 P - UTILITIES EXPENSE 1. 00 OPERATION OF PLANT 7. 00 0 304, 820	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
30. 00 MULTI SPECIALTY CLINIC 90. 06 11, 414 31. 00 EMERGENCY 91. 00 14, 207 32. 00 OBSERVATION BEDS (DISTINCT 92. 01 9, 785 PART) 2, 682 34. 00 COMMUNITY HEALTH SERVICES 190. 11 19, 269 0 0 563, 417 P - UTILITIES EXPENSE 1. 00 OPERATION OF PLANT 7. 00 0 304, 820	30. 00 31. 00 32. 00 33. 00 34. 00
31. 00 EMERGENCY 91. 00 14, 207 32. 00 OBSERVATI ON BEDS (DISTINCT 92. 01 9, 785 33. 00 PROMPTCARE 190. 01 2, 682 34. 00 COMMUNITY HEALTH SERVICES 190. 11 19, 269 0 0 563, 417 P - UTILITIES EXPENSE 1. 00 OPERATION OF PLANT 7. 00 0 304, 820	31. 00 32. 00 33. 00 34. 00 1. 00 2. 00
32. 00 OBSERVATI ON BEDS (DI STI NCT 92. 01 9, 785 92. 01 92. 01 93. 00 94. 00 95. 00	32. 00 33. 00 34. 00 1. 00 2. 00
PART PART	33. 00 34. 00 1. 00 2. 00
34. 00 COMMUNITY HEALTH SERVICES 190. 11 19, 269 0 563, 417 P - UTILITIES EXPENSE 7. 00 0 304, 820	1. 00 2. 00
0 0 563, 417 P - UTILITIES EXPENSE 1. 00 OPERATION OF PLANT 7. 00 0 304, 820	1. 00 2. 00
0 0 563, 417 P - UTILITIES EXPENSE 1. 00 OPERATION OF PLANT 7. 00 0 304, 820	2.00
1.00 OPERATION OF PLANT 7.00 0 304,820	2.00
	2.00
	•
3.00 0.00 0 0	3.00
4.00	4.00
5.00 0.00 0 0	5. 00
6.00 0 0 0	6.00
7.00 0 0 0 0	7.00
8. 00 0. 00 0 0 0 9. 00 0 0 0	8.00
10.00	9. 00 10. 00
11.00	11.00
12.00	12.00
13. 00	13.00
14.00	14. 00
15.00	15. 00
16.00	16. 00
17. 00	17. 00
18.00	18. 00
19.00	19. 00
0 304,820	
R - OCCUPATIONAL HEALTH ADMIN	
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 253, 504 0 0 0 0 0 0 0 0 0	1.00
S - NURSERY	
1.00 NURSERY 43.00 722, 788 246, 022	1.00
2.00	2.00
0 722, 788 246, 022 T - BEDFORD ALLOCATION	
1.00 I U HEALTH BEDFORD HOSPITAL 194.01 1,374,313 665,302	1.00
2.00 0 10 11 11 12 11 11 1	2.00
3.00	3.00
4.00	4. 00
5.00	5. 00
6.00	6. 00
7.00 0.00 0 0	7. 00
8.00	8. 00
0 1, 374, 313 665, 302	
U - PAOLI ALLOCATION	
1. 00 IU HEALTH PAOLI HOSPITAL 194. 00 724, 397 350, 183	1.00
2.00 0.00 0	2.00
3.00	3.00
4. 00 0. 00 0 0 5. 00 0 0	4.00
	5.00
6. 00	6. 00 7. 00
8.00 0.00 0 0	8.00
724, 397	8.00
V - LI BERTY BUILDING DEPRECIATION	
1. 00 IU HEALTH SIP 194. 03 129, 549	1.00
2.00	2.00
0	2.00
AC - GRANT	
1.00 OTHER SPONSORED ACTIVITIES 191.02 4, 361, 133 1, 898, 114	1.00
0 4, 361, 133 1, 898, 114	
AD - PHYSICIAN	
1.00 ADULTS & PEDIATRICS 30.00 0 47, 200	1.00
2. 00 OPERATING ROOM 50. 00 1, 940, 897	2.00
3. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 627, 020	3.00
4. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 10, 000	4.00
5. 00 LABORATORY 60. 00 0 285, 651	5. 00

Heal th	Financial Systems	I	U HEALTH BLOOM	INGTON HOSPITAL	L	In Lie	u of Form CMS	-2552-10
RECLASS	SIFICATIONS			Provi der 0	CCN: 15-0051	Peri od:	Worksheet A-	6
						From 01/01/2023 To 12/31/2023		
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
6.00	RESPIRATORY THERAPY	65.00	0	16, 400				6. 00
7.00	ELECTROCARDI OLOGY	69.00	0	16, 500				7.00
	0		0	2, 943, 668				
	AE - MED OBS							
1.00	ADULTS & PEDIATRICS	30.00	903, 821	173, 355				1.00
	0		903, 821	173, 355				
500.00	Grand Total: Increases		9, 908, 053	144, 697, 473				500.00

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

Cont Center 1 in							To 12/31/2023 Date/Time Pr 5/29/2024 1:	
December 100			Decreases					
No. REPUTET TS.							-	
ADMINISTRATIVE & SCHEMAL 5.00 0 /46, 932 0 1.00			7.00	8. 00	9. 00	10. 00		
2.00	1 00		5.00	٥	746 932	0		1 00
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7. 0.0 PHARMACY 15. 0.0 905, 352 0 7. 0.0 9. 0.0 ENTRAL STERILIZATION 18. 0.1 0 190, 627 0 8. 0.0 9. 0.0 PROMEE ED PROGREPHARMACY 23. 0.0 0 24, 813 0 0 0 9. 0.0 PROMEE ED PROGREPHARMACY 23. 0.0 0 24, 813 0 0 9. 0.0 DITAL STERILIZATION 18. 0.1 0 10. 0.0 9. 0.0 DITAL STERILIZATION 18. 0.1 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 32, 26.02 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 464, 160 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 17, 205, 624 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 17, 205, 624 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 17, 205, 624 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 17, 205, 624 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0 9. 0.0 DITAL STERILIZATION 18. 0.0 0 0 0 0 0			1				l .	1
0.00 CANISMA STIRELLY ATLEN 18.01 0 13.9, 637 0 9.00 9.			1	ĭ		1	l .	1
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12.00 MEGNATAL INTERSIVE CARE UNIT 35.00 0 451.148 0 112.00	10.00	ADULTS & PEDIATRICS	30.00	0	3, 802, 602	-	l .	10.00
13.00 OFFERT INC. RODION			1	ĭ	·		l .	1
14.00 SCOVPEN ROOM 51.00 0 913,833 0 14.00 15.			1	ŭ			l .	1
15.00 DELLYERY ROOM & LABOR ROOM 52.00 0 517,514 0 15.00 16.00 RADIOLOGY—DIRANSTIC 54.00 0 347,139 0 17.00			1	ĭ			l .	1
16. 00 ADIOLOGY-JIERAMOSTIC 54. 00 0 547, 739 0 16. 00 17. 00 ADIOLOGY-THERAPEUT C 55. 00 0 98, 047 0 18. 00 17. 00 ADIOLOGY-THERAPEUT C 55. 00 0 98, 047 0 18. 00 17. 00 ADIOLOGY-THERAPEUT C 55. 00 0 98, 047 0 18. 00 17. 00 ADIOLOGY-THERAPEUT C 55. 00 0 98, 047 0 18. 00 17. 00 ADIOLOGY-THERAPEUT C 56. 00 0 98, 047 0 17. 00 ADIOLOGY-THERAPEUT C 60. 00 0 57. 75 0 22. 00 ADIOLOGY-THERAPEUT C 60. 00 0 547, 275 0 22. 00 ADIOLOGY-THERAPEUT C 60. 00 0 547, 275 0 22. 00 ADIOLOGY-THERAPEUT C 60. 00 0 187, 032 0 22. 00 ADIOLOGY-THERAPEUT C 60. 00 0 187, 032 0 22. 00 ADIOLOGY-THERAPEUT C 73. 01 0 90, 789 0 26. 00 25. 00 ADIOLOGY-THERAPEUT C 73. 01 0 90, 789 0 26. 00 27. 00 ADIOLOGY-THERAPEUT C 70. 00 ADIOLOGY-THERAPEUT			1	٥		_	l .	1
17. 00 ADD OLOSY-THERAPEUTC 55. 00 0 304, 588 0 17. 00 19. 00 MAGNETI C RESONANCE INAGING 58. 00 0 93, 748 0 19. 00 19. 00 MAGNETI C RESONANCE INAGING 58. 00 0 93, 748 0 19. 00 20. 00 CARDING CATHETER TATION 59. 00 0 317, 602 0 20. 00 21. 00 CARDING CATHETER TATION 59. 00 0 317, 602 0 22. 00 22. 00 RESON RATORY HERAPY 65. 00 0 5.42 0 22. 00 23. 00 RESON RATORY HERAPY 65. 00 0 1, 127, 78 0 22. 00 24. 00 LECTROPROPY 65. 00 0 1, 127, 78 0 22. 00 25. 00 LECTROPROPY 70. 00 0 107, 526 0 22. 00 26. 00 LECTROPROPHILIDEY 70. 00 0 107, 526 0 22. 00 27. 00 CARDING REHABLITATION 76. 07 0 97, 662 0 27. 00 28. 00 OF PARMACY 73. 01 0 90, 789 0 22. 00 29. 00 OP ONOCLOGY INFUSION CENTER 90. 01 0 880, 814 0 29. 00 31. 00 PAN CLEME CHEE 90. 03 0 121, 409 0 31. 00 33. 00 DOUGLOGY CARE CENTER 90. 03 0 121, 409 0 31. 00 33. 00 DOUGLOGY CARE CENTER 90. 03 0 121, 409 0 31. 00 33. 00 DOUGLOGY CARE CENTER 90. 03 0 121, 409 0 31. 00 34. 00 DOUGLOGY INFUSION CENTER 90. 04 0 585, 855 0 33. 00 35. 00 DOUGLOGY CARE CENTER 90. 04 0 585, 855 0 33. 00 36. 00 DOUGLOGY CARE CENTER 90. 04 0 585, 855 0 33. 00 37. 00 SESENATION BEDS (DISTINCT 90. 04 0 585, 855 0 33. 00 38. 00 DOUGLOGY CARE CENTER 90. 04 0 101, 3742 0 33. 00 39. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003 0 30. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003 0 30. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003 0 30. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003 0 30. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003 0 30. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003 0 30. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003 0 30. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003 0 30. 00 DOUGLOGY CARE CENTER 90. 01 0 304, 003			1	-			l .	1
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23.00 HYSICAL THERAPY 66,00 0 1,129,143 0 22,00 24.00 ELECTROCARDIOLOGY 69,00 0 187,032 0 24,00 25.00 ELECTROENCEPHALOGRAPHY 70,00 0 107,526 0 25,00 27.00 CARDIAC REHABLLITATION 76,97 0 97,062 0 27,00 28.00 CLIN C 0 0 0 0 0 0 0 29.00 O O 0 0 0 0 0 0 29.00 O O O 0 0 0 0 0 29.00 O O O O 0 0 0 0 29.00 O O O O 0 0 0 29.00 O O O O O 0 0 29.00 O O O O O 0 29.00 O O O O O O 29.00 O O O O O O 29.00 O O 29.00 O O O 29.00 O O O 29.00 O O 29.00 O O 29.00 O O O 29.00 O			1	-			l .	1
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29. 00 OP ONCOLOGY INFUSION CENTER 90. 01 0 880, 814 0 30. 00 000100 CARE CENTER 90. 02 0 899, 998 0 0 31. 00 31. 00 32. 00 08 LINI C 90. 04 0 588, 855 0 32. 00 08 LINI C 90. 05 0 265, 240 0 33. 00 30. 00 OP PSYCH CLINIC 90. 06 0 549, 884 0 34. 00 35. 00 EMERGENCY 91. 00 0 1.013, 742 0 35. 00 36. 00 08 ERWATION BEDS (DISTINCT 92. 01 0 364, 073 0 0 36. 00 37. 00 70.	27.00	CARDIAC REHABILITATION	76. 97	o	97, 062	2 0		27. 00
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32. 00 OB CLINIC OD 0.64 O 588, 855 O 33. 00 34. 00 MULTI SPECIALTY CLINIC OD 0.65 O 246, 240 O 33. 00 34. 00 MULTI SPECIALTY CLINIC OD 0.66 O 549, 884 O 35. 00 35. 00 EMERGENCY OD 0.66 O 549, 884 O 35. 00 36. 00 OBSCEWARTION BEDS (DISTINCT 92. 01 O 364, 073 O 364, 073 O 364, 073 O 366, 00 37. 00 PROMPTCARE OD 0.66 O 1, 013, 742 O 364, 073 O 366, 00 38. 00 COMMUNITY HEALTH SERVICES 190. 01 O 1, 287, 714 O 38. 00 39. 00 OD 0.66 OD				0				1
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B - CAPITAL RELATED	39.00	TO HEALTH STP	194.03					39.00
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 3.747 9 2.00 ADMINISTRATI VE & GENERAL 5.00 3.023. 159 9 2.00 3.00 OPERATION OF PLANT 7.00 12.134, 354 0 3.00 4.00 HOUSEKEEPING 9.00 87, 504 0 4.00 6.00 DIETARY 10.00 11, 875 0 5.00 6.00 NURSING ADMINISTRATION 13.00 933. 731 0 6.00 6.00 7.00 CENTRAL SERVICES & SUPPLY 14.00 2.547 0 8.00 9.00 88.00 9.00 6.00 88.00 9.00 CENTRAL STERILIZATION 18.01 427, 974 0 9.00 9.00 0.00 ADDILTS & PEDIATRICS 30.00 2.743, 278 0 11.00 11		B - CAPITAL RELATED		<u></u>	21, 717, 014	1		
3.00 OPERATION OF PLANT 7.00 12, 134, 354 0 3.00	1.00		4. 00		3, 747	9		1.00
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15. 00 DELI VERY ROOM & LABOR ROOM 16. 00 RADI OLOGY-DI AGNOSTI C 17. 00 RADI OLOGY-THERAPEUTI C 18. 00 CT SCAN 19. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 20. 00 CARDI AC CATHETERI ZATI ON 21. 00 LABORATORY 22. 00 RESPI RATORY THERAPY 22. 00 RESPI RATORY THERAPY 23. 00 DHYSI CAL THERAPY 24. 00 ELECTROCARDI OLOGY 24. 00 ELECTROCARDI OLOGY 25. 00 ELECTROCARDI OLOGY 26. 00 OP PHARMACY 27. 00 RENAL DI ALYSI S 28. 00 29. 00 DP HARMACY 27. 00 RENAL DI ALYSI S 28. 00 29. 00 20. 00 21. 00 21. 00 22. 00 23. 00 24. 797 25. 00 26. 00 27. 00 28. ADI AC CATHETERI CATI ON 29. 00 29. 00 20.							l .	1
16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 160, 443 0 16. 00 17. 00 RADI OLOGY-THERAPEUTI C 55. 00 1, 982, 123 0 17. 00 18. 00 CT SCAN 57. 00 577, 306 0 18. 00 19. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58. 00 1, 189, 512 0 19. 00 20. 00 CARDI AC CATHETERI ZATI ON 59. 00 2, 055, 894 0 20. 00 21. 00 LABORATORY 60. 00 245, 249 0 21. 00 22. 00 RESPI RATORY THERAPY 65. 00 203, 655 0 22. 00 23. 00 PHYSI CAL THERAPY 66. 00 17, 485 0 23. 00 24. 00 ELECTROCARDI OLOGY 69. 00 137, 161 0 24. 00 25. 00 ELECTROENCEPHALOGRAPHY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSI S 74. 00 24, 797 0 27. 00							l .	1
17. 00 RADI OLOGY-THERAPEUTI C 55. 00 1, 982, 123 0 17. 00 18. 00 CT SCAN 57. 00 577, 306 0 18. 00 19. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 58. 00 1, 189, 512 0 19. 00 20. 00 CARDI AC CATHETERI ZATI ON 59. 00 2, 055, 894 0 20. 00 21. 00 LABORATORY 60. 00 245, 249 0 21. 00 22. 00 RESPI RATORY THERAPY 65. 00 203, 655 0 22. 00 23. 00 PHYSI CAL THERAPY 66. 00 17, 485 0 23. 00 24. 00 ELECTROCARDI OLOGY 69. 00 137, 161 0 24. 00 25. 00 ELECTROENCEPHALOGRAPHY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSI S 74. 00 24, 797 0 27. 00							l .	1
18.00 CT SCAN 57.00 577,306 0 18.00 19.00 MAGNETIC RESONANCE I MAGING (MRI) 58.00 1,189,512 0 19.00 20.00 CARDIAC CATHETERI ZATION 59.00 2,055,894 0 20.00 21.00 LABORATORY 60.00 245,249 0 21.00 22.00 RESPI RATORY THERAPY 65.00 203,655 0 22.00 23.00 PHYSI CAL THERAPY 66.00 17,485 0 23.00 24.00 ELECTROCARDI OLOGY 69.00 137,161 0 24.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 143,381 0 25.00 26.00 OP PHARMACY 73.01 15,645 0 26.00 27.00 RENAL DI ALYSI S 74.00 24,797 0 27.00							l .	1
19. 00 MAGNETIC RESONANCE IMAGING (MRI) 20. 00 CARDIAC CATHETERIZATION 59. 00 2,055,894 0 20. 00 21. 00 LABORATORY 60. 00 245,249 0 21. 00 22. 00 RESPIRATORY THERAPY 65. 00 203,655 0 22. 00 23. 00 PHYSICAL THERAPY 66. 00 17,485 0 23. 00 24. 00 ELECTROCARDIOLOGY 69. 00 137, 161 0 24. 00 25. 00 ELECTROCARDIOLOGY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15,645 0 26. 00 27. 00 RENAL DIALYSIS 74. 00 24, 797						-	l .	1
(MRI) 20. 00 CARDI AC CATHETERI ZATI ON 59. 00 2, 055, 894 0 20. 00 21. 00 LABORATORY 60. 00 245, 249 0 21. 00 22. 00 RESPI RATORY THERAPY 65. 00 203, 655 0 22. 00 23. 00 PHYSI CAL THERAPY 66. 00 17, 485 0 23. 00 24. 00 ELECTROCARDI OLOGY 69. 00 137, 161 0 24. 00 25. 00 ELECTROENCEPHALOGRAPHY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSI S 74. 00 24, 797 0 27. 00			1				1	
21. 00 LABORATORY 60. 00 245, 249 0 21. 00 22. 00 RESPI RATORY THERAPY 65. 00 203, 655 0 22. 00 23. 00 PHYSI CAL THERAPY 66. 00 17, 485 0 23. 00 24. 00 ELECTROCARDI OLOGY 69. 00 137, 161 0 24. 00 25. 00 ELECTROENCEPHALOGRAPHY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSI S 74. 00 24, 797 0 27. 00		(MRI)						
22. 00 RESPI RATORY THERAPY 65. 00 203, 655 0 22. 00 23. 00 PHYSI CAL THERAPY 66. 00 17, 485 0 23. 00 24. 00 ELECTROCARDI OLOGY 69. 00 137, 161 0 24. 00 25. 00 ELECTROENCEPHALOGRAPHY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSI S 74. 00 24, 797 0 27. 00							l .	1
23. 00 PHYSI CAL THERAPY 66. 00 17, 485 0 23. 00 24. 00 ELECTROCARDI OLOGY 69. 00 137, 161 0 24. 00 25. 00 ELECTROENCEPHALOGRAPHY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSI S 74. 00 24, 797 0 27. 00							l .	1
24. 00 ELECTROCARDI OLOGY 69. 00 137, 161 0 24. 00 25. 00 ELECTROENCEPHALOGRAPHY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSI S 74. 00 24, 797 0 27. 00							l .	1
25. 00 ELECTROENCEPHALOGRAPHY 70. 00 143, 381 0 25. 00 26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSIS 74. 00 24, 797 0 27. 00							l .	1
26. 00 OP PHARMACY 73. 01 15, 645 0 26. 00 27. 00 RENAL DI ALYSIS 74. 00 24, 797 0 27. 00							l .	1
27. 00 RENAL DI ALYSI S 74. 00 24, 797 0 27. 00							l .	1
	28. 00	CARDIAC REHABILITATION	76. 97		17, 105	0		28. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 1:53 pm Provider CCN: 15-0051

						5/29/2024 1:	53 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
29. 00	CLINIC	90.00		315	0		29. 00
30. 00	OP ONCOLOGY INFUSION CENTER	90. 01		32, 914	0		30. 00
31. 00	WOUND CARE CENTER	90.02		47, 704	0	l e e e e e e e e e e e e e e e e e e e	31. 00
32.00	PAIN CLINIC	90.03		66, 833	0		32.00
33. 00	OB CLINIC	90.04		8, 521	0		33. 00
34. 00	OP PSYCH CLINIC	90. 05		3, 373	0		34. 00
35. 00	MULTI SPECIALTY CLINIC	90.06		67, 970	0		35. 00
36. 00 37. 00	EMERGENCY PROMPTCARE	91. 00 190. 01		261, 236	0		36. 00 37. 00
38.00	COMMUNITY HEALTH SERVICES	190. 01		19, 327 534	0	l l	38.00
39. 00	PHYSICIANS' PRIVATE OFFICES	190. 11		3, 537	0		39.00
37.00	n FRIVATE OFFICES	192.00	— — ₀	31, 413, 406			39.00
	C - BILLABLE MEDICAL SUPPLIES		O _I	31, 413, 400			
1.00	OPERATION OF PLANT	7. 00		25	0		1.00
2. 00	NURSING ADMINISTRATION	13. 00		1, 469	0		2. 00
3. 00	CENTRAL SERVICES & SUPPLY	14. 00		3, 034, 029	0		3. 00
4.00	PHARMACY	15. 00		56	0		4. 00
5.00	CENTRAL STERILIZATION	18. 01		6, 925	0		5. 00
6.00	ADULTS & PEDIATRICS	30.00		226, 289	0		6. 00
7.00	INTENSIVE CARE UNIT	31.00		63, 561	0		7. 00
8.00	NEONATAL INTENSIVE CARE UNIT	35. 00		7, 983	0		8. 00
9.00	OPERATING ROOM	50.00		1, 585, 919	0		9. 00
10.00	RECOVERY ROOM	51.00		10, 704	0		10. 00
11.00	DELIVERY ROOM & LABOR ROOM	52.00		223, 654	0		11. 00
12.00	RADI OLOGY-THERAPEUTI C	55. 00		1, 555	0		12. 00
13.00	CT SCAN	57. 00		4, 228	0	l	13. 00
14. 00	MAGNETIC RESONANCE I MAGING	58. 00		676	0		14. 00
4= 00	(MRI)	50.00		- 07- 044			45.00
15. 00	CARDI AC CATHETERI ZATI ON	59.00		5, 375, 244	0		15. 00
16.00	RESPIRATORY THERAPY	65.00		533	0		16. 00
17. 00	PHYSI CAL THERAPY	66.00		2, 048	0		17. 00
18.00	ELECTROCARDI OLOGY	69.00		3, 405	0		18. 00
19. 00 20. 00	ELECTROENCEPHALOGRAPHY RENAL DI ALYSI S	70. 00 74. 00		1, 282 4, 242	0		19. 00 20. 00
21. 00	CARDIAC REHABILITATION	74.00 76.97		4, 242 52	0		21. 00
22. 00	CLINIC	90.00		561	0	l .	22. 00
23. 00	OP ONCOLOGY INFUSION CENTER	90.00		75, 692	0	l e e e e e e e e e e e e e e e e e e e	23. 00
24. 00	WOUND CARE CENTER	90.01		93, 287	0		24. 00
25. 00	PAIN CLINIC	90. 03		12, 635	0		25. 00
26. 00	OP PSYCH CLINIC	90. 05		91	0		26. 00
27. 00	MULTI SPECIALTY CLINIC	90. 06		7, 486	0		27. 00
28. 00	EMERGENCY	91.00		72, 905	0		28. 00
29.00	PROMPTCARE	190. 01		3, 080	0		29. 00
	0 — — — — —		0	10, 819, 616			
	D - NONBILLABLE MEDICAL SUPPL						
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	7	0		1. 00
2.00	NURSING ADMINISTRATION	13. 00	0	81, 653			2. 00
3.00	PHARMACY	15. 00	0	170, 887			3. 00
4.00	CENTRAL STERILIZATION	18. 01	0	38, 031	0		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	985, 966	0		5. 00
6.00	INTENSIVE CARE UNIT	31.00	0	187, 274	0	l e e e e e e e e e e e e e e e e e e e	6. 00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	45, 017	0		7. 00
8. 00 9. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	7, 584, 135 196, 440	0	1	8. 00 9. 00
10. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	161, 944	0		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	433	0	l e e e e e e e e e e e e e e e e e e e	11. 00
12. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	17, 882	0	l e e e e e e e e e e e e e e e e e e e	12. 00
13. 00	CT SCAN	57. 00	0	35, 483	0	l e e e e e e e e e e e e e e e e e e e	13. 00
14. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	1, 650	0	l I	14. 00
00	(MRI)	55.55	Ĭ	., 555	Ü		1 00
15. 00	CARDIAC CATHETERIZATION	59. 00	0	939, 260	0		15. 00
16. 00	LABORATORY	60.00	Ō	4	0	l l	16. 00
17. 00	RESPIRATORY THERAPY	65.00	0	559, 984	0	l l	17. 00
18.00	ELECTROENCEPHALOGRAPHY	70. 00	0	47, 952	0		18. 00
19.00	OP PHARMACY	73. 01	0	1, 098	0	l e	19. 00
20.00	RENAL DIALYSIS	74. 00	0	7, 827	0	l e e e e e e e e e e e e e e e e e e e	20. 00
21. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	160, 539	0	l .	21. 00
22. 00	WOUND CARE CENTER	90. 02	0	10, 911	0	l e e e e e e e e e e e e e e e e e e e	22. 00
23. 00	PAIN CLINIC	90. 03	0	36, 184	0	l e	23. 00
24. 00	OB CLINIC	90.04	0	9, 925	0	l I	24. 00
25. 00	MULTI SPECIALTY CLINIC	90.06	0	33, 205	0	l I	25. 00
26. 00	EMERGENCY	91.00	0	562, 168	0	l I	26. 00
27. 00	PROMPTCARE	190. 01	0	12, 363	0	l e	27. 00
28. 00	COMMUNITY HEALTH SERVICES	190. 11	0	1, 027	0	I	28. 00

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

| Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 1:53 pm

						5/29/2024 1	
		Decreases		0.1		ı	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
29. 00	6.00 PHYSICIANS' PRIVATE OFFICES	7. 00	8. 00	9. 00 15, 582	10.00		29. 00
29.00	n PRIVATE OFFICES	192.00	— — — ў	13, 382 11, 904, 831			29.00
	E - IMPLANTS SUPPLIES		<u> </u>	11, 704, 031		l	
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	212, 772	0		1.00
2.00	PHARMACY	15. 00	0	362			2. 00
3.00	CENTRAL STERILIZATION	18. 01	o	1, 444	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	220	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	29			5. 00
6.00	OPERATING ROOM	50.00	0	9, 725, 492			6. 00
7.00	RECOVERY ROOM	51.00	0	656	0		7. 00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	15, 221	0		8. 00
9.00	CARDI AC CATHETERI ZATI ON	59.00	0	7, 097, 519			9.00
10. 00 11. 00	OP ONCOLOGY INFUSION CENTER	69. 00 90. 01	0	140 3, 090			10. 00 11. 00
12. 00	EMERGENCY	91. 00	0	159			12.00
13. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	17			13. 00
10.00	PART)	72.01	Ĭ	.,	Ü		10.00
	0 -		— — — d				
	F - LEASE EXPENSE		-'	,	l.		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 855	10		1. 00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49, 238	0		2. 00
3.00	OPERATION OF PLANT	7. 00	0	238, 585	0		3. 00
4.00	NURSING ADMINISTRATION	13. 00	0	15, 172	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	8, 995			5. 00
6.00	RADI OLOGY-THERAPEUTI C	55. 00	0	2, 151	0		6. 00
7.00	LABORATORY	60.00	0	20, 989			7. 00
8.00	PHYSI CAL THERAPY ELECTROENCEPHALOGRAPHY	66.00	0	650, 473			8. 00
9. 00 10. 00	CLINIC	70. 00 90. 00	0	54, 488 1, 872			9. 00 10. 00
11. 00	WOUND CARE CENTER	90.00	ol	109, 242	0		11. 00
12. 00	PAIN CLINIC	90. 02	0	48, 532	0		12. 00
13. 00	OP PSYCH CLINIC	90.05	ő	94, 957	0		13. 00
14. 00	EMERGENCY	91.00	o	58, 571	0		14. 00
15. 00	PROMPTCARE	190. 01	o	42, 008	0		15. 00
16.00	COMMUNITY HEALTH SERVICES	190. 11	O	112, 941	0		16. 00
	0		0	1, 510, 069			
	G - BILLABLE DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		30, 615		l .	1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00		71, 534			2. 00
3.00	CENTRAL SERVICES & SUPPLY	14.00		33, 093			3. 00
4.00	PHARMACY	15.00		38, 142, 962			4.00
5. 00 6. 00	CENTRAL STERILIZATION ADULTS & PEDIATRICS	18. 01 30. 00		1, 962 117, 244			5. 00 6. 00
7. 00	INTENSIVE CARE UNIT	31. 00		23, 520	0		7. 00
8. 00	NEONATAL INTENSIVE CARE UNIT	35.00		1, 867	0		8.00
9. 00	OPERATING ROOM	50.00		320, 169	0		9. 00
10.00	RECOVERY ROOM	51.00		26, 953			10.00
11. 00	DELIVERY ROOM & LABOR ROOM	52.00		22, 814			11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00		97, 704	0		12. 00
13.00	RADI OLOGY-THERAPEUTI C	55.00		100, 853	0		13. 00
14. 00	CT SCAN	57.00		311, 947			14. 00
15. 00	MAGNETIC RESONANCE I MAGING	58. 00		91, 353	0		15. 00
1/ 00	(MRI)	FO. 00		100 715			1/ 00
16.00	CARDI AC CATHETERI ZATI ON	59.00		199, 715			16.00
17. 00 18. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00		13, 867 119	_		17. 00 18. 00
19. 00	ELECTROCARDI OLOGY	69. 00		268, 889			19. 00
20. 00	RENAL DIALYSIS	74.00		25, 020			20.00
21. 00	CARDI AC REHABI LI TATI ON	76. 97		29, 020			21. 00
22. 00	CLI NI C	90.00		1, 504			22. 00
23. 00	OP ONCOLOGY INFUSION CENTER	90. 01		25, 475			23. 00
24.00	WOUND CARE CENTER	90. 02		10, 009	0		24. 00
25.00	PAIN CLINIC	90. 03		167, 706	0		25. 00
26.00	OB CLINIC	90. 04		7, 743	0		26. 00
27. 00	MULTI SPECIALTY CLINIC	90. 06		28, 188			27. 00
28. 00	EMERGENCY	91.00		78, 588			28. 00
29. 00	PROMPTCARE	190. 01		80, 886			29. 00
30.00	COMMUNITY HEALTH SERVICES	190. 11		16, 085			30.00
31. 00	PHYSICIANS' PRIVATE OFFICES	192.00		966			31. 00
	H - NON-BILLABLE DRUGS		U	40, 319, 379			_
1. 00	DI ETARY	10.00	o	12	0		1.00
2. 00	NURSING ADMINISTRATION	13. 00	o	1, 621		l .	2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	Ö	16, 408		l e	3. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		~	-, -==		'	

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 1:53 pm Provider CCN: 15-0051

						5/29/2024 1	
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
4.00	ADULTS & PEDIATRICS	30. 00	0	284, 477	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	118, 625	0		5. 00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	12, 436	0		6. 00
7.00	OPERATING ROOM	50.00	0	182, 258	0		7. 00
8.00	RECOVERY ROOM	51.00	0	114, 763	0		8. 00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	41, 020	0		9.00
10. 00 11. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0	13, 376 15, 079	0		10. 00 11. 00
12. 00	CT SCAN	55. 00 57. 00	0	36, 341	0		12.00
13. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	17, 679	o		13. 00
13.00	(MRI)	30.00		17,079	١		13.00
14. 00	CARDIAC CATHETERIZATION	59. 00	0	79, 910	o		14. 00
15. 00	RESPIRATORY THERAPY	65. 00	0	55	ol		15. 00
16. 00	ELECTROCARDI OLOGY	69. 00	0	9, 915	o		16. 00
17.00	RENAL DIALYSIS	74. 00	0	10, 328	o		17. 00
18.00	CARDIAC REHABILITATION	76. 97	0	35	o		18. 00
19.00	CLINIC	90.00	0	2, 870	o		19. 00
20.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	242, 540	0		20. 00
21.00	PAIN CLINIC	90. 03	0	279	0		21. 00
22. 00	EMERGENCY	91. 00	0	457, 317	0		22. 00
23.00	PROMPTCARE	190. 01	0	16	0		23. 00
24. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	643	0		24. 00
	O LANTEDECT EXPENSE		0	1, 658, 003			
1. 00	J - I NTEREST EXPENSE ADMI NI STRATI VE & GENERAL	5. 00	٥	74	11		1.00
1.00	O GENERAL		0		├─ ─ ─'¦		1.00
	K - PHARMACY RESIDENCY		<u> </u>	, , ,			
1.00	PHARMACY	15. 00	203, 574	15, 574	0		1.00
2.00	CLINIC	90.00	23, 026	1, 761	o		2. 00
	0		226, 600	17, 335			
	L - PSYCH ADMIN						
1.00	ADULTS & PEDIATRICS	30.00	6 <u>8, 2</u> 84	11 <u>1, 1</u> 83	0		1. 00
	0		68, 284	111, 183			_
1 00	M - SOFTWARE LICENSE ADMINISTRATIVE & GENERAL	5. 00		118	14		1 00
1. 00 2. 00	NURSING ADMINISTRATION	13. 00		35	0		1. 00 2. 00
3. 00	OPERATING ROOM	50.00		26, 005	o		3. 00
4. 00	RADI OLOGY-THERAPEUTI C	55. 00		11, 967	o		4.00
5. 00	CARDI AC CATHETERI ZATI ON	59. 00		49, 716	l ő		5. 00
6. 00	RESPIRATORY THERAPY	65.00		2, 098	o		6. 00
7. 00	OP PHARMACY	73. 01		431	o		7. 00
8.00	OP ONCOLOGY INFUSION CENTER	90. 01		3, 360	o		8. 00
9.00	PAIN CLINIC	90. 03		233	o		9. 00
10.00	MULTI SPECIALTY CLINIC	90.06		5, 370	o		10. 00
11.00	PROMPTCARE	190. 01		29, 100	o		11. 00
12.00	COMMUNITY HEALTH SERVICES	19011		790	0		12. 00
	0		0	129, 223			
4 00	N - CAFETERIA	40.00	4 070 040	F / 4 000			
1.00	DI ETARY	10.00	1, 273, 213	564, 989	0		1.00
2. 00			1, 273, 213	<u> </u>	0		2. 00
	O - SHORT TERM DISABILITY/FLM	MA	1, 273, 213	304, 707			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	1, 424	0	O		1.00
2. 00	OPERATION OF PLANT	7. 00	7, 837	0	l .		2. 00
3.00	HOUSEKEEPI NG	9. 00	11, 021	0			3. 00
4.00	DI ETARY	10.00	5, 495	0	o		4. 00
5.00	NURSING ADMINISTRATION	13. 00	57, 958	0	o		5. 00
6.00	PHARMACY	15. 00	91, 556	0	o		6. 00
7.00	CENTRAL STERILIZATION	18. 01	1, 596	0	0		7. 00
8.00	ADULTS & PEDIATRICS	30. 00	89, 083	0	0		8. 00
9. 00	INTENSIVE CARE UNIT	31. 00	7, 727	0	0		9. 00
10. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	11, 427	0	0		10. 00
11. 00	OPERATING ROOM	50.00	27, 849	0	0		11.00
12.00	RECOVERY ROOM	51.00	39, 618	0	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52. 00 54. 00	43, 946	0	0		13.00
14.00	RADI OLOGY - DI AGNOSTI C	54. 00	9, 816	0	l .		14.00
15. 00	RADI OLOGY-THERAPEUTI C	55. 00 57. 00	925 1, 995	0	0		15.00
16. 00 17. 00	CT SCAN MAGNETIC RESONANCE IMAGING	57. 00 58. 00	1, 995	0	0		16. 00 17. 00
17.00	(MRI)	56.00	443	U			17.00
18. 00	CARDIAC CATHETERIZATION	59. 00	1, 043	0	О		18. 00
19. 00	RESPIRATORY THERAPY	65. 00	17, 504	0	o		19. 00
20.00	PHYSICAL THERAPY	66. 00	23, 308	0			20. 00
21. 00	ELECTROCARDI OLOGY	69. 00	586	0	0		21.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 1:53 pm Provider CCN: 15-0051

						0 12/31/2023	5/29/2024 1:53 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
22. 00	ELECTROENCEPHALOGRAPHY	70.00	1, 806	0			22. 00
23. 00	CARDIAC REHABILITATION	76. 97	2, 344	0			23. 00
24. 00	CLINIC	90.00	1, 355	0			24. 00
25. 00	OP ONCOLOGY INFUSION CENTER	90. 01	16, 212	0			25. 00
26. 00	WOUND CARE CENTER	90. 02	4, 125	0			26. 00
27. 00	PAIN CLINIC	90. 03	7, 219	0			27. 00
28. 00	OB CLINIC	90. 04	20, 340	0			28. 00
29. 00	OP PSYCH CLINIC	90. 05	502	0			29. 00
30. 00	MULTI SPECIALTY CLINIC	90. 06	11, 414	0			30.00
31. 00	EMERGENCY	91.00	14, 207	0	_		31.00
32. 00	OBSERVATION BEDS (DISTINCT	92. 01	9, 785	0	0		32. 00
	PART)			_	_		
33. 00	PROMPTCARE	190. 01	2, 682	0	_		33.00
34. 00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11	1 <u>9, 2</u> 69	0			34.00
	0		563, 417	0			
	P - UTILITIES EXPENSE				_		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		3, 631	0		1.00
2.00	NURSI NG ADMI NI STRATI ON	13. 00		107	0		2.00
3. 00	ADULTS & PEDIATRICS	30.00		12	0		3.00
4.00	OPERATING ROOM	50.00		6, 414	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00		12	0		5. 00
6.00	RADI OLOGY - DI AGNOSTI C	54.00		15, 502	0		6.00
7.00	RADI OLOGY-THERAPEUTI C	55. 00		182, 464	0		7. 00
8.00	MAGNETIC RESONANCE I MAGING	58. 00		25	0		8. 00
0.00	(MRI)	50.00			_		0.00
9.00	CARDI AC CATHETERI ZATI ON	59.00		44	0		9.00
10.00	LABORATORY	60.00		2, 476			10.00
11. 00	RESPIRATORY THERAPY	65.00		12	0		11.00
12.00	PHYSI CAL THERAPY	66.00		27, 521	0		12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00		2, 845			13.00
14. 00	OP ONCOLOGY INFUSION CENTER	90. 01		1, 792	0		14.00
15. 00	PAIN CLINIC	90. 03		6, 241	0		15. 00
16.00	OP PSYCH CLINIC	90.05		12	0		16.00
17. 00	OBSERVATION BEDS (DISTINCT	92. 01		12	0		17. 00
10 00	PART)	100 11		25 744	0		18.00
18.00	COMMUNITY HEALTH SERVICES	190. 11		35, 766			18.00
19. 00	PHYSICIANS' PRIVATE OFFICES	192.00	+	19, 932			19. 00
	D OCCUPATIONAL HEALTH ADMIN		0	304, 820			
1. 00	R - OCCUPATIONAL HEALTH ADMIN	190. 01	253, 504		0		1.00
1.00	PROMPTCARE	— 1 90. 01	253, 504	$ \frac{0}{0}$	<u> </u>		1.00
	S - NURSERY		255, 504	0			
1. 00	ADULTS & PEDIATRICS	30.00	694, 729	230, 531	0		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	28, 059	15, 491	0		2.00
2.00	O ROOM & LABOR ROOM _		722, 788	246, 022			2.00
	T - BEDFORD ALLOCATION		122, 100	240, 022			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	11, 829	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	790, 569	450, 974			2.00
3.00	OPERATION OF PLANT	7. 00	36, 961	3, 821			3.00
4. 00	NURSING ADMINISTRATION	13. 00	105, 271	53, 929			4.00
5. 00	PHARMACY	15. 00	278, 180	87, 848			5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	45, 641	17, 612			6. 00
7. 00	RESPIRATORY THERAPY	65. 00	12, 692	3, 088			7. 00
8. 00	PHYSI CAL THERAPY	66.00	104, 999	36, 201			8. 00
0.00	0		1, 374, 313	665, 302			0.00
	U - PAOLI ALLOCATION		., 5, 7, 515	333, 302			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	٥	6, 087	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	405, 457	235, 321	0		2. 00
3. 00	OPERATION OF PLANT	7. 00	36, 961	3, 821			3. 00
4. 00	NURSING ADMINISTRATION	13. 00	46, 946	25, 426			4. 00
5. 00	PHARMACY	15. 00	93, 856	31, 176			5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	23, 486	9, 063			6. 00
7. 00	RESPIRATORY THERAPY	65. 00	12, 692	3, 088			7. 00
8. 00	PHYSI CAL THERAPY	66.00	104, 999	36, 201			8. 00
5. 50	0	— 	724, 397	350, 183			0.00
	V - LIBERTY BUILDING DEPRECIA	ATI ON	727, 377	555, 105	1		
1.00	CAP REL COSTS-BLDG & FIXT	1.00		127, 729	9		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00		1, 820			2.00
2.00	0	<u> </u>		129, 549			2.00
	AC - GRANT	1	9	.27,047			
1.00	COMMUNITY HEALTH SERVICES	190. 11	4, 361, 133	1, 898, 114	0		1.00
	0	— ·····	4, 361, 133	1, 898, 114			
	•		1		'		1

Heal th Financial SystemsIU HEALTH BLOOMINGTON HOSPITALIn Lieu of Form CMS-2552-10RECLASSIFICATIONSProvider CCN: 15-0051Period: From 01/01/2023Worksheet A-6

						FI UII U 1/U 1/2023		
					-	To 12/31/2023	Date/Time Pr	epared:
							5/29/2024 1:	
							372772024 1.	JJ PIII
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.			
	6. 00	7.00	8. 00	9. 00	10.00			
	AD - PHYSICIAN							
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 943, 668	C			1. 00
2.00		0.00	0	0	C			2. 00
3.00		0.00	0	0	C			3. 00
4.00		0.00	0	0	C			4. 00
5.00		0.00	0	0	C			5. 00
6.00		0.00	0	0	C)		6. 00
7.00		0.00	0	0	0			7. 00
	1-		_			1		1

903, 821

903, 821

10, 471, 470

92. 01

2, 943, 668

173, 355

173, 355

144, 134, 056

1.00

500.00

AE - MED OBS
OBSERVATION BEDS (DISTINCT PART)

0 500.00 Grand Total: Decreases

1.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0051

				Ť	o 12/31/2023	Date/Time Pre 5/29/2024 1:5	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET				_		
1.00	Land	18, 174, 895	0	0	0	216, 497	1. 00
2.00	Land Improvements	2, 017, 882	0	0	0	1, 943, 031	2. 00
3.00	Buildings and Fixtures	523, 012, 355	510, 492	0	510, 492		
4.00	Building Improvements	14, 999, 750	434, 223	0	434, 223	4, 526, 403	
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	143, 519, 980	5, 189, 426	0	5, 189, 426	20, 161, 629	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	701, 724, 862	6, 134, 141	0	6, 134, 141	145, 929, 555	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	701, 724, 862	6, 134, 141	0	6, 134, 141	145, 929, 555	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	17, 958, 398	0				1. 00
2.00	Land Improvements	74, 851	74, 851				2. 00
3.00	Buildings and Fixtures	404, 440, 852	23, 263, 581				3. 00
4.00	Building Improvements	10, 907, 570	4, 766, 252				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	128, 547, 777	13, 404, 244				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	561, 929, 448	41, 508, 928				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	561, 929, 448	41, 508, 928				10. 00

Health Financial S	Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF	CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2023 To 12/31/2023		pared:
		SUMMARY OF CAPITAL					
Cost	Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
	STS-BLDG & FLXT	0	0)	0	0	1. 00
	STS-MVBLE EQUIP	0	0		0	0	2. 00
3.00 Total (sum	of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
Cost (Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
PART II - R	ECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COS	STS-BLDG & FLXT	0	0)			1.00
2.00 CAP REL COS	STS-MVBLE EQUIP	0	0)		I	2. 00
3.00 Total (sum	of lines 1-2)	0	0)			3. 00

Heal th	n Financial Systems II	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	1	Period: From 01/01/2023 Fo 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/29/2024 1:53	
		COMI	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.	instructions)	Insurance	
		1.00		2)	4.00	5.00	
	DART III DECONOLILIATION OF CARLTAL COCTO OF	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE			422 201 474	0 771000		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	433, 381, 670 128, 547, 777	l e	433, 381, 670 128, 547, 77			1. 00 2. 00
3.00	Total (sum of lines 1-2)	561, 929, 447	l .	561, 929, 44			3. 00
3.00	Total (Sull of Titles 1-2)		TION OF OTHER (DF CAPITAL	3.00
		ALLOOA	TION OF OTHER C	ALL TAL	JONINIART C	OALLIAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	col s. 5	·		
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(26, 313, 285		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(22, 539, 090		2. 00
3.00	Total (sum of lines 1-2)	0	0	(48, 852, 375	1, 271, 247	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				ĺ	d Costs (see	through 14)	
					instructions)		
		11.00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FLXT	-14, 354, 847	0		0	13, 231, 540	1. 00
2 00	CAD DEL COSTS MADLE FOLLID	Λ	Ι	1 (1 20 222	22 666 450	2 00

0 -14, 354, 847

0 0 0

129, 223 129, 223

13, 231, 540 1. 00 22, 666, 458 2. 00 35, 897, 998 3. 00

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

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0051

					Γο 12/31/2023	Date/Time Prep 5/29/2024 1:53	
				Expense Classification on	Worksheet A	372772024 1.30	э рііі
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	T	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL	A	-13, 866, 365	CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	-	0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAI REE COSTS-WVDEE EQUIT	2.00	Ĭ	2.00
3.00	Investment income - other		0		0.00	О	3.00
	(chapter 2)						
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
0.00	expenses (chapter 8)		0		0.00	Ĭ	0.00
6.00	Rental of provider space by		0		0.00	o	6.00
	suppliers (chapter 8)						
7. 00	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
	(chapter 21)						
9. 00	Parking lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician	A-8-2	-22, 911, 171			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
11.00	(chapter 23)		O		0.00	Ĭ	11.00
12.00	Related organization	A-8-1	51, 065, 745			o	12.00
	transactions (chapter 10)						
13. 00	Laundry and linen service	_	0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		0	CAFETERI A	11.00	0	14. 00
15. 00	Rental of quarters to employee and others	1	0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	o	16. 00
	supplies to other than						
	patients		_			_	
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and		0		0.00	o	18. 00
10.00	abstracts		0		0.00	Ĭ	10.00
19. 00	Nursing and allied health		0		0.00	O	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
21.00	interest, finance or penalty		· ·		0.00		200
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to	'					
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	Λ	RESPI RATORY THERAPY	65.00		23. 00
20.00	therapy costs in excess of	7. 0 0	· ·		00100		20.00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		Λ	UTILIZATION REVIEW-SNF	114.00		25. 00
	physicians' compensation		· ·				
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	이	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		^	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
27.00	COSTS-MVBLE EQUIP		0	NEE GOSTO WINDEL EQUIP	2.00		27.00
28. 00	Non-physician Anesthetist]	0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		Λ	ADULTS & PEDIATRICS	30.00		30. 99
//	instructions)		0		33.00		
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
JZ. UU	Depreciation and Interest		Ü		0.00		JZ. UU
33. 00	MI SCELLANEOUS I NCOME	В	-1, 568, 941	ADMINISTRATIVE & GENERAL	5.00	o	33. 00

From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				T	o 12/31/2023	Date/Time Pre 5/29/2024 1:5	
				Expense Classification on	Worksheet A	37 2 97 2024 1. 3	J pili
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 01	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7. 00	0	00.0.
33. 02	MI SCELLANEOUS I NCOME	В	· ·	HOUSEKEEPI NG	9. 00	0	
33. 03	MI SCELLANEOUS I NCOME	В		DI ETARY	10. 00	0	33. 03
33. 04	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00	0	33. 04
33. 05	MI SCELLANEOUS I NCOME	В		PHARMACY	15. 00	0	
33. 06	MI SCELLANEOUS I NCOME	В	· ·	ADULTS & PEDIATRICS	30. 00	0	33. 06
33. 07	MI SCELLANEOUS I NCOME	В		LABORATORY	60. 00	0	
33. 08	MI SCELLANEOUS I NCOME	В	-350, 619	OP PHARMACY	73. 01	0	33. 08
33. 09	MI SCELLANEOUS I NCOME	В	-17, 880		90.00	0	33. 09
33. 10	MI SCELLANEOUS I NCOME	В	-26, 850	PROMPTCARE	190. 01	0	
33. 11	MI SCELLANEOUS I NCOME	В	· ·	CAP REL COSTS-BLDG & FIXT	1. 00	10	
33. 12	MI SCELLANEOUS I NCOME	В		EMERGENCY	91. 00	0	
33. 13	UNNECESSARY BORROWING	A	· ·	CAP REL COSTS-BLDG & FIXT	1. 00	11	
33. 14	TELEPHONE EXPENSE	A		OPERATION OF PLANT	7. 00	0	
33. 15	HAF FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	WEGMILLER CAPITALIZED INTEREST	A		CAP REL COSTS-BLDG & FIXT	1. 00	11	
33. 17	1983 CAPITALIZED INTEREST	A		CAP REL COSTS-BLDG & FIXT	1. 00	11	
33. 19	OTHER CARRYFORWARD ADJUSTMENTS		98, 927	CAP REL COSTS-BLDG & FIXT	1. 00	9	00 ,
33. 20	NEW HOSPITAL START UP -	A	7, 119, 434	ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
	AMORTI ZATI ON						
33. 21	NONALLOWABLE MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00	0	00
33. 22	NONALLOWABLE MARKETING	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 23	NONALLOWABLE MARKETING	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 23
33. 24	NONALLOWABLE MARKETING	A		RADI OLOGY-THERAPEUTI C	55. 00	0	
33. 25	NONALLOWABLE MARKETING	A	· ·	RESPI RATORY THERAPY	65. 00	0	33. 25
33. 26	NONALLOWABLE MARKETING	A		EMERGENCY	91. 00	0	33. 26
33. 27	SIP PHARMACY RESIDENCY	A	49, 783	PARAMED ED PRGM-PHARMACY	23. 00	0	33. 27
	DEVICE T EVENUE		04 045 :-:	RESI DENCY	,	_	
33. 28	BENEFIT EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 29	CONTRI BUTI ON EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 29
33. 31	CONTRIBUTION EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 32	CONTRIBUTION EXPENSE	A	-152	OBSERVATION BEDS (DISTINCT	92. 01	0	33. 32
22 22	LINIMONITED CLITHATIONS		10 040	PART)	10.00	_	22.22
33. 33	UNWONTED SITUATIONS	A		NURSI NG ADMI NI STRATI ON	13.00	0	00.00
33. 34	UNWONTED SITUATIONS	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 34
50. 00	TOTAL (sum of lines 1 thru 49)		-28, 263, 536				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.

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

Provider CCN: 15-0051
From 01/01/2023
To 12/31/2023
Date/Time Prepared:
5/29/2024 1:53 pm

Li ne No. Cost Center Expense I tems Amount Al I owable	Cost Included in Wks. A, column 5 5.00	
Al I owabl e	Wks. A, column 5 5.00	
	5 5. 00	
	5. 00	
1.00 2.00 3.00 4.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATION HOME OFFICE COSTS:	S OR CLAIMED	
1.00 1.00 CAP REL COSTS-BLDG & FIXT HO ALLOCATION 15,83	3 032	1.00
	, 559	2. 00
3.00 4.00EMPLOYEE BENEFITS DEPARTMENT HO ALLOCATION 21, 78	•	1
3. 01 5. OO ADMINISTRATIVE & GENERAL HO ALLOCATION 69, 73		1
3. 03 30. OOIADULTS & PEDIATRICS HO ALLOCATION	0 -28, 147	1
3. 04 91. OOEMERGENCY HO ALLOCATION	0 -618	1
3. 05 90. 02 WOUND CARE CENTER HO ALLOCATION	0 2, 314	3. 05
3. 06 90. 03 PAIN CLINIC HO ALLOCATION	0 2, 314	3.06
4.00 91.00 EMERGENCY SIPER 8,47	2, 085, 952	4.00
4. 00 EMPLOYEE BENEFITS DEPARTMENT SHARED EMPLOYEES 7.	2, 272 712, 272	4. 01
4.02 5.00 ADMINISTRATIVE & GENERAL SHARED EMPLOYEES 56	566, 070	4. 02
4.03 30.00 ADULTS & PEDIATRICS SHARED EMPLOYEES 7,39	5, 288 7, 395, 288	4. 03
4.04 35.00 NEONATAL INTENSIVE CARE UNIT SHARED EMPLOYEES 85	2, 930 852, 930	4. 04
4.05 50.00 OPERATING ROOM SHARED EMPLOYEES 3,54	7, 344 3, 547, 344	4. 05
4. 06 55. 00 RADI OLOGY-THERAPEUTI C SHARED EMPLOYEES 64	, 782 641, 782	4. 06
4. 07 57. 00 CT SCAN SHARED EMPLOYEES	14, 000	4. 07
4. 08 60. 00 LABORATORY SHARED EMPLOYEES 17, 47	5, 547 17, 475, 547	4. 08
4. 09 70. 00 ELECTROENCEPHALOGRAPHY SHARED EMPLOYEES 1, 36	2, 078 1, 362, 078	4. 09
4. 10 90. 01 OP ONCOLOGY INFUSION CENTER SHARED EMPLOYEES 7.	, 998 711, 998	4. 10
4.11 91.00 EMERGENCY SHARED EMPLOYEES -50	3, 886 -508, 88 <i>6</i>	4. 11
4. 12 190. 01 PROMPTCARE SHARED EMPLOYEES 38), 724 380, 724	4. 12
4. 14 190. 11 COMMUNITY HEALTH SERVICES SHARED EMPLOYEES), 626 70, 62 <i>6</i>	4. 14
	2, 000 22, 000	1
4. 17 0. 00	0 (4. 17
4. 18 0. 00	0 (4. 18
5.00 0 150,7'	-	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.

That he been posted to worksheet A, cordinas I dad or 2, the amount arrowable should be indicated in cordina 4 or this part.									
				Related Organization(s) and/or Home Office					
						l			
						ı			
						ı			
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1. 00	2. 00	3. 00	4. 00	5. 00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00	С		0.00	IU HEALTH SIP	0.00	6. 00
7.00	С		0.00	IU HEALTH PAOLI	0.00	7.00
8.00	В	IU HEALTH	0.00		0. 00	8. 00
9.00			0.00		0. 00	9. 00
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provide $ilde{ ext{r}}.$
- 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.

OTTTOL	00313				To 12/31/2023	Date/Time Prepared: 5/29/2024 1:53 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED OF	RGANIZATIONS OR (CLAI MED
	HOME OFFICE CO					
1.00	15, 828, 032					1.00
2.00	1, 641, 559					2.00
3.00	21, 771, 875					3.00
3. 01	5, 406, 179					3. 0
3.03	28, 147					3. 03
3.04	618					3. 04
3.05	-2, 314					3. 05
3.06	-2, 314	0				3.00
4.00	6, 393, 963	0				4. 00
4.01	0	0				4. 0
4.02	0	0				4. 02
4.03	0	0				4. 03
4.04	0	0				4. 04
4.05	0	0				4. 05
4.06	0	0				4. 06
4.07	0	0				4. 0
4.08	0	0				4. 08
4.09	0	0				4. 09
4. 10	0	0				4. 10
4. 11	0	0				4. 1
4. 12	0	0				4. 12
4.14	0	0				4. 14
4. 16	0	0				4. 10
4. 17	0	0				4. 17
4. 18	0	0				4. 18
5.00	51, 065, 745					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.

nas no	t boon pooted to normaneer //	cordinate transfer 2, the amount arrowable should be that eated the cordinate this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	FED 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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0051

							To 12/31/2023	Date/Time Pre 5/29/2024 1:5	
	Wkst. A Line #	Cost Center/Physician	Total	Prot	fessi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Co	mponent	Component		ider Component	
								Hours	
	1. 00	2. 00	3. 00		4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	7, 384, 107	1	7, 145, 084	239, 023	,	9, 320	1.00
2.00	35. 00	NEONATAL INTENSIVE CARE UNIT	841, 749	1	418, 867	422, 882	169, 700	3, 974	2. 00
3.00		OPERATING ROOM	4, 544, 647		4, 544, 647	C			3. 00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	527, 020	ıl .	527, 020	C			4. 00
5.00	55. 00	RADI OLOGY-THERAPEUTI C	549, 739	1	549, 739	C	271, 900	0	5.00
6.00	70. 00	ELECTROENCEPHALOGRAPHY	1, 360, 861		1, 360, 861	C	271, 900	0	6. 00
7.00	90. 01	OP ONCOLOGY INFUSION CENTER	459, 614		459, 614	C	181, 300	0	7. 00
8.00	90. 06	MULTI SPECIALTY CLINIC	43, 071		43, 071	C	181, 300	0	8. 00
9.00	91. 00	EMERGENCY	7, 763, 611		7, 763, 611	C	211, 500	0	9. 00
10.00	0. 00		0		0	C	0	0	10.00
200.00			23, 474, 419		22, 812, 514	661, 905		13, 294	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	
		l denti fi er	Li mi t			Memberships &		of Malpractice	
					Limit	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00	2.00	8. 00		9. 00	12. 00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	947, 683		47, 384	O		0	1.00
2.00		NEONATAL INTENSIVE CARE UNIT	324, 225	1	16, 211	C		0	2.00
3.00		OPERATING ROOM	0	1	0	C	0	0	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	1	0	O	0	0	4. 00
5.00		RADI OLOGY-THERAPEUTI C	0	1	0	Ü	0	0	5. 00
6.00		ELECTROENCEPHALOGRAPHY	0	1	0	O	0	0	6. 00
7.00		OP ONCOLOGY INFUSION CENTER	0	1	0	Ü	0	0	7. 00
8.00		MULTI SPECIALTY CLINIC	0	1	0	O	0	0	8. 00
9.00		EMERGENCY	0	1	0	O	0	0	9. 00
10.00	0. 00		0	1	0	C		0	10. 00
200.00		0 1 0 1 (5)	1, 271, 908		63, 595			0	200. 00
	Wkst. A Line #	,	Provi der		usted RCE	RCE	Adjustment		
		Identi fi er	Component		Limit	Di sal I owance			
			Share of col.						
	1. 00	2.00	14 15. 00		16. 00	17. 00	18.00		
1.00		ADULTS & PEDIATRICS	13.00		947, 683	17.00			1. 00
2. 00		NEONATAL INTENSIVE CARE UNIT	0		324, 225				2. 00
3.00		OPERATING ROOM	0		02 1, 220	70, 007			3. 00
4. 00		RADI OLOGY-DI AGNOSTI C	0		0	O			4. 00
5. 00		RADI OLOGY-THERAPEUTI C	0		Ö	Ö			5. 00
6. 00		ELECTROENCEPHALOGRAPHY	0		0	0			6. 00
7. 00		OP ONCOLOGY INFUSION CENTER			0	0	1,000,001		7. 00
8. 00		MULTI SPECIALTY CLINIC	0		0	0	,		8. 00
9. 00		EMERGENCY			0	0			9. 00
10.00	0.00				0	0			10. 00
200.00	0.00				1, 271, 908				200. 00
200.00	I	I	1	1	1, 2/1, 700	70,007	22,711,1/1		200.00

			U HEALTH BLOOMI				U OT FORM CMS	2552-10
COST	LLUCA	TION - GENERAL SERVICE COSTS		Provi der C		Period: From 01/01/2023	Worksheet B Part I	
						Γο 12/31/2023	Date/Time Pre	pared:
				OADLTAL DE	ATER COCTO		5/29/2024 1:5	3 pm
				CAPITAL REI	LATED COSTS			
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		oost outter bescription	for Cost	DEDO G TTAT	MIVEL EQUIT	BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7)					
	T		0	1. 00	2. 00	4. 00	4A	
4 00		AL SERVICE COST CENTERS	40 004 540	40 004 540	ı			1 00
1.00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	13, 231, 540 22, 666, 458	13, 231, 540	22, 666, 45			1. 00 2. 00
2. 00 4. 00		EMPLOYEE BENEFITS DEPARTMENT	23, 185, 575	0		23, 185, 575		4.00
5. 00		ADMINISTRATIVE & GENERAL	88, 172, 356	737, 034			91, 105, 744	1
7. 00	1	OPERATION OF PLANT	17, 083, 790	1, 057, 779			20, 434, 560	1
8.00		LAUNDRY & LINEN SERVICE	190, 944	0	, , , , ,	o	190, 944	1
9.00		HOUSEKEEPI NG	4, 620, 959	56, 580	96, 94	398, 334	5, 172, 819	9. 00
10.00		DIETARY	2, 394, 620	226, 445	387, 99	361, 124	3, 370, 188	10.00
11. 00	1	CAFETERI A	1, 742, 842	194, 283			2, 507, 339	1
13. 00		NURSI NG ADMI NI STRATI ON	11, 225, 384	78, 655			13, 233, 080	
14. 00		CENTRAL SERVICES & SUPPLY	15, 033, 690				15, 402, 863	
15. 00 16. 00		PHARMACY MEDI CAL RECORDS & LI BRARY	7, 974, 806	101, 919			9, 296, 033 93, 966	
18. 00		SOCIAL SERVICES	0	34, 630	1		93, 900	1
18. 01		CENTRAL STERI LI ZATI ON	1, 758, 232	208, 331	1		2, 474, 409	1
23. 00		PARAMED ED PRGM-PHARMACY RESIDENCY	450, 475	22, 980			580, 534	1
		TENT ROUTINE SERVICE COST CENTERS	1997 119				222722	1
30.00	03000	ADULTS & PEDIATRICS	38, 344, 128	2, 739, 221	4, 693, 47	3, 927, 735	49, 704, 563	30.00
31. 00	1	INTENSIVE CARE UNIT	5, 888, 795	248, 715	426, 15	757, 846	7, 321, 513	31.00
32.00		CORONARY CARE UNIT	0	0	(0	0	
35. 00		NEONATAL INTENSIVE CARE UNIT	3, 488, 651	228, 026	390, 70	433, 228	4, 540, 612	1
42. 00		SUBPROVI DER	0	0	100 (0	0	0	
43. 00		NURSERY LARY SERVICE COST CENTERS	968, 810	107, 176	183, 63	3 134, 879	1, 394, 503	43. 00
50. 00		OPERATING ROOM	17, 795, 991	909, 527	1, 558, 41	1, 282, 661	21, 546, 595	50.00
50. 01		CV SURGERY	17,773,771	707, 327		0	21, 340, 373	1
51. 00		RECOVERY ROOM	5, 998, 698	627, 070		-	8, 631, 867	1
52. 00		DELIVERY ROOM & LABOR ROOM	4, 265, 186	371, 838			5, 778, 753	
53.00		ANESTHESI OLOGY	0	0			0	1
54.00	05400	RADI OLOGY-DI AGNOSTI C	5, 174, 203	242, 481	415, 47	602, 211	6, 434, 371	54.00
55.00		RADI OLOGY-THERAPEUTI C	3, 663, 012	365, 445	626, 16	448, 083	5, 102, 706	1
56. 00	1	RADI OI SOTOPE	0	0		0	0	
57. 00		CT SCAN	2, 600, 266	65, 637			2, 905, 051	1
58.00		MAGNETIC RESONANCE IMAGING (MRI)	1, 288, 846				1, 672, 877	
59. 00 60. 00		CARDIAC CATHETERIZATION LABORATORY	2, 298, 902 18, 679, 926	525, 737 257, 701	900, 81 ⁻ 441, 55		4, 124, 495 19, 379, 455	
64. 00	1	I NTRAVENOUS THERAPY	10, 077, 720	237, 701	441, 33	2/4	17, 377, 433	1
65. 00		RESPI RATORY THERAPY	3, 925, 501	8, 986	15, 39	625, 574	4, 575, 458	1
66.00		PHYSI CAL THERAPY	7, 520, 887				9, 937, 125	
69. 00	06900	ELECTROCARDI OLOGY	1, 639, 856	77, 056	132, 03	1 224, 622	2, 073, 565	
70.00	07000	ELECTROENCEPHALOGRAPHY	520, 826	35, 696	61, 16:	82, 231	699, 915	70.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 818, 204	0	1	0	10, 818, 204	1
72. 00		I MPL. DEV. CHARGED TO PATIENTS	17, 056, 457	0	(0	17, 056, 457	1
73. 00		DRUGS CHARGED TO PATIENTS	40, 316, 022	0	05 50	0	40, 316, 022	1
73. 01		OP PHARMACY RENAL DIALYSIS	5, 561, 295	49, 903			5, 800, 598 1, 832, 641	
74. 00 76. 97		CARDIAC REHABILITATION	1, 689, 957 574, 285	52, 584		94, 860	669, 145	1
77. 00		ALLOGENEIC STEM CELL ACQUISITION	0	0		0 74, 800	007, 143	1
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0			0	1
		TIENT SERVICE COST CENTERS		_		-1		1
90.00	09000	CLINIC	1, 202, 723	332, 644	569, 96	204, 969	2, 310, 300	90.00
90. 01		OP ONCOLOGY INFUSION CENTER	5, 575, 862	495, 707	849, 36		7, 788, 863	90. 01
90. 02	09002	WOUND CARE CENTER	766, 512	79, 525			1, 102, 312	1
90. 03		PAIN CLINIC	930, 512	53, 277	91, 28		1, 185, 477	
90. 04		OB CLINIC	2, 776, 112	554, 063			4, 744, 719	1
90.05		OP PSYCH CLINIC	1, 059, 723	215, 346			1, 807, 873	1
90. 06 91. 00		MULTI SPECIALTY CLINIC EMERGENCY	2, 617, 815 17, 376, 163	624, 957		,	3, 024, 853 20, 241, 075	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	17, 370, 103	024, 737	1,070,02	1, 107, 132	20, 241, 073	1
92. 01		OBSERVATION BEDS (NON-DISTINCT PART)	5, 617, 038	240, 972	412, 890	201, 889	6, 472, 789	
		REIMBURSABLE COST CENTERS	97 9 1 1 7 9 9 9				<u> </u>	1
94.00		HOME PROGRAM DIALYSIS	0	0		0	0	94.00
		AMBULANCE SERVICES	0	0		o o	0	
		I&R SERVICES-NOT APPRVD PRGM	0	0	•	0		100. 00
		HOME HEALTH AGENCY	0	0		0		101.00
102.00		OPIOID TREATMENT PROGRAM	0	0	1	0	0	102. 00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE			I			112 00
113.00	/ 1 1 3 U C	/ INIERESI EAFENSE	1	<u> </u>	I	<u> </u>		113. 00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051 Peri od: Worksheet B From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) O 0 115 00 0 116. 00 11600 HOSPI CE 0 0 0 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 447, 732, 835 12, 880, 161 22, 069, 322 21, 258, 486 444, 857, 231 118. 00 NONREI MBURSABLE COST CENTERS 174, 354 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 93,640 29, 746 50, 968 190. 01 19001 PROMPTCARE 3, 058, 524 106, 874 183, 121 417, 893 3, 766, 412 190. 01 190. 02 19002 RENTAL PROPERTIES 0 190. 02 0 0 0 190. 03 19003 OLCOTT 0 0 190. 03 0 0 Ω 0 190. 04 190. 04 19004 PHYSICIAN RECRUITMENT 0 0 0 0 190. 05 19005 FOUNDATI ON 0 0 0 0 0 190. 05 0 0 190. 06 19006 MARKETI NG 0 0 0 190. 06 190. 07 19007 HME STORE 0 0 190, 07 Ω 190. 08 19008 UNUSED SPACE 0 0 0 0 190. 08 190. 09 19009 CLINI CAL TRI ALS 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 0 190. 11 19011 COMMUNITY HEALTH SERVICES 3, 097, 311 0 302, 901 3, 400, 212 190. 11 191. 00 19100 RESEARCH 0 191.00 191. 01 19101 RESEARCH 0 0 191. 01 191. 02 19102 OTHER SPONSORED ACTIVITIES 7, 073, 074 191. 02 6, 259, 247 0 813, 827 192. 00 19200 PHYSICIANS' PRIVATE OFFICES O 51, 224 192. 00 48, 217 2,877 130 193. 00 19300 NONPALD WORKERS 0 193.00 C 194.00 07950 IU HEALTH PAOLI HOSPITAL 76, 239 1, 416, 629 194. 00 1,074,580 130, 631 135, 179 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 2, 039, 615 135, 643 232, 416 256, 459 2, 664, 133 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPITAL 0 0 194. 02 194. 03 07953 IU HEALTH SIP 134, 945 194. 03 134, 245 0 700 0 194.04 07954 HOME CARE 0 0 0 194. 04 194. 05 07955 HOSPI CE 0 1,775 C 0 1, 775 194. 05 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 463, 539, 989 13, 231, 540 23, 185, 575 463, 539, 989 202. 00 22, 666, 458

Provider CCN: 15-0051

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 1:53 pm

					0 12/31/2023	5/29/2024 1:5	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	· ·	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	91, 105, 744					5. 00
7. 00	00700 OPERATION OF PLANT	4, 998, 743	25, 433, 303				7. 00
	00800 LAUNDRY & LINEN SERVICE	46, 709	0	237, 653			8. 00
	00900 HOUSEKEEPI NG	1, 265, 385	125, 825	45	6, 564, 074		9. 00
	01000 DI ETARY	824, 422	503, 575	1, 430			10.00
	01100 CAFETERI A	613, 350	432, 053		13, 579		11. 00
	01300 NURSING ADMINISTRATION	3, 237, 102	174, 914	63	0	0	13. 00
	01400 CENTRAL SERVICES & SUPPLY	3, 767, 879	298, 330	0	181, 057	0	14. 00
15. 00	01500 PHARMACY	2, 274, 014	226, 650	0	67, 896	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	22, 986	77, 011	0	30, 176	0	16. 00
18. 00	01850 SOCI AL SERVI CES	0	0	0	0	0	18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	605, 295	463, 292	1, 565	0	0	18. 01
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	142, 011	51, 104	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	12, 158, 960	6, 091, 549	80, 795	3, 257, 521	4, 280, 269	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 791, 003	553, 099	9, 215	286, 674	435, 943	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	1, 110, 734	507, 090	1, 746	0	0	35. 00
42. 00	04200 SUBPROVI DER	o	0	0	0	0	42.00
43. 00	04300 NURSERY	341, 126	238, 340	2, 989	102, 599	0	43.00
ĺ	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	5, 270, 771	2, 022, 632	38, 252	603, 524	0	50.00
50. 01	05001 CV SURGERY	O	0	0	0	0	50. 01
51. 00	05100 RECOVERY ROOM	2, 111, 545	1, 394, 496	13, 767	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 413, 610	826, 903	11, 504	254, 234	0	52. 00
53. 00	05300 ANESTHESI OLOGY	o	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 573, 989	539, 237	21, 853	181, 057	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	1, 248, 234	812, 686		0	0	55. 00
	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
	05700 CT SCAN	710, 639	145, 966	0	0	Ö	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	409, 223	204, 771		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	1, 008, 942	1, 169, 149		0	Ö	59.00
	06000 LABORATORY	4, 740, 641	573, 082		30, 176		60.00
	06400 I NTRAVENOUS THERAPY	4, 740, 041	373,002		30, 170		64.00
	06500 RESPIRATORY THERAPY	1, 119, 258	19, 983		0		65.00
	06600 PHYSI CAL THERAPY	2, 430, 839	947, 357		67, 896		66.00
	06900 ELECTROCARDI OLOGY	507, 240	171, 360				69.00
	07000 ELECTROENCEPHALOGRAPHY	171, 215	79, 381		101,037		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1	19, 301		0		71.00
1	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 646, 371	0		0	0	1
	07300 DRUGS CHARGED TO PATIENTS	4, 172, 385	0		0	- 1	72.00
		9, 862, 186	110.075		0	0	73. 00
	07302 OP PHARMACY	1, 418, 954	110, 975	1	0	0	73. 01
	07400 RENAL DI ALYSI S	448, 304	116, 939		0	0	74.00
1	07697 CARDI AC REHABI LI TATI ON	163, 688	0	1	0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
	07800 CAR T-CELL IMMUNOTHERAPY	0	0)	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	E/E 1E0	720 742	1 24	0		00 00
	09000 CLI NI C	565, 150	739, 742			0	90.00
	09001 OP ONCOLOGY INFUSION CENTER	1, 905, 327	1, 102, 367				90. 01
1	09002 WOUND CARE CENTER	269, 650	176, 849		45, 264		90. 02
	09003 PAIN CLINIC	289, 994	118, 479		0	0	90. 03
	09004 OB CLINIC	1, 160, 663	1, 232, 141		0	0	90. 04
	09005 OP PSYCH CLINIC	442, 246	478, 892		0	0	90. 05
	09006 MULTI SPECIALTY CLINIC	739, 946	0	10	0	0	90.06
	09100 EMERGENCY	4, 951, 412	1, 389, 796	37, 043	1, 176, 871	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	09202 OBSERVATION BEDS (DISTINCT PART)	1, 583, 387	535, 880	8, 396	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	
	09500 AMBULANCE SERVI CES	0	0	0	0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
	10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
	11600 HOSPI CE	0	0	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	86, 535, 528	24, 651, 895	237, 653	6, 496, 178	4, 716, 212	118. 00
				<u> </u>		<u> </u>	
		_	_	_	_		

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0051 Per

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/29/2024 1:53 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 42,651 66, 151 0 0 0 190. 01 19001 PROMPTCARE 921, 347 237, 669 0 0 190. 01 190. 02 19002 RENTAL PROPERTIES 0 0 190. 02 190. 03 19003 OLCOTT 0 0 0 190. 03 Ω 0 190. 04 19004 PHYSI CI AN RECRUITMENT o 0 190. 04 0 190. 05 19005 FOUNDATI ON 0 0 0 0 190. 05 190. 06 19006 MARKETI NG 190. 07 19007 HME STORE 0 0 0 0 190.06 ol 0 67, 896 0 190, 07 0 190.08 19008 UNUSED SPACE 0 0 190. 08 190. 09 19009 CLINI CAL TRI ALS 0 0 0 0 190. 09 0 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 190. 10 0 0 0 190. 11 19011 COMMUNITY HEALTH SERVICES 0 190. 11 831, 767 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 0 0 191. 00 191. 01 19101 RESEARCH 0 191. 01 0 191. 02 19102 OTHER SPONSORED ACTIVITIES 0 0 191. 02 1, 730, 230 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 6, 398 0 12, 531 0 192. 00 193. 00 19300 NONPALD WORKERS 0 193. 00 194.00 07950 IU HEALTH PAOLI HOSPITAL 0 0 194. 00 346, 539 169.543 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 194. 01 651, 706 301, 647 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 194. 02 194. 03 07953 IU HEALTH SIP 0 0 194. 03 33, 011 0 0 194. 04 07954 HOME CARE 0 194. 04 C 194. 05 07955 HOSPI CE 434 C 0 0 194. 05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 6, 564, 074 4, 716, 212 202. 00 91, 105, 744 25, 433, 303 237, 653

Provider CCN: 15-0051

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31

				10	12/31/2023	Date/lime Pre 5/29/2024 1:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON			RECORDS &	
		11.00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	OO400						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	3, 566, 321	1/ 015 /00				11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	270, 539 1, 493					13. 00 14. 00
15. 00	01500 PHARMACY	129, 216		98, 466	12, 092, 275		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0		16. 00
18. 00	01850 SOCIAL SERVICES	0	0	0	0	0	18. 00
18. 01	01851 CENTRAL STERILIZATION	41, 714	0	30, 848	0	0	18. 01
23. 00	O2301 PARAMED ED PRGM-PHARMACY RESIDENCY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	9, 983	U	0	U	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	695, 738	5, 456, 697	492, 126	81, 122	18, 760	30.00
31. 00	03100 NTENSI VE CARE UNI T	123, 950		· ·	34, 188		1
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	66, 441	622, 366		3, 584	1, 312	
42. 00	04200 SUBPROVI DER	0	101 252	0	1 051	0	42.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	22, 229	191, 252	10, 074	1, 051	465	43.00
50. 00	05000 OPERATING ROOM	184, 300	1, 327, 250	3, 836, 401	52, 527	31, 239	50.00
50. 01	05001 CV SURGERY	0	0	0	0	0	50. 01
51. 00	05100 RECOVERY ROOM	153, 964	1, 421, 282		33, 075		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	82, 732	663, 763		11, 636		1
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	97, 386	122 012	20. 972	2 055	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	69, 113	133, 812 108, 034		3, 855 4, 346		1
56. 00	05600 RADI OI SOTOPE	0,,110	0	0	0	0	56.00
57.00	05700 CT SCAN	18, 051	9, 655	29, 824	10, 474	4, 569	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	18, 093	0	2, 011	5, 095		
59. 00	05900 CARDI AC CATHETERI ZATI ON	58, 607	413, 271	847, 020	23, 030		1
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	110, 127	0	2 0	0	14, 623 0	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	92, 443	0	272, 383	16	-	
66. 00	06600 PHYSI CAL THERAPY	192, 023	0	4, 093	0		66. 00
69. 00	06900 ELECTROCARDI OLOGY	40, 611	47, 440		2, 858	4, 070	1
70.00	07000 ELECTROENCEPHALOGRAPHY	16, 000	0	23, 945	0		1
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	5, 107, 014 8, 051, 934	0		1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0, 051, 934	0 11, 619, 199	19, 448 34, 553	1
	07302 OP PHARMACY	12, 949	0		433		1
	07400 RENAL DIALYSIS	0	0	5, 176	2, 977		74. 00
	07697 CARDI AC REHABI LI TATI ON	18, 170	52, 073		10		
77. 00	O7700 ALLOGENEIC STEM CELL ACQUISITION O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
78. 00	OUTPATIENT SERVICE COST CENTERS	0	U	l U	U		78.00
90. 00	09000 CLINI C	31, 962	139, 271	3, 106	827	144	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	141, 297	1, 158, 967		69, 901	5, 514	90. 01
90. 02	09002 WOUND CARE CENTER	20, 125			0	782	1
90. 03	09003 PAIN CLINIC	23, 515			81	501	90. 03
90. 04 90. 05	09004 OB CLINIC	94, 357	547, 599 111, 783		0	301	90. 04
90.05	O9005 OP PSYCH CLINIC O9006 MULTI SPECIALTY CLINIC	39, 568 86, 845			0	564 475	90. 05 90. 06
91. 00	09100 EMERGENCY	213, 267	1, 797, 295		131, 800		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		, , ,	,	, , , , , , , , , , , , , , , , , , , ,		92. 00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	63, 128	585, 246	0	0	2, 620	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0	0	-	0		94. 00 95. 00
	109300 AMBULANCE SERVICES 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101.00	10100 HOME HEALTH AGENCY	0	Ö	Ö	0		101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0		102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)	_	0	o	0	_	114. 00 115. 00
	11600 HOSPI CE		0	0	0		116. 00
118.00	1	3, 239, 936	16, 450, 458	- 1	12, 092, 085		
	· · · · · · · · · · · · · · · · · · ·		'		'		

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared:

			10	12/31/2023	Date/IIme Prepared: 5/29/2024 1:53 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
·		ADMI NI STRATI ON	SERVICES &		RECORDS &
			SUPPLY		LI BRARY
	11. 00	13. 00	14.00	15. 00	16. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
190. 01 19001 PROMPTCARE	65, 446	154, 820	8, 672	5	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0 190. 02
190. 03 19003 OLCOTT	0	0	0	0	0 190. 03
190. 04 19004 PHYSI CLAN RECRUI TMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	0	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0 190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	0	0	0	0 190. 09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	217, 615	310, 420	2, 566	0	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
191. 01 19101 RESEARCH	0	0	0	0	0 191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	0	0	0	0	0 191. 02
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	39	0	7, 617	185	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	14, 822	0	0	0	0 194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	28, 329	0	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194. 03 07953 IU HEALTH SIP	134	0	0	0	0 194. 03
194. 04 07954 HOME CARE	0	0	0	0	0 194. 04
194. 05 07955 HOSPI CE	0	0	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 566, 321	16, 915, 698	19, 651, 622	12, 092, 275	224, 139 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/29/2024 1:53 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

					12/31/2023	5/29/2024 1:5	
		OTHER GENE	RAL SERVICE				
	Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &	
		SERVI CES	STERILIZATION	PRGM-PHARMACY RESI DENCY		Residents Cost & Post	
						Stepdown	
		10.00	10.01	22.00	24.00	Adjustments	
	GENERAL SERVICE COST CENTERS	18. 00	18. 01	23. 00	24. 00	25. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
18. 00	01850 SOCIAL SERVICES	C					18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	c	3, 617, 123				18. 01
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	C	0	783, 632			23. 00
30. 00	O3000 ADULTS & PEDIATRICS) 0	O	82, 318, 100	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT		1		11, 744, 578	l .	31. 00
32. 00	03200 CORONARY CARE UNIT	i c	o o	Ö	0	Ö	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	C	0	0	6, 879, 753	0	35. 00
42. 00	04200 SUBPROVI DER	C	-	0	0	0	42.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C	0	0	2, 304, 628	0	43. 00
50. 00	05000 OPERATING ROOM		3, 617, 123	0	38, 530, 614	0	50. 00
50. 01	05001 CV SURGERY		1		0	0	50. 01
51.00	05100 RECOVERY ROOM	c	0	0	13, 869, 056	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	1		9, 139, 777	0	52. 00
53.00	05300 ANESTHESI OLOGY		0	0	0 011 040	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C			0	9, 011, 060 7, 376, 812	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE		o o	Ö	0	o o	56. 00
57.00	05700 CT SCAN	c	0	0	3, 834, 229	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0	0	2, 313, 475	l .	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	C	0	-	7, 654, 734 24, 848, 106	l .	59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY			_	24, 646, 100	0	64. 00
65. 00	06500 RESPIRATORY THERAPY		Ö	0	6, 081, 570		65. 00
66. 00	06600 PHYSI CAL THERAPY	C	0	0	13, 582, 444	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	C	0	0	3, 046, 396	l .	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0	991, 172 18, 581, 726		70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS		1	_	29, 300, 224	l .	
73. 00	07300 DRUGS CHARGED TO PATIENTS	C	0	783, 632	62, 615, 592	l .	73. 00
	07302 OP PHARMACY	C	0	0	7, 345, 450	l .	73. 01
	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON		0	0	2, 407, 332		74. 00 76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION			0	904, 144 0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY		o o	Ö	0	ő	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	C	1		3, 790, 526		90.00
90. 01 90. 02	O9001 OP ONCOLOGY INFUSION CENTER O9002 WOUND CARE CENTER		0	_	12, 269, 387 1, 769, 098		90. 01 90. 02
90. 02	09002 WOUND CARE CENTER) 0		1, 769, 098 1, 735, 877		90. 02
90. 04	09004 OB CLINIC		o o	Ö	7, 790, 401	Ö	90. 04
90. 05	09005 OP PSYCH CLINIC	c	0	0	2, 880, 985	0	90. 05
	09006 MULTI SPECIALTY CLINIC	C	0	0	4, 216, 701	l .	90. 06
91. 00	09100 EMERGENCY	C	0	0	30, 241, 648	0	91.00
	O9200 OBSERVATION BEDS (NON-DISTINCT PART) O9202 OBSERVATION BEDS (DISTINCT PART)		0	0	9, 251, 446	_	92. 00 92. 01
72.01	OTHER REIMBURSABLE COST CENTERS		,		7, 231, 440		72.01
94.00	09400 HOME PROGRAM DIALYSIS	C	0	0	0	0	94.00
	09500 AMBULANCE SERVICES		0	0	0	0	95. 00
	10000 &R SERVICES-NOT APPRVD PRGM		0	0	0	l .	100. 00 101. 00
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM				0	l .	101.00
102.00	SPECIAL PURPOSE COST CENTERS		, 0	<u> </u>	0		. 52. 55
113.00	11300 NTEREST EXPENSE						113. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part I Provider CCN: 15-0051

			To	rom 01/01/2023 o 12/31/2023	
	OTHER GENER	DAI SEDVICE			5/29/2024 1:53 pm
	OTHER GENER	RAL SERVICE			
Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &
cost center bescription			PRGM-PHARMACY		Residents Cost
	02.00	0122.2	RESI DENCY		& Post
			MEGI BENGI		Stepdown
					Adjustments
	18. 00	18. 01	23. 00	24. 00	25. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	О	0	0	0	0 115. 00
116. 00 11600 HOSPI CE	o	0	0	0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	o	3, 617, 123	783, 632	438, 627, 041	0 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	283, 156	0 190. 00
190. 01 19001 PROMPTCARE	0	0	0	5, 154, 371	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0 190. 02
190. 03 19003 OLCOTT	0	0	0	0	0 190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	0	0	0	67, 896	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0 190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	0	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0	0	4, 762, 580	
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
191. 01 19101 RESEARCH	0	0	0	0	0 191. 01
191.02 19102 OTHER SPONSORED ACTIVITIES	0	0	0	8, 803, 304	0 191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	77, 994	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	1, 947, 533	
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	3, 645, 815	
194. 02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194. 03 07953 I U HEALTH SI P	0	0	0	168, 090	
194. 04 07954 HOME CARE	0	0	0	0	0 194. 04
194. 05 07955 HOSPI CE	0	0	0	2, 209	
200.00 Cross Foot Adjustments	_	_	0	0	0 200. 00
201. 00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	이	3, 617, 123	783, 632	463, 539, 989	0 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/29/2024 1:53 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

			5/29/2024 1:5	
	Cost Center Description	Total		
	GENERAL SERVICE COST CENTERS	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY			13.00
	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
	01850 SOCIAL SERVICES			18. 00
	01851 CENTRAL STERILIZATION			18. 01
	02301 PARAMED ED PRGM-PHARMACY RESIDENCY			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	82, 318, 100		30.00
	1 1	11, 744, 578		31. 00
32. 00	03200 CORONARY CARE UNIT	0		32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 879, 753		35. 00
42.00	04200 SUBPROVI DER	0		42. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 304, 628		43. 00
50. 00	05000 OPERATING ROOM	38, 530, 614		50.00
	05001 CV SURGERY	30, 330, 614		50. 00
51. 00	05100 RECOVERY ROOM	13, 869, 056		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	9, 139, 777		52.00
53. 00	05300 ANESTHESI OLOGY	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 011, 060		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 376, 812		55.00
56.00	05600 RADI 0I SOTOPE	0		56. 00
57. 00	05700 CT SCAN	3, 834, 229		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 313, 475		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 654, 734		59. 00
60.00	06000 LABORATORY	24, 848, 106		60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 6, 081, 570		64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 582, 444		66.00
	06900 ELECTROCARDI OLOGY	3, 046, 396		69. 00
	07000 ELECTROENCEPHALOGRAPHY	991, 172		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 581, 726		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	29, 300, 224		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	62, 615, 592		73. 00
	07302 OP PHARMACY	7, 345, 450		73. 01
	07400 RENAL DIALYSIS	2, 407, 332		74. 00
	07697 CARDI AC REHABI LI TATI ON	904, 144		76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION	0		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	3, 790, 526		90.00
	09001 OP ONCOLOGY INFUSION CENTER	12, 269, 387		90.00
	09002 WOUND CARE CENTER	1, 769, 098		90. 02
	09003 PAIN CLINIC	1, 735, 877		90. 03
	09004 OB CLINIC	7, 790, 401		90. 04
90. 05	09005 OP PSYCH CLINIC	2, 880, 985		90. 05
90.06	09006 MULTI SPECIALTY CLINIC	4, 216, 701		90. 06
	09100 EMERGENCY	30, 241, 648		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	9, 251, 446		92. 01
04.05	OTHER REIMBURSABLE COST CENTERS	=1		-
	09400 HOME PROGRAM DI ALYSI S	0		94.00
	09500 AMBULANCE SERVICES	0		95. 00 100. 00
	10000 &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	ol Ol		100.00
	10100 HOME HEALTH AGENCY 10200 OPIOLD TREATMENT PROGRAM	ol Ol		101.00
102.00	SPECIAL PURPOSE COST CENTERS	U		102.00
113 00	11300 I NTEREST EXPENSE			113. 00
	11400 UTI LI ZATI ON REVI EW-SNF			114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	О		115. 00
	11600 HOSPI CE	o		116. 00
118.00	1 1	438, 627, 041		118. 00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	283, 156		190. 00

		5/29/2024 1:53 pm
Cost Center Description	Total	
	26. 00	
190. 01 19001 PROMPTCARE	5, 154, 371	190. 01
190. 02 19002 RENTAL PROPERTIES	0	190. 02
190. 03 19003 OLCOTT	0	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	190. 04
190. 05 19005 FOUNDATI ON	0	190. 05
190. 06 19006 MARKETI NG	0	190. 06
190.07 19007 HME STORE	67, 896	190. 07
190. 08 19008 UNUSED SPACE	0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	4, 762, 580	190. 11
191. 00 19100 RESEARCH	0	191. 00
191. 01 19101 RESEARCH	0	191. 01
191.02 19102 OTHER SPONSORED ACTIVITIES	8, 803, 304	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	77, 994	192. 00
193.00 19300 NONPALD WORKERS	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	1, 947, 533	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	3, 645, 815	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	194. 02
194. 03 07953 IU HEALTH SIP	168, 090	194. 03
194.04 07954 HOME CARE	0	194. 04
194. 05 07955 HOSPI CE	2, 209	194. 05
200.00 Cross Foot Adjustments	0	200. 00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	463, 539, 989	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

			Τ̈́	o 12/31/2023	Date/Time Pre 5/29/2024 1:5	
		CAPI TAL REI	LATED COSTS		372772024 1.3	У РШ
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capital Related Costs				DEPARTMENT	
	0	1.00	2. 00	2A	4. 00	
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT		Γ	Τ	T		1.00
2. 00 OO200 CAP REL COSTS - MVBLE EQUI P						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT	0	737, 034 1, 057, 779			0	5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	0	1, 012, 437	0	0	8. 00
9. 00 00900 HOUSEKEEPI NG	0	56, 580			0	9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	226, 445 194, 283			0	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	78, 655			0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	134, 152			0	14. 00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	0	101, 919 34, 630			0	15. 00 16. 00
18. 00 01850 SOCIAL SERVICES	0	34, 030	34, 330	93, 900	0	18. 00
18. 01 01851 CENTRAL STERI LI ZATI ON	0		356, 961		0	18. 01
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY I NPATIENT ROUTINE SERVICE COST CENTERS	0	22, 980	39, 375	62, 355	0	23. 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	2, 739, 221	4, 693, 479	7, 432, 700	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0				0	31.00
32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	300 707	(10, 722	0	32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 42. 00 04200 SUBPROVI DER	0	228, 026	390, 707	618, 733 0	0	35. 00 42. 00
43. 00 04300 NURSERY	0	107, 176	183, 638	290, 814	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	ΙΟ	000 527	1 550 41/	2 447 042	0	FO 00
50.00 05000 OPERATI NG ROOM 50.01 05001 CV SURGERY	0	909, 527 0	1, 558, 41 <i>6</i>		0	50. 00 50. 01
51.00 05100 RECOVERY ROOM	0	627, 070	1, 074, 444	1, 701, 514	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	371, 838			0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	242, 481	415, 476	_	0	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	365, 445			0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	65, 637 92, 080			0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	525, 737			0	59.00
60. 00 06000 LABORATORY	0	257, 701	441, 554	699, 255	0	60. 00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0 8, 986	(15, 397	0 24, 383	0	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	426, 003		•	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	77, 056			0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	35, 696			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ö	ď	0	Ö	73.00
73. 01 07302 OP PHARMACY	0	49, 903				73. 01
74. 00 07400 RENAL DI ALYSI S 76. 97 07697 CARDI AC REHABI LI TATI ON	0	52, 584	90, 100	142, 684	0 0	74. 00 76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	Ö		0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	T 0	332, 644	569, 964	902, 608	0	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0	495, 707			0	90.00
90. 02 09002 WOUND CARE CENTER	0	79, 525	136, 261	215, 786	0	90. 02
90. 03 09003 PAIN CLINIC	0	53, 277			0	90. 03
90. 04 09004 0B CLINIC 90. 05 09005 0P PSYCH CLINIC	0	554, 063 215, 346			0	90. 04 90. 05
90. 06 09006 MULTI SPECIALTY CLINIC	0	0	000, 701	0	Ö	90.06
91. 00 09100 EMERGENCY	0	624, 957	1, 070, 823	1, 695, 780	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 09202 OBSERVATION BEDS (DISTINCT PART)	0	240, 972	412, 890	0 653, 862	0	92. 00 92. 01
OTHER REIMBURSABLE COST CENTERS	0	240, 972	412, 690	055, 802	0	72.01
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES 100. 00 10000 I&R SERVI CES-NOT APPRVD PRGM	0	0		0	0	95. 00 100. 00
101.00 10100 HOME HEALTH AGENCY				0		100.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	C	0		102. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		!				114. 00
			•	•	•	

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0051

			То	12/31/2023	Date/Time Prepared: 5/29/2024 1:53 pm
		CAPI TAL REL	ATED COSTS		
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT
	0	1.00	2.00	2A	4. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115.00
116. 00 11600 HOSPI CE	o	0	0	o	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	12, 880, 161	22, 069, 322	34, 949, 483	0 118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29, 746		80, 714	0 190. 00
190. 01 19001 PROMPTCARE	0	106, 874	183, 121	289, 995	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0 190. 02
190. 03 19003 OLCOTT	0	0	0	0	0 190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	0	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0 190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	0	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0	0	0	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191.00
191. 01 19101 RESEARCH	0	0	0	0	0 191. 01
191.02 19102 OTHER SPONSORED ACTIVITIES	0	0	0	0	0 191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	2, 877	0	2, 877	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	76, 239		206, 870	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	135, 643	232, 416	368, 059	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194. 03 07953 IU HEALTH SIP	0	0	0	0	0 194. 03
194. 04 07954 HOME CARE	0	0	0	0	0 194. 04
194. 05 07955 HOSPI CE	0	0	0	0	0 194. 05
200.00 Cross Foot Adjustments		_	_	0	200.00
201.00 Negative Cost Centers		0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	0	13, 231, 540	22, 666, 458	35, 897, 998	0 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/29/2024 1:53 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 1, 999, 894 5 00 5 00 7.00 00700 OPERATION OF PLANT 109, 734 2, 979, 950 7.00 1, 025 00800 LAUNDRY & LINEN SERVICE 1,025 8.00 8.00 9.00 00900 HOUSEKEEPI NG 27, 778 14.743 196, 047 9.00 C 01000 DI ETARY 692, 046 10.00 18.098 59,002 6 496 10.00 01100 CAFETERI A 13, 464 50, 622 406 11.00 11.00 0 13 00 01300 NURSING ADMINISTRATION 71,062 20, 494 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 82, 713 34, 954 0 5.408 14 00 0 14.00 15.00 01500 PHARMACY 49, 920 26, 556 0 2, 028 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 505 9,023 0 901 0 16.00 01850 SOCIAL SERVICES 18.00 0 18.00 0 0 01851 CENTRAL STERILIZATION 13.288 7 18.01 54, 283 0 0 18 01 23.00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY 3, 117 5, 988 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 266, 837 628, 077 30.00 713, 731 349 97.290 03100 INTENSIVE CARE UNIT 31.00 39, 317 64, 805 40 8.562 63.969 31 00 03200 CORONARY CARE UNIT 0 32.00 0 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 24, 383 59, 414 8 0 35.00 0 04200 SUBPROVI DER 42.00 0 0 0 42.00 43.00 04300 NURSERY 7.488 27, 926 13 3,064 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 115, 705 236, 986 18, 025 165 05001 CV SURGERY 50.01 C Λ 50.01 51.00 05100 RECOVERY ROOM 46, 353 163, 389 59 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 31,032 96, 886 50 7, 593 0 52.00 05300 ANESTHESI OLOGY 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 34.553 63, 181 94 5, 408 0 54.00 55.00 95, 220 05500 RADI OLOGY-THERAPEUTI C 27, 402 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 57 00 05700 CT SCAN 15 600 17 102 O 0 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 8, 983 23, 992 0 0 58.00 05900 CARDIAC CATHETERIZATION 22, 149 136, 986 0 0 0 59.00 59.00 60.00 06000 LABORATORY 104.068 0 901 0 60.00 67, 146 06400 INTRAVENOUS THERAPY 0 64.00 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 24,570 2, 341 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 53, 362 110, 999 0 2, 028 0 66.00 69 00 06900 ELECTROCARDI OLOGY 20.078 5 408 69 00 11, 135 14 0 70.00 07000 ELECTROENCEPHALOGRAPHY 3, 759 9, 301 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 58, 094 0 71.00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 91, 593 0 0 72.00 C 07300 DRUGS CHARGED TO PATIENTS 0 216, 497 73 00 73 00 0 07302 OP PHARMACY 73.01 31, 149 13,003 0 0 0 73.01 74.00 07400 RENAL DIALYSIS 9, 841 13, 701 3 0 0 74.00 07697 CARDIAC REHABILITATION 0 0 76. 97 3.593 0 76. 97 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 C 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 12, 406 0 0 0 90.00 86.674 09001 OP ONCOLOGY INFUSION CENTER 90 01 41 826 129, 161 21 0 0 90 01 09002 WOUND CARE CENTER 5, 919 20, 721 90.02 90.02 C 1, 352 0 90.03 09003 PAIN CLINIC 6, 366 13, 882 0 O 90.03 0 09004 OB CLINIC 25.479 90.04 90.04 144.367 0 0 0 90.05 09005 OP PSYCH CLINIC 9.708 56, 110 0 0 0 90.05 09006 MULTI SPECIALTY CLINIC 90.06 90.06 16, 243 0 0 91.00 09100 EMERGENCY 162, 839 160 35, 149 91.00 108, 695 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 92.01 34, 759 62, 788 36 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 94.00 0 0 0 09500 AMBULANCE SERVICES 0 95.00 0 C 0 0 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 o C 0 0 101.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102, 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115, 00

1, 899, 568

2, 888, 394

0

194, 019

1, 025

0 116.00

692, 046 118. 00

116. 00 11600 HOSPI CE

SUBTOTALS (SUM OF LINES 1 through 117)

118.00

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES

194.00 07950 IU HEALTH PAOLI HOSPITAL

194. 01 07951 IU HEALTH BEDFORD HOSPITAL

194. 02 07952 IU HEALTH MORGAN HOSPITAL

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

193. 00 19300 NONPALD WORKERS

194. 03 07953 IU HEALTH SIP

194. 04 07954 HOME CARE

194. 05 07955 HOSPI CE

200.00

201.00

202.00

0 192. 00

0 193. 00

0 194.00

0 194. 01

0 194. 02

0 194. 03

0 194. 04

0 194. 05

0 201. 00

692, 046 202. 00

200.00

0

0

0

0

0

1, 025

0

196, 047

IU HEALTH BLOOMINGTON HOSPITAL ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 936 7, 751 0 0 0 0 190. 01 19001 PROMPTCARE 0 20, 226 27, 847 0 190. 01 190. 02 19002 RENTAL PROPERTIES 0 190. 02 0 0 0 0 190. 03 19003 OLCOTT 0 0 190. 03 Ω 0 190. 04 19004 PHYSI CI AN RECRUITMENT o 0 190. 04 0 190. 05 19005 FOUNDATI ON 0 0 0 0 190. 05 190. 06 19006 MARKETI NG 190. 07 19007 HME STORE 0 0 o 0 190.06 0 0 0 0 190, 07 0 2, 028 190.08 19008 UNUSED SPACE 0 190. 08 0 190. 09 19009 CLINI CAL TRI ALS 0 0 0 0 190. 09 0 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 0 0 190. 11 19011 COMMUNITY HEALTH SERVICES 0 190. 11 18, 259 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 0 0 0 0 191. 00 191. 01 19101 RESEARCH 0 0 0 191. 01 0 191. 02 19102 OTHER SPONSORED ACTIVITIES 0 191. 02 37.982 C

275

725

0

10

7,607

14, 306

1, 999, 894

750

0

C

C

19.865

35, 343

2, 979, 950

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | T

				10	5 12/31/2023	Date/lime Pre 5/29/2024 1:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON			RECORDS &	
		11.00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	591, 667	240.045				11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	44, 884 248	1				13. 00 14. 00
15. 00	01500 PHARMACY	21, 437	Ö	2, 442	378, 933		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0		16. 00
18. 00	01850 SOCIAL SERVICES	0	0	0	0	0	18. 00
18. 01	01851 CENTRAL STERILIZATION	6, 921	0	765	0	0	18. 01
23. 00	O2301 PARAMED ED PRGM-PHARMACY RESIDENCY INPATIENT ROUTINE SERVICE COST CENTERS	1, 656	0	0	U	0	23. 00
30. 00	03000 ADULTS & PEDI ATRI CS	115, 424	112, 859	12, 204	2, 542	8, 717	30.00
31.00	03100 INTENSIVE CARE UNIT	20, 564	l ·		1, 071	1, 092	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	_	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	11, 023	1		112	610	1
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	3, 688	0 3, 956	· ·	0 33	0 216	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	3,000	3, 730	[250		210	43.00
50.00	05000 OPERATI NG ROOM	30, 576	27, 451	95, 139	1, 646	14, 515	50.00
50. 01	05001 CV SURGERY	0	0	I -	0	0	50. 01
51.00	05100 RECOVERY ROOM	25, 543	1		1, 036		1
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	13, 726	13, 729 0		365 0		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 157	2, 768	· -	121	2, 150	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	11, 466	1		136		55. 00
56.00	05600 RADI OI SOTOPE	0	0		0		56. 00
57. 00	05700 CT SCAN	2, 995	200		328		
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	3, 002 9, 723	0 8, 548	50 21, 005	160 722		58. 00 59. 00
60.00	06000 LABORATORY	18, 271	0, 340	21,005	722	· ·	
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö	1	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	15, 337	0	6, 755	0	943	65. 00
66.00	06600 PHYSI CAL THERAPY	31, 857	0		0		
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	6, 738 2, 654	981 0	369 594	90 0	1, 891 333	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,034	0	126, 649	0	4, 710	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	Ö	199, 674	0	9, 037	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	364, 109	16, 302	73. 00
73. 01	07302 OP PHARMACY	2, 148	0		14	261	
	O7400 RENAL DI ALYSI S O7697 CARDI AC REHABI LI TATI ON	3, 014	0 1, 077	128	93 0	300 189	74.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	3,014	1,077	16 0	0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	Ö	Ö	0	0	Ö	
	OUTPATIENT SERVICE COST CENTERS						
	1 1	5, 303			26		90.00
90. 01 90. 02	09001 OP ONCOLOGY INFUSION CENTER 09002 WOUND CARE CENTER	23, 442 3, 339			2, 190 0		1
90. 02	09003 PAIN CLINIC	3, 339	1, 987		3	363 233	1
90. 04	09004 OB CLINIC	15, 654	1		0	140	1
90. 05	09005 OP PSYCH CLINIC	6, 565			0	262	90. 05
90. 06	09006 MULTI SPECIALTY CLINIC	14, 408	1		0	221	90.06
91.00	09100 EMERGENCY	35, 382	37, 173	6, 876	4, 130	11, 989	
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09202 OBSERVATION BEDS (DISTINCT PART)	10, 473	12, 105	0	0	1, 217	92. 00 92. 01
72.01	OTHER REIMBURSABLE COST CENTERS	10, 473	12, 103	<u> </u>	<u> </u>	1,217	72.01
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES	0	0	·	0		
	10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	0	0	0	0		101. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS		ı	ı	0	U	1.02.00
	11300 INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	537, 519	340, 243	486, 867	0 378, 927		116. 00 118. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 007,017	1 010,240	100,007	3,3,721	101,070	1. 10. 00

Provider CCN: 15-0051

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023

Cost Center Description
NONRE MBURSABLE COST CENTERS 11.00 13.00 14.00 15.00 16.00
11.00 13.00 14.00 15.00 16.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 190. 00 190. 01 19001 PROMPTCARE 10,858 3,202 215 0 0 190. 01 190. 02 19002 RENTAL PROPERTI ES 0 0 0 0 0 0 190. 02 190. 03 19003 OLOTT 0 0 0 0 0 0 0 190. 03 19003 OLOTT 0 0 0 0 0 0 0 0 190. 03 190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 0 0 0 0 190. 04 190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 0 0 0 0 190. 05 190. 05 19005 FOUNDATI ON 0 0 0 0 0 0 190. 05 190. 06 19006 MARKETI NG 0 0 0 0 0 0 190. 06 190. 06 19006 MARKETI NG 0 0 0 0 0 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 0 190. 09 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 0 190. 09 190. 10 190. 10 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 0 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 0 191. 01 191. 01 19101 RESEARCH 0 0 0 0 0 191. 01 191. 01 19101 RESEARCH 0 0 0 0 0 191. 01 191. 01 19101 RESEARCH 0 0 0 0 0 191. 01 191.
190. 00
190. 01 19001 19001 19001 19001 19001 19000 19
190. 02 19002 RENTAL PROPERTIES 0 0 0 0 0 190. 02 190. 03 19003 OLCOTT 0 0 0 0 0 190. 03 19003 OLCOTT 0 0 0 0 0 0 190. 03 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 0 0 0 0 190. 04 190. 05 19005 FOUNDATION 0 0 0 0 0 0 190. 05 190. 06 19006 MARKETI NG 0 0 0 0 0 0 190. 05 190. 07 19007 HME STORE 0 0 0 0 0 0 0 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 0 0 190. 08 190. 10
190. 03 19003 OLCOTT 0 0 0 0 190. 03 19004 PHYSI CI AN RECRUI TMENT 0 0 0 0 0 190. 04 190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 0 0 0 190. 04 190. 05 19005 FOUNDATI ON 0 0 0 0 0 0 190. 05 190. 06 190. 06 19006 MARKETI NG 0 0 0 0 0 0 190. 06 190. 07 190.07 HME STORE 0 0 0 0 0 0 0 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 0 0 190. 08 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 0 0 0 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 191. 01 191. 01 19101 RESEARCH
190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 0 0 0 190. 04 190. 05 19005 FOUNDATI ON 0 0 0 0 0 190. 05 190. 06 190. 06 19006 MARKETI NG 0 0 0 0 0 0 190. 06 190. 07 190.07 HME STORE 0 0 0 0 0 0 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 0 0 190. 08 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 0 0 190. 08 190. 10 190. 10 190. 10 190. 10 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 0 0 0 190. 10 190. 11 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 191. 00 191. 01 191. 01 19101 RESEARCH
190. 05 19005 FOUNDATION 0 0 0 0 190. 05 19006 MARKETING 0 0 0 0 0 190. 06 190. 06 190. 07 19007 HME STORE 0 0 0 0 0 0 190. 07 190. 08 190.08 UNUSED SPACE 0 0 0 0 0 0 190. 08 190.09 19009 CLINICAL TRIALS 0 0 0 0 0 0 190. 08 190. 09 190.09 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 0 0 190. 07 190. 11 19010 MORGAN OP BEHAVIORAL HEALTH SERVICES 36, 103 6, 420 64 0 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 01 191. 01 19101 RESEARCH
190. 06 19006 MARKETI NG 0 0 0 0 190. 06 190. 07 19007 HME STORE 0 0 0 0 0 0 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 0 190. 09 190. 09 19001 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 0 0 190. 09 190. 11 19011 COMMUNI TY HEALTH SERVI CES 36, 103 6, 420 64 0 0 191. 01 191. 01 191. 01 19101 RESEARCH 0 0 0 0 0 191. 01
190. 07 19007 HME STORE 0 0 0 0 0 190. 07 19007 HME STORE 0 0 0 0 0 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 0 0 0 190. 11 19011 COMMUNI TY HEALTH SERVI CES 36, 103 6, 420 64 0 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 191. 01 191. 01 19101 RESEARCH 0 0 0 0 0 0 191. 01
190. 08 19008 UNUSED SPACE 0 0 0 0 190. 08 19009 CLI NI CAL TRI ALS 0 0 0 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 0 0 190. 11 19011 COMMUNI TY HEALTH SERVI CES 36, 103 6, 420 64 0 0 191. 00 191. 01 191. 01 19101 RESEARCH 0 0 0 0 0 0 191. 01 191. 01 19101 RESEARCH 0 0 0 0 0 191. 01
190. 09 19009 CLINICAL TRIALS 0 0 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 0 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 36, 103 6, 420 64 0 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 191. 01 19101 RESEARCH 0 0 0 0 0 191. 01
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC 0 0 0 0 190. 10 190. 11 19011 COMMUNI TY HEALTH SERVI CES 36, 103 6, 420 64 0 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 191. 01 19101 RESEARCH 0 0 0 0 0 191. 01
190. 11 19011 COMMUNI TY HEALTH SERVI CES 36, 103 6, 420 64 0 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 191. 00 191. 00 191. 01 19101 RESEARCH 0 0 0 0 0 191. 01
191. 00 19100 RESEARCH
191. 01 19101 RESEARCH 0 0 0 0 191. 01
101 00140400 071150 0001000050 40711117150
191. 02 19102 OTHER SPONSORED ACTIVITIES 0 0 0 0 0 191. 02
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 6 0 189 6 0 192. 00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL 2,459 0 0 0 0 194.00
194.01 07951 IU HEALTH BEDFORD HOSPITAL 4,700 0 0 0 0 194.01
194. 02 07952 I U HEALTH MORGAN HOSPITAL 0 0 0 0 0 194. 02
194. 03 07953 I U HEALTH SIP 22 0 0 0 0 194. 03
194. 04 07954 HOME CARE 0 0 0 0 0 194. 04
194. 05 07955 HOSPI CE 0 0 0 0 0 194. 05
200.00 Cross Foot Adjustments 200.00
201.00 Negative Cost Centers 0 0 0 0 201.00
202.00 TOTAL (sum lines 118 through 201) 591,667 349,865 487,335 378,933 104,395 202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				'	o 12/31/2023	Date/lime Pre 5/29/2024 1:5	
		OTHER GENE	RAL SERVICE			0,2,,,2021 1.0	o piii
	Cost Center Description	SOCI AL SERVI CES	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		18. 00	18. 01	23. 00	24.00	25. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 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 01000 DIETARY 01100 CAFETERIA						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00 14. 00 15. 00 16. 00 18. 00 18. 01 23. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	C	640, 556	i e			13. 00 14. 00 15. 00 16. 00 18. 00 18. 01 23. 00
30. 00 31. 00 32. 00 35. 00 42. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04200 SUBPROVIDER 04300 NURSERY	C C C C C C C C C C C C C C C C C C C	0 0		9, 390, 730 899, 253 0 727, 797 0 337, 448	0 0 0 0	30. 00 31. 00 32. 00 35. 00 42. 00 43. 00
71. 00 72. 00 73. 00 73. 01 74. 00 76. 97 77. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07302 OP PHARMACY 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS				3, 648, 707 0 1, 972, 461 1, 176, 405 0 782, 907 1, 134, 479 286, 694 1, 630, 436 896, 436 0 74, 329 1, 355, 724 255, 791 113, 499 189, 453 300, 304 596, 908 182, 007 166, 750 7, 889 0	0 0 0 0 0 0 0 0 0 0	50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 64. 00 65. 00 66. 00 69. 00 71. 00 72. 00 73. 01 74. 00 76. 97 77. 00 78. 00
92.00	09002 WOUND CARE CENTER 09003 PAIN CLINIC 09004 OB CLINIC 09005 OP PSYCH CLINIC 09006 MULTI SPECIALTY CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09202 OBSERVATION BEDS (DISTINCT PART)	C C C C C C C C C C C C C C C C C C C	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 010, 042 1, 570, 528 250, 717 171, 475 1, 700, 643 659, 285 38, 513 2, 098, 173	0 0 0 0 0 0	90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00 92. 01
95. 00 100. 00 101. 00 102. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	C C C C C	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0	0 0	94. 00 95. 00 100. 00 101. 00 102. 00 113. 00

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

				o 12/31/2023	Date/Time Prepared: 5/29/2024 1:53 pm
	OTHER GENER	RAL SERVICE			
Cost Center Description	SOCI AL SERVI CES	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	18. 00	18. 01	23. 00	24.00	25. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		10.0.			114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0 115.00
116. 00 11600 HOSPI CE	0	0		0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	640, 556	l c	34, 618, 213	0 118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		89, 401	0 190. 00
190. 01 19001 PROMPTCARE	0	0		352, 343	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0		0	0 190. 02
190. 03 19003 OLCOTT	0	0		0	0 190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0		0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0		0	0 190. 05
190. 06 19006 MARKETI NG	0	0		0	0 190. 06
190. 07 19007 HME STORE	0	0		2, 028	0 190. 07
190. 08 19008 UNUSED SPACE	0	0		0	0 190. 08
190. 09 19009 CLINI CAL TRI ALS	0	0		0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0		0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0		60, 846	0 190. 11
191. 00 19100 RESEARCH	0	0		0	0 191. 00
191. 01 19101 RESEARCH	0	0		0	0 191. 01
191.02 19102 OTHER SPONSORED ACTIVITIES	0	0		37, 982	0 191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		4, 103	
193.00 19300 NONPALD WORKERS	0	0		0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0		236, 801	0 194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0		422, 408	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0		0	0 194. 02
194. 03 07953 IU HEALTH SIP	0	0		747	0 194. 03
194.04 07954 HOME CARE	0	0		0	0 194. 04
194. 05 07955 HOSPI CE	0	0		10	0 194. 05
200.00 Cross Foot Adjustments			73, 116	73, 116	
201.00 Negative Cost Centers	0	0	C	1	0 201.00
202.00 TOTAL (sum lines 118 through 201)	0	640, 556	73, 116	35, 897, 998	0 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 1:53 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

			5/29/2024 1:	
	Cost Center Description	Total	372772024 1.	JS pill
	CENEDAL CEDALCE COST CENTEDS	26. 00		
1 00	GENERAL SERVI CE 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			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL			5. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE			8.00
9. 00	00900 HOUSEKEEPING			9. 00
10. 00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
18. 00	01850 SOCIAL SERVICES			18. 00
	01851 CENTRAL STERILIZATION			18. 00
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY			23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			- 23.00
30. 00	03000 ADULTS & PEDIATRICS	9, 390, 730		30.00
31. 00	03100 NTENSI VE CARE UNI T	899, 253		31. 00
32. 00	l l	099, 203		
	03200 CORONARY CARE UNIT	-1		32.00
35. 00 42. 00	02060 NEONATAL INTENSIVE CARE UNIT	727, 797		35. 00 42. 00
	04200 SUBPROVI DER	-1		
43. 00	04300 NURSERY	337, 448		43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	2 (40 707		
50.00	05000 OPERATI NG ROOM 05001 CV SURGERY	3, 648, 707 0		50.00
50. 01	1 1	1		50. 01
51.00	05100 RECOVERY ROOM	1, 972, 461		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 176, 405		52. 00
53.00	05300 ANESTHESI OLOGY	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	782, 907		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 134, 479		55. 00
56. 00	05600 RADI OI SOTOPE	0		56. 00
57. 00	05700 CT SCAN	217, 190		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	286, 694		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 630, 436		59. 00
60.00	06000 LABORATORY	896, 436		60.00
64. 00	06400 I NTRAVENOUS THERAPY	0		64. 00
65.00	06500 RESPI RATORY THERAPY	74, 329		65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 355, 724		66. 00
69. 00	06900 ELECTROCARDI OLOGY	255, 791		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	113, 499		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	189, 453		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	300, 304		72. 00
	07300 DRUGS CHARGED TO PATIENTS	596, 908		73. 00
	07302 OP PHARMACY	182, 007		73. 01
	07400 RENAL DIALYSIS	166, 750		74. 00
	07697 CARDI AC REHABI LI TATI ON	7, 889		76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1, 010, 042		90.00
	09001 OP ONCOLOGY INFUSION CENTER	1, 570, 528		90. 01
	09002 WOUND CARE CENTER	250, 717		90. 02
90. 03	09003 PAIN CLINIC	171, 475		90. 03
90. 04	09004 OB CLINIC	1, 700, 643		90. 04
90. 05	09005 OP PSYCH CLINIC	659, 285		90. 05
90.06	09006 MULTI SPECIALTY CLINIC	38, 513		90.06
	09100 EMERGENCY	2, 098, 173		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	775, 240		92. 01
	OTHER REIMBURSABLE COST CENTERS			
	09400 HOME PROGRAM DIALYSIS	0		94. 00
	09500 AMBULANCE SERVI CES	0		95. 00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	o		100.00
101.00	10100 HOME HEALTH AGENCY	o		101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	O		102. 00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113. 00
114.00	11400 UTILIZATION REVIEW-SNF			114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	o		115. 00
	11600 HOSPI CE	o		116.00
118.00	1 1	34, 618, 213		118.00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	89, 401		190. 00
	<u> </u>			

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 1:53 pm

		5/29/2024 1:53 pm
Cost Center Description	Total	
	26.00	
190. 01 19001 PROMPTCARE	352, 343	190. 01
190. 02 19002 RENTAL PROPERTI ES	0	190. 02
190. 03 19003 OLCOTT	0	190. 03
190. 04 19004 PHYSI CLAN RECRUI TMENT	0	190. 04
190. 05 19005 FOUNDATI ON	0	190. 05
190. 06 19006 MARKETI NG	0	190. 06
190.07 19007 HME STORE	2, 028	190. 07
190. 08 19008 UNUSED SPACE	0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	60, 846	190. 11
191. 00 19100 RESEARCH	0	191. 00
191. 01 19101 RESEARCH	0	191. 01
191. 02 19102 OTHER SPONSORED ACTIVITIES	37, 982	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	4, 103	192. 00
193.00 19300 NONPALD WORKERS	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	236, 801	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	422, 408	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	194. 02
194. 03 07953 IU HEALTH SIP	747	194. 03
194.04 07954 HOME CARE	0	194. 04
194. 05 07955 HOSPI CE	10	194. 05
200.00 Cross Foot Adjustments	73, 116	200. 00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	35, 897, 998	202. 00

	•	U HEALTH BLOOMI				Wassissian D. 1	
COST A	ILLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2023	Worksheet B-1	
					To 12/31/2023	Date/Time Pre	
		0481741 85				5/29/2024 1:5	3 pm
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Poconci Li ati on	ADMI NI STRATI VE	
	cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE FEET)	(SQUARE TEET)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(7.000	
				SALARI ES)			
		1. 00	2.00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	745, 061	1				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		744, 899				2.00
4.00	OO400	41 502	1	.,		272 424 245	4. 00 5. 00
5. 00 7. 00	00700 OPERATION OF PLANT	41, 502 59, 563				372, 434, 245 20, 434, 560	•
8. 00	00800 LAUNDRY & LINEN SERVICE	37, 303	37, 303				8.00
9. 00	00900 HOUSEKEEPI NG	3, 186	3, 186		-	5, 172, 819	•
10.00	01000 DI ETARY	12, 751	1				•
11.00	01100 CAFETERI A	10, 940	10, 940	1, 271, 76	3 0	2, 507, 339	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 429	4, 429	9, 615, 13!	5 0	13, 233, 080	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	7, 554	1				
15.00	01500 PHARMACY	5, 739				9, 296, 033	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 950	1	1	0	93, 966	1
18. 00 18. 01	01850 SOCIAL SERVICES 01851 CENTRAL STERILIZATION	11, 731	0 11, 731		0 3 0		18. 00 18. 01
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	1, 294					ı
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,2/1	1,2/7	302,012		300, 334	25.00
30. 00	03000 ADULTS & PEDI ATRI CS	154, 244	154, 244	21, 047, 920	5 0	49, 704, 563	30.00
31.00	03100 INTENSIVE CARE UNIT	14, 005	1				
32.00	03200 CORONARY CARE UNIT	0	0		0		32. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	12, 840	12, 840	2, 321, 580	0	4, 540, 612	35. 00
42.00	04200 SUBPROVI DER	0	0	(0		42. 00
43. 00	04300 NURSERY	6, 035	6, 035	722, 788	3 0	1, 394, 503	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	F1 01F	F1 01F	(072 52		21 54/ 505	
50. 00 50. 01	05000 OPERATING ROOM 05001 CV SURGERY	51, 215	1				
51. 00	05100 RECOVERY ROOM	35, 310	-		-	•	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	20, 938					1
53. 00	05300 ANESTHESI OLOGY	20, 730	0			0,770,733	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	13, 654	13, 654	3, 227, 126	6 0	6, 434, 371	•
55.00	05500 RADI OLOGY-THERAPEUTI C	20, 578					
56.00	05600 RADI 0I SOTOPE	0	0		0	0	56. 00
57. 00	05700 CT SCAN	3, 696	1				
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	5, 185	1			1, 672, 877	
59. 00	05900 CARDI AC CATHETERI ZATI ON	29, 604	1				
60.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	14, 511	14, 511			19, 379, 455	1
64. 00 65. 00	06500 RESPIRATORY THERAPY	506	1		5	0 4, 575, 458	
66. 00	06600 PHYSI CAL THERAPY	23, 988	1				
	06900 ELECTROCARDI OLOGY	4, 339	1				
	07000 ELECTROENCEPHALOGRAPHY	2,010					
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	10, 818, 204	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	17, 056, 457	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	40, 316, 022	
73. 01	07302 OP PHARMACY	2, 810			5 0	5, 800, 598	
	07400 RENAL DIALYSIS	2, 961	2, 961		0	1, 832, 641	ı
76. 97	07697 CARDI AC REHABI LI TATI ON	0		508, 33		669, 145	
	07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	1		0 0	-	
76.00	OUTPATIENT SERVICE COST CENTERS		,ı <u>0</u>		5 0	0	76.00
90.00	09000 CLI NI C	18, 731	18, 731	1, 098, 38!	5 0	2, 310, 300	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	27, 913	•				
90. 02	09002 WOUND CARE CENTER	4, 478	1				•
90. 03	09003 PAIN CLINIC	3, 000	3, 000	591, 618	3 0	1, 185, 477	90. 03
90. 04	09004 OB CLINIC	31, 199	31, 199	2, 492, 87	7 0	4, 744, 719	90. 04
90. 05	09005 OP PSYCH CLINIC	12, 126	12, 126			1, 807, 873	•
	09006 MULTI SPECIALTY CLINIC	0	0	2, 181, 23		3, 024, 853	•
91.00	09100 EMERGENCY	35, 191	35, 191	6, 265, 142	2 0	20, 241, 075	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12 5/0	12 5/0	1 001 001	-	4 470 700	92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	13, 569	13, 569	1, 081, 88!	5 0	6, 472, 789	92. 01
94 00	09400 HOME PROGRAM DIALYSIS	<u> </u>		(0	0	94.00
	09500 AMBULANCE SERVICES	0	ا ا	1		0	1
	10000 I &R SERVI CES-NOT APPRVD PRGM	0	ol o		ol o		100.00
	10100 HOME HEALTH AGENCY	0	O		0	0	101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0	0	102. 00
	SPECIAL PURPOSE COST CENTERS		1				
113.00	11300 I NTEREST EXPENSE	1				<u> </u>	113. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE BENEFITS** (SQUARE FEET) (SQUARE FEET) & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115 00 0 0 116. 00 11600 HOSPI CE 0 0 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 725, 275 725, 275 113, 919, 930 -91, 105, 744 353, 751, 487 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 174, 354 190. 00 1,675 1,675 190. 01 19001 PROMPTCARE 6,018 6,018 2, 239, 402 0 3, 766, 412 190. 01 0 190. 02 190. 02 19002 RENTAL PROPERTIES 0 0 0 190. 03 19003 OLCOTT 0 0 190. 03 0 Ω 190. 04 19004 PHYSICIAN RECRUITMENT 0 0 0 190.04 190. 05 19005 FOUNDATI ON 0 0 0 190. 05 0 0 0 0 0 0 0 0 0 190. 06 19006 MARKETI NG 0 0 190. 06 00000 190. 07 19007 HME STORE 0 0 190. 07 Ω 190. 08 19008 UNUSED SPACE 0 0 190. 08 190. 09 19009 CLINI CAL TRI ALS 0 190.09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 190. 10 0 190. 11 19011 COMMUNITY HEALTH SERVICES 1, 623, 185 3, 400, 212 190. 11 0 191. 00 19100 RESEARCH 0 191.00 191. 01 19101 RESEARCH 0 0 191. 01 191. 02 19102 OTHER SPONSORED ACTIVITIES 7, 073, 074 191. 02 0 0 4, 361, 133 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 162 r 694 51, 224 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 0 194.00 07950 IU HEALTH PAOLI HOSPITAL 4, 293 4, 293 724, 397 1, 416, 629 194. 00 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 7,638 7,638 1, 374, 313 2, 664, 133 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPITAL 0 194. 02 194. 03 07953 IU HEALTH SIP 134, 945 194. 03 0 3, 753 0 194.04 07954 HOME CARE C 0 0 194. 04 194. 05 07955 HOSPI CE 0 0 1, 775 194. 05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 91, 105, 744 202. 00 202.00 13, 231, 540 22, 666, 458 23, 185, 575 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 17. 759002 30. 428901 0.186609 0. 244622 203. 00 204.00 Cost to be allocated (per Wkst. B, 1, 999, 894 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 0.000000 205.00 0.005370 205.00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207. 00 NAHE unit cost multiplier (Wkst. D, 207.00

Parts III and IV)

			U HEALTH BLOOMI		CN. 1E 00E1 F		u of Form CMS-	
CUST A	LLUCA	TION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2023	Worksheet B-1	
						o 12/31/2023	Date/Time Pre	pared:
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/29/2024 1: 5 CAFETERI A	3 piii
			PLANT	LINEN SERVICE	(HOURS OF	(PATIENT DAYS)	(MANHOURS)	
			(SQUARE FEET)	(POUNDS OF	SERVI CE)			
			7. 00	LAUNDRY) 8. 00	9.00	10.00	11. 00	
	GENER	AL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	1	OPERATION OF PLANT	643, 996					7. 00
8. 00		LAUNDRY & LINEN SERVICE	0	1, 578, 205				8. 00
9.00		HOUSEKEEPI NG	3, 186	ł	8, 701	1		9. 00
10. 00 11. 00		DI ETARY CAFETERI A	12, 751 10, 940	9, 494	22	1	3, 112, 744	10.00
13. 00		NURSING ADMINISTRATION	4, 429	421] 18 0	1	236, 131	1
14. 00		CENTRAL SERVICES & SUPPLY	7, 554	0	240		1, 303	1
15. 00	1	PHARMACY	5, 739	l e	90	1	112, 782	1
16.00		MEDICAL RECORDS & LIBRARY	1, 950	0	40	1	0	
18. 00 18. 01		SOCIAL SERVICES CENTRAL STERILIZATION	11, 731	10, 390		1	36, 409	
		PARAMED ED PRGM-PHARMACY RESIDENCY	1, 294	0	Č		8, 713	
		IENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDI ATRI CS	154, 244	536, 534	4, 318		607, 252	1
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	14, 005	61, 197	380		108, 186 0	1
35. 00	1	NEONATAL INTENSIVE CARE UNIT	12, 840	11, 594		I I	57, 991	
42.00	1	SUBPROVI DER	0	0	C	1	0	1
43.00		NURSERY	6, 035	19, 847	136	0	19, 402	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	E1 21E	254 024	800	ol	140 040	E0 00
50. 00		CV SURGERY	51, 215	254, 026 0	1 800	l .	160, 860 0	1
51. 00		RECOVERY ROOM	35, 310	91, 423	Č	1	134, 382	
52. 00		DELIVERY ROOM & LABOR ROOM	20, 938	76, 399	337	1	72, 210	1
53.00	1	ANESTHESI OLOGY	12 (54	145 124	246	1	0	
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	13, 654 20, 578	145, 124	240		85, 000 60, 323	1
56. 00	1	RADI OI SOTOPE	0	Ö	Ċ	1	00, 020	1
57.00		CT SCAN	3, 696	0	c	- 1	15, 755	1
58. 00		MAGNETIC RESONANCE I MAGING (MRI)	5, 185	0	C		15, 792	1
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	29, 604 14, 511	0	C 40		51, 153 96, 121	1
64. 00	1	I NTRAVENOUS THERAPY	0	Ö	0	1	0, 121	1
65. 00	06500	RESPI RATORY THERAPY	506	0	C	- 1	80, 686	1
66. 00		PHYSI CAL THERAPY	23, 988		90	1	167, 601	
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	4, 339 2, 010	1	240	1	35, 446 13, 965	69. 00 70. 00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	2,010	l				71.00
		IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	1
		DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
	1	OP PHARMACY RENAL DIALYSIS	2, 810 2, 961	l .			11, 302 0	1
	1	CARDIAC REHABILITATION	2, 961	109			15, 859	1
		ALLOGENEIC STEM CELL ACQUISITION	0	0	Č	o o	0	1
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
00.00		TIENT SERVICE COST CENTERS	10 721	141		ol ol	27 907	90.00
90. 00 90. 01		OP ONCOLOGY INFUSION CENTER	18, 731 27, 913			- 1	27, 897 123, 326	1
90. 02		WOUND CARE CENTER	4, 478		60	1	17, 565	
		PAIN CLINIC	3, 000		C		20, 524	1
90. 04		OB CLINIC OP PSYCH CLINIC	31, 199	ł	C		82, 356	1
90. 05 90. 06	1	MULTI SPECIALTY CLINIC	12, 126	69) (34, 536 75, 800	1
		EMERGENCY	35, 191	245, 993	1, 560		186, 143	1
		OBSERVATION BEDS (NON-DISTINCT PART)			·			92. 00
92. 01		OBSERVATION BEDS (DISTINCT PART)	13, 569	55, 759	C) 0	55, 099	92. 01
94 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS		<u> </u>		ol ol	0	94. 00
		AMBULANCE SERVICES	0	Ö	Ċ		0	1
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	C			100. 00
		HOME HEALTH AGENCY	0	0	C			101.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	<u> </u>) 0	0	102. 00
113.00		INTEREST EXPENSE						113. 00
114.00	11400	UTILIZATION REVIEW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0	0	C			115.00
116.00	111600	HOSPI CE	0	1 0	[C) 0	0	116. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		eri od:	Worksheet B-1	
			F T	rom 01/01/2023 to 12/31/2023	Date/Time Pre	pared:
					5/29/2024 1:5	3 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(PATIENT DAYS)	(MANHOURS)	
	(SQUARE TEET)	LAUNDRY)	JERVI CE)			
	7. 00	8. 00	9. 00	10.00	11. 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	624, 210	1, 578, 205	8, 611	51, 355	2, 827, 870	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 675			1		190. 00
190. 01 19001 PROMPTCARE	6, 018		0	0	57, 122	
190. 02 19002 RENTAL PROPERTI ES 190. 03 19003 0LCOTT	0	0	0	0		190. 02 190. 03
190. 04 19004 PHYSI CI AN RECRUITMENT	0	0	0			190. 03
190. 05 19005 FOUNDATION	0	0	Ö	o o		190. 05
190. 06 19006 MARKETI NG	0	0	O	o	0	190. 06
190.07 19007 HME STORE	0	0	90	0	0	190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0		190. 08
190. 09 19009 CLINI CAL TRI ALS	0	0	0	0		190. 09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES 191. 00 19100 RESEARCH	0	0	0	0	189, 938	190. 11
191. 00 19100 RESEARCH	0	0	0	0		191. 00
191. 02 19102 OTHER SPONSORED ACTIVITIES	0	0	0			191. 02
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	162	Ö	Ö	o		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	o	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	4, 293		0	0	12, 937	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	7, 638	0	0	0	24, 726	
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0		194. 02
194. 03 07953 I U HEALTH SI P	0	0	0	0		194. 03
194. 04 07954 HOME CARE 194. 05 07955 HOSPI CE	0	0	0			194. 04 194. 05
200.00 Cross Foot Adjustments	0	U	0	, o	U	200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	25, 433, 303	237, 653	6, 564, 074	4, 716, 212	3, 566, 321	
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	39. 492952			1	1. 145716	
204.00 Cost to be allocated (per Wkst. B,	2, 979, 950	1, 025	196, 047	692, 046	591, 667	204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	4. 627280	0. 000649	22. 531548	13. 475728	0. 190079	205 00
III)	4. 02/280	0.000649	22. 531548	13.4/5/28	0. 190079	205.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

	•	U HEALTH BLOOMI		N 45 0054 5		eu of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2023	Worksheet B-1	
					o 12/31/2023	Date/Time Pre	pared:
						5/29/2024 1:5	3 pm
						OTHER GENERAL	
		NUDGLNG	OFNEDAL	DUIA DIA A OV	MEDICAL	SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI ON		(COSTED	RECORDS &	SERVICES	
		(DI DECT NUDC	SUPPLY	REQUI S.)	LI BRARY	(TIME SPENT)	
		(DI RECT NURS.	(COSTED		(GROSS		
		HRS.) 13. 00	REQUISITIONS) 14.00	15. 00	CHARGES) 16.00	18. 00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	18.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUI P						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION	1, 475, 123					13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	41, 628, 113				14.00
15. 00	01500 PHARMACY	0	208, 581	41, 957, 488	3		15. 00
16, 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(2, 270, 217, 201		16.00
18. 00	01850 SOCIAL SERVICES	0	o	(0	0	1
18. 01	01851 CENTRAL STERI LI ZATI ON	0	65, 345	C	0	0	1
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	0	0	(0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS					_	
30.00	03000 ADULTS & PEDI ATRI CS	475, 848	1, 042, 472	281, 476	189, 499, 955	0	30.00
31.00	03100 INTENSIVE CARE UNIT	94, 614	215, 381	118, 625	23, 729, 391	0	31.00
32.00	03200 CORONARY CARE UNIT	0	o	. (0	0	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	54, 273	54, 797	12, 436	13, 253, 909	0	1
42.00	04200 SUBPROVI DER	0	o	. (0	0	42.00
43.00	04300 NURSERY	16, 678	21, 340	3, 646	4, 696, 522	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	115, 742	8, 126, 659	182, 258	315, 540, 720	0	50.00
50. 01	05001 CV SURGERY	0	o	(0	50. 01
51.00	05100 RECOVERY ROOM	123, 942	219, 138	114, 763	56, 662, 722	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	57, 883	196, 679	40, 375	38, 335, 678	0	52.00
53.00	05300 ANESTHESI OLOGY	0	o	(0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 669	44, 214	13, 376	46, 743, 885	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	9, 421	40, 053	15, 079		0	55.00
56.00	05600 RADI OI SOTOPE	0	o	(0	0	56.00
57.00	05700 CT SCAN	842	63, 177	36, 341	46, 151, 438	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	4, 259	17, 679			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	36, 039	1, 794, 246	79, 910	103, 230, 438	0	59.00
60.00	06000 LABORATORY	0	4	(147, 708, 049	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	576, 989	55	20, 495, 011	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	8, 671	(31, 423, 703	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 137	31, 556	9, 915	41, 109, 770	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	50, 722	(70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 818, 204	(102, 395, 709	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	17, 056, 456	(196, 446, 230	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	40, 316, 021	355, 192, 809	0	73. 00
73. 01	07302 OP PHARMACY	0	2, 075	1, 504	5, 671, 191	0	73. 01
	07400 RENAL DI ALYSI S	0	10, 965	10, 328			74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	4, 541	1, 347	35	4, 103, 355	0	1
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	_					
90. 00	09000 CLI NI C	12, 145	6, 579	2, 870	1, 456, 643	0	
90. 01	09001 OP ONCOLOGY INFUSION CENTER	101, 067	195, 270		55, 694, 258	0	
90. 02	09002 WOUND CARE CENTER	12, 395			7, 700, 101		
90. 03	09003 PAIN CLINIC	8, 379		280			90. 03
90. 04	09004 OB CLINIC	47, 753		(3, 037, 108		
90. 05	09005 OP PSYCH CLINIC	9, 748	1	(5, 692, 838		
	09006 MULTI SPECIALTY CLINIC	29, 668		(4, 801, 155		
91. 00	09100 EMERGENCY	156, 732	587, 381	457, 317	260, 620, 713	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	51, 036	0	(26, 467, 245	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	이	(0	0	
	09500 AMBULANCE SERVI CES	0	이	(0	0	
	10000 I &R SERVI CES-NOT APPRVD PRGM	0	이	(0		100.00
	10100 HOME HEALTH AGENCY	0	이	(0		101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(0	0	102. 00
44	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE		<u> </u>	<u> </u>	<u> </u>	<u> </u>	113. 00
	<u> </u>						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm OTHER GENERAL SERVI CE MEDI CAL Cost Center Description NURSI NG CENTRAL PHARMACY SOCI AL ADMI NI STRATI ON RECORDS & SERVI CES SERVICES & (COSTED REQUIS.) LI BRARY (TIME SPENT) SUPPLY (DI RECT NURS. (COSTED (GROSS HRS.) REQUISITIONS) CHARGES) 13.00 14.00 15. 00 16.00 18. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115 00 0 116. 00 11600 HOSPI CE 0 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 1, 434, 552 41, 588, 173 41, 956, 829 2, 270, 217, 201 0 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 190. 01 19001 PROMPTCARE 13, 501 18, 370 16 0 0 190. 01 0 190. 02 190. 02 19002 RENTAL PROPERTIES 0 0 0 190. 03 19003 OLCOTT 0 0 190. 03 0 Ω 190. 04 19004 PHYSICIAN RECRUITMENT 0 0 0 0 190. 04 190. 05 19005 FOUNDATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 190. 05 0 190. 06 19006 MARKETI NG 0 0 190. 06 0 190. 07 19007 HME STORE 0 190. 07 0 Ω 190. 08 19008 UNUSED SPACE 0 0 0 0 190. 08 190. 09 19009 CLINICAL TRIALS 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 0 190. 11 19011 COMMUNITY HEALTH SERVICES 27,070 5.435 0 0 190 11 191. 00 19100 RESEARCH 0 191.00 191. 01 19101 RESEARCH 0 0 0 191. 01 191. 02 19102 OTHER SPONSORED ACTIVITIES 0 0 191. 02 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 16, 135 643 193. 00 19300 NONPALD WORKERS 0 193.00 0000 0 0 194.00 194.00 07950 IU HEALTH PAOLI HOSPITAL 0 0 194. 01 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 194. 02 07952 I U HEALTH MORGAN HOSPITAL C 0 0 194. 02 194. 03 07953 IU HEALTH SIP 0 0 194. 03 0 o 194.04 07954 HOME CARE 0 0 0 194. 04 194. 05 07955 HOSPI CE 0 0 194. 05 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 0 202. 00 16, 915, 698 12, 092, 275 224, 139 202.00 Cost to be allocated (per Wkst. B, 19, 651, 622 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 11. 467314 0.472076 0.288203 0.000099 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 349, 865 487, 335 378, 933 104, 395 0 204.00 Part II) Unit cost multiplier (Wkst. B, Part 0. 000000 205. 00 205.00 0.009031 0.000046 0. 237177 0.011707 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207. 00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Period: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm Provider CCN: 15-0051

				5/29/2024 1:53	3 pm
		OTHER GENERAL			•
		SERVI CE			
	Cost Center Description	CENTRAL	PARAMED ED		
		STERI LI ZATI ON	PRGM-PHARMACY		
		(TIME SPENT)	RESI DENCY		
			(TIME SPENT)		
	T	18. 01	23. 00		
4 00	GENERAL SERVI CE COST CENTERS				4 00
1. 00 2. 00	00100 CAP REL COSTS BLDG & FIXT				1.00
4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT				2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
10. 00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15. 00	01500 PHARMACY				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
18. 00	01850 SOCIAL SERVICES				18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	100	1		18. 01
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	0	100		23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT		0		32.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	0		35. 00
42. 00	04200 SUBPROVI DER	0			42. 00
43. 00	04300 NURSERY	0			43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>		10.00
50.00	05000 OPERATING ROOM	100	0		50.00
50. 01	05001 CV SURGERY	0	o		50. 01
51.00	05100 RECOVERY ROOM	0	o		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESI OLOGY	0	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00	05600 RADI OI SOTOPE	0			56. 00
57. 00	05700 CT SCAN	0	1		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	1		59.00
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	0		60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0			65. 00
66. 00	06600 PHYSI CAL THERAPY	0			66. 00
69. 00	06900 ELECTROCARDI OLOGY	0			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o o	l ol		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100		73. 00
	07302 OP PHARMACY	0	0		73. 01
	07400 RENAL DI ALYSI S	0	0		74. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0		90. 00
90.00	09001 OP ONCOLOGY INFUSION CENTER		1		90.00
90. 01	09002 WOUND CARE CENTER				90.01
90. 02	09003 PAIN CLINIC	0			90. 03
90. 04	09004 OB CLINIC	o o	l ol		90. 04
90. 05	09005 OP PSYCH CLINIC	0	0		90. 05
90.06	09006 MULTI SPECIALTY CLINIC	0	o		90. 06
91. 00	09100 EMERGENCY	0	o		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0	0		92. 01
	OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		94.00
	09500 AMBULANCE SERVICES	0	0		95.00
	10000 I &R SERVICES-NOT APPRVD PRGM	0	1		100.00
	10100 HOME HEALTH AGENCY	0	1		101.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		102. 00
113 00	11300 INTEREST EXPENSE				113. 00
	11400 UTILIZATION REVIEW-SNF				114. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	I	ı İ		

| Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0051

OTHER GENERAL SERVI CE 5/29/2024 1:	53 piii
Cost Center Description CENTRAL PARAMED ED	
STERI LI ZATI ON PROM-PHARMACY	
(TIME SPENT) RESIDENCY	
(TIME SPENT)	
18. 01 23. 00	
115. OO 11500 AMBULATORY SURGICAL CENTER (D. P.) O O	115. 00
116. 00 11600 HOSPI CE 0 0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 100	118. 00
NONREI MBURSABLE COST CENTERS	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0	190. 00
190. 01 19001 PROMPTCARE 0 0	190. 01
190. 02 19002 RENTAL PROPERTIES 0 0	190. 02
190. 03 19003 OLCOTT 0 0	190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0	190. 04
190. 05 19005 FOUNDATION 0 0	190. 05
190. 06 19006 MARKETI NG 0 0	190.06
190. 07 19007 HME STORE 0 0	190. 07
190. 08 19008 UNUSED SPACE 0 0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	190.00
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES 0 0	190. 10
191. 00 19100 RESEARCH 0 0	191. 00
191. 01 19101 RESEARCH 0 0	191. 00
191. 02 19102 OTHER SPONSORED ACTIVITIES 0 0	191. 01
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0	192. 00
193. 00/19300 NONPALD WORKERS 0	193. 00
194. 00 07950 U HEALTH PAOLI HOSPITAL 0 0	194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 0	194. 00
194. 02 07952 1U HEALTH BEDFORD NOSPITAL 0 0 0	194. 01
194. 03 07953 IU HEALTH MORGAN HOSPITAL 0 0 0	194. 02
194. 04 07954 HOME CARE 0 0	194. 03
194.05 07955 HOSPICE 0 0 0 200.00 Cross Foot Adjustments	194. 05 200. 00
201.00 Negative Cost Centers	201. 00
202.00 Cost to be allocated (per Wkst. B, 3,617,123 783,632	202. 00
Part I) 203 00	202 00
203.00 Unit cost multiplier (Wkst. B, Part I) 36, 171. 230000 7, 836. 320000	203. 00
204.00 Cost to be allocated (per Wkst. B, 640,556 73,116	204. 00
Part II) 205 00	205 00
205.00 Unit cost multiplier (Wkst. B, Part 6, 405. 560000) 731.160000	205. 00
204_00 MALE adjustment amount to be allegated	204 00
206.00 NAHE adjustment amount to be allocated 0	206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000	207.00
Parts III and IV)	207. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1

| In Lieu of Form CMS-2552-10 | Period: Worksheet C | From 01/01/2023 Part I | To 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051

						5/29/2024 1:5	3 pm
			Ti tl e	: XVIII	Hospi tal	PPS	•
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oust denter bescription	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10101 00313	
			Auj .		Di Sai i Owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	82, 318, 100		82, 318, 100	0	82, 318, 100	30. 00
31.00	03100 INTENSIVE CARE UNIT	11, 744, 578		11, 744, 578		11, 744, 578	
32. 00	03200 CORONARY CARE UNIT	1, ,		0		0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	4 070 752					•
	1 1	6, 879, 753		6, 879, 753		6, 978, 410	1
42.00	04200 SUBPROVI DER	0			0	0	42. 00
43.00	04300 NURSERY	2, 304, 628		2, 304, 628	0	2, 304, 628	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	38, 530, 614		38, 530, 614	0	38, 530, 614	50.00
50. 01	05001 CV SURGERY	0			o	0	50. 01
51. 00	05100 RECOVERY ROOM	13, 869, 056		13, 869, 056		13, 869, 056	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	9, 139, 777		9, 139, 777	_	9, 139, 777	52.00
		9, 139, 111					ł
53.00	05300 ANESTHESI OLOGY	0		C		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 011, 060		9, 011, 060	0	9, 011, 060	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 376, 812		7, 376, 812	0	7, 376, 812	55. 00
56.00	05600 RADI OI SOTOPE	0			0	0	56. 00
57.00	05700 CT SCAN	3, 834, 229		3, 834, 229	ol	3, 834, 229	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 313, 475		2, 313, 475		2, 313, 475	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 654, 734				7, 654, 734	
				7, 654, 734			1
60. 00	06000 LABORATORY	24, 848, 106		24, 848, 106		24, 848, 106	60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	6, 081, 570	0	6, 081, 570	0	6, 081, 570	65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 582, 444	l o	13, 582, 444	ol	13, 582, 444	66. 00
69.00	06900 ELECTROCARDI OLOGY	3, 046, 396		3, 046, 396		3, 046, 396	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	991, 172		991, 172		991, 172	
	1	1					
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 581, 726		18, 581, 726			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	29, 300, 224		29, 300, 224		29, 300, 224	
73.00	07300 DRUGS CHARGED TO PATIENTS	62, 615, 592		62, 615, 592	0	62, 615, 592	73. 00
73. 01	07302 OP PHARMACY	7, 345, 450		7, 345, 450	0	7, 345, 450	73. 01
74.00	07400 RENAL DIALYSIS	2, 407, 332		2, 407, 332	0	2, 407, 332	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	904, 144		904, 144		904, 144	76. 97
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0		0		0	77. 00
				•			1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		C	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	3, 790, 526		3, 790, 526	0		90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	12, 269, 387		12, 269, 387	0	12, 269, 387	90. 01
90. 02	09002 WOUND CARE CENTER	1, 769, 098		1, 769, 098		1, 769, 098	90. 02
90. 03	09003 PAIN CLINIC	1, 735, 877		1, 735, 877		1, 735, 877	90. 03
90. 04	09004 OB CLINIC	7, 790, 401		7, 790, 401		7, 790, 401	90. 04
90. 05	09005 OP PSYCH CLINIC	2, 880, 985		2, 880, 985		2, 880, 985	
90.06	09006 MULTI SPECIALTY CLINIC	4, 216, 701		4, 216, 701	0	4, 216, 701	90. 06
91. 00	09100 EMERGENCY	30, 241, 648		30, 241, 648	0	30, 241, 648	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 133, 360		4, 133, 360		4, 133, 360	92.00
	09202 OBSERVATION BEDS (DISTINCT PART)	9, 251, 446		9, 251, 446			
, 2. 0 .	OTHER REIMBURSABLE COST CENTERS	7,201,110		7,201,110	<u> </u>	7, 201, 110	/2.0.
04.00						0	04.00
	09400 HOME PROGRAM DI ALYSI S	0			0	0	1
	09500 AMBULANCE SERVICES	0		0	0	0	
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0		0	100. 00
101.00	10100 HOME HEALTH AGENCY	0				0	101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0				0	102. 00
	SPECIAL PURPOSE COST CENTERS				I		
112 00	11300 I NTEREST EXPENSE			I	I		113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0			115. 00
116.00	11600 H0SPI CE	0				0	116. 00
200.00	Subtotal (see instructions)	442, 760, 401	0	442, 760, 401	98, 657	442, 859, 058	200. 00
201.00		4, 133, 360		4, 133, 360		4, 133, 360	
202.00		438, 627, 041					
	, , , , , , , , , , , , , , , , , , , ,		,		, 5, 56, 1	,,20,070	,

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 1:53 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 173, 367, 868 173, 367, 868 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 23, 729, 391 23, 729, 391 31.00 03200 CORONARY CARE UNIT 32.00 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 13, 253, 909 13, 253, 909 35.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 4, 696, 522 43.00 4, 696, 522 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 227, 418, 848 0.122110 0.000000 50.00 88, 121, 872 315, 540, 720 05001 CV SURGERY 50.01 0.000000 0.000000 50.01 51.00 05100 RECOVERY ROOM 8, 461, 877 48, 200, 845 56, 662, 722 0. 244765 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 37, 714, 301 621, 377 38, 335, 678 0. 238414 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 13, 670, 880 54.00 05400 RADI OLOGY-DI AGNOSTI C 33, 073, 005 46, 743, 885 0.192775 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 257, 605 125, 886, 495 0.057121 0.000000 129, 144, 100 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0.000000 56.00 14, 081, 280 05700 CT SCAN 32, 070, 158 46, 151, 438 0.083079 57 00 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2, 952, 018 11, 241, 130 14, 193, 148 0.162999 0.000000 58.00 05900 CARDIAC CATHETERIZATION 41, 294, 518 61, 935, 920 103, 230, 438 0.074152 59.00 0.000000 59.00 06000 LABORATORY 147, 708, 049 0.000000 60.00 53, 663, 097 94, 044, 952 0.168224 60.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 14, 961, 132 5, 533, 879 20, 495, 011 0.296734 0.000000 65.00 66.00 66.00 06600 PHYSI CAL THERAPY 9, 465, 937 21, 957, 766 31, 423, 703 0.432236 0.000000 41, 109, 770 69 00 06900 ELECTROCARDI OLOGY 16, 382, 318 24, 727, 452 0 074104 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 051, 774 6, 177, 692 7, 229, 466 0.137102 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 34, 793, 256 67, 602, 453 102, 395, 709 0. 181470 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 85, 720, 927 110, 725, 303 196, 446, 230 0.149151 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 355, 192, 809 73.00 82, 425, 035 272, 767, 774 0.176286 0.000000 73.00 73.01 07302 OP PHARMACY 5, 671, 191 5, 671, 191 1. 295222 0.000000 73.01 74.00 07400 RENAL DIALYSIS 4, 572, 414 1, 951, 945 6, 524, 359 0.368976 0.000000 74.00 76 97 07697 CARDIAC REHABILITATION 179, 754 3, 923, 601 4, 103, 355 0 220343 0.000000 76 97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 \cap 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 12.762 1, 443, 881 1, 456, 643 2 602234 0.000000 90 00 09001 OP ONCOLOGY INFUSION CENTER 3, 652, 400 52, 041, 858 90.01 55, 694, 258 0.220299 0.000000 90.01 7, 900, 181 09002 WOUND CARE CENTER 3,737 7, 896, 444 0.223931 0.000000 90.02 90.02 90.03 09003 PAIN CLINIC 6, 401 5, 059, 101 5, 065, 502 0.342686 0.000000 90.03 90 04 09004 OB CLINIC 11,789 3, 025, 319 3.037.108 2 565072 0.000000 90 04 90.05 09005 OP PSYCH CLINIC 2,530 5, 690, 308 5, 692, 838 0.506072 0.000000 90.05 90.06 09006 MULTI SPECIALTY CLINIC 227, 381 4, 573, 774 4, 801, 155 0.878268 0.000000 90.06 09100 EMERGENCY 91.00 59, 588, 151 201, 032, 562 260, 620, 713 0.000000 91.00 0.116037 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,006,855 92.00 15, 125, 232 16, 132, 087 0.256220 0.000000 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 92.01 377, 094 26, 090, 151 26, 467, 245 0.349543 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 94.00 94.00 95. 00 |09500 AMBULANCE SERVICES 0 0 C 0.000000 0.000000 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 792, 706, 785 1, 477, 510, 416 2, 270, 217, 201 200.00

792, 706, 785 1, 477, 510, 416 2, 270, 217, 201

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

				5/29/2024 1:5	3 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
31.00 03100 INTENSIVE CARE UNIT					31. 00
32. 00 03200 CORONARY CARE UNIT					32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT					35. 00
42. 00 04200 SUBPROVI DER					42.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 122110				50.00
50. 01 05001 CV SURGERY	0.000000				50. 01
51. 00 05100 RECOVERY ROOM	0. 244765				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 238414				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 192775				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 057121				55. 00
56. 00 05600 RADI 01 SOTOPE	0. 000000				56. 00
57. 00 05700 CT SCAN	0. 083079				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 162999				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 074152				59. 00
60. 00 06000 LABORATORY	0. 168224				60. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 296734				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 432236				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 432230				69. 00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 137102				70.00
+ I	1 1				70.00
	0. 181470				
+ I	0. 149151				72.00
	0. 176286				73.00
73. 01 07302 OP PHARMACY	1. 295222				73. 01
74. 00 07400 RENAL DI ALYSI S	0. 368976				74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 220343				76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
OUTPATIENT SERVICE COST CENTERS	0 (00004				00.00
90. 00 09000 CLI NI C	2. 602234				90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0. 220299				90. 01
90. 02 09002 WOUND CARE CENTER	0. 223931				90. 02
90. 03 09003 PAI N CLI NI C	0. 342686				90. 03
90. 04 09004 0B CLINIC	2. 565072				90. 04
90. 05 09005 OP PSYCH CLINIC	0. 506072				90. 05
90. 06 09006 MULTI SPECIALTY CLINIC	0. 878268				90. 06
91. 00 09100 EMERGENCY	0. 116037				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 256220				92. 00
92. 01 09202 OBSERVATION BEDS (DISTINCT PART)	0. 349543				92. 01
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000				94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000				95. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM					100. 00
101.00 10100 HOME HEALTH AGENCY					101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM					102. 00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					115. 00
116. 00 11600 H0SPI CE					116. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 1:53 pm Hospi tal Title XIX PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 82, 318, 100 82, 318, 100 82, 318, 100 30.00 03100 INTENSIVE CARE UNIT 11, 744, 578 0 31.00 31.00 11, 744, 578 11, 744, 578 03200 CORONARY CARE UNIT 32.00 0 32.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 6, 879, 753 6, 879, 753 98, 657 6, 978, 410 35, 00 04200 SUBPROVI DER 42.00 Λ 42.00 43.00 04300 NURSERY 2, 304, 628 2, 304, 628 0 2, 304, 628 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 38, 530, 614 38, 530, 614 38, 530, 614 50.01 05001 CV SURGERY 0 0 50.01 51.00 05100 RECOVERY ROOM 13, 869, 056 13, 869, 056 0 0 13, 869, 056 51.00 05200 DELIVERY ROOM & LABOR ROOM 9, 139, 777 52.00 9, 139, 777 9, 139, 777 52.00 05300 ANESTHESI OLOGY 53.00 \cap Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9,011,060 9, 011, 060 0 9, 011, 060 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 7, 376, 812 7, 376, 812 0 0 0 0 0 7, 376, 812 55.00 05600 RADI OI SOTOPE 56 00 56 00 0 57.00 05700 CT SCAN 3, 834, 229 3, 834, 229 3, 834, 229 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 313, 475 2, 313, 475 2, 313, 475 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 7, 654, 734 7, 654, 734 7, 654, 734 59.00 06000 LABORATORY 24, 848, 106 24, 848, 106 24, 848, 106 60 00 60 00 64.00 0 06400 INTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 6, 081, 570 65.00 6, 081, 570 0 6, 081, 570 65.00 66 00 06600 PHYSI CAL THERAPY 13.582.444 13, 582, 444 13, 582, 444 66 00 06900 ELECTROCARDI OLOGY 69.00 3,046,396 3, 046, 396 3, 046, 396 69.00 0 07000 ELECTROENCEPHALOGRAPHY 991, 172 991, 172 991, 172 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 18, 581, 726 18, 581, 726 0 18, 581, 726 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 29 300 224 29 300 224 29, 300, 224 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 62, 615, 592 62, 615, 592 62, 615, 592 73.00 7, 345, 450 07302 OP PHARMACY 7, 345, 450 7, 345, 450 0 73.01 73.01 0 74.00 07400 RENAL DIALYSIS 2, 407, 332 2, 407, 332 2, 407, 332 74.00 76.97 07697 CARDIAC REHABILITATION 904, 144 904, 144 904, 144 76.97 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0 C 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 3, 790, 526 3, 790, 526 0 3, 790, 526 90 00 09000 CLI NI C 09001 OP ONCOLOGY INFUSION CENTER 12, 269, 387 12, 269, 387 0 12, 269, 387 90.01 90.01 90 02 09002 WOUND CARE CENTER 1, 769, 098 1, 769, 098 0 1, 769, 098 90 02 09003 PALN CLINIC 1.735.877 1.735.877 1, 735, 877 90.03 90.03

0 09004 OB CLINIC 7, 790, 401 90.04 7, 790, 401 7, 790, 401 90 04 90.05 09005 OP PSYCH CLINIC 2, 880, 985 2, 880, 985 0 2, 880, 985 90.05 0 90.06 09006 MULTI SPECIALTY CLINIC 4, 216, 701 4, 216, 701 4, 216, 701 90.06 09100 EMERGENCY 91.00 30, 241, 648 30, 241, 648 30, 241, 648 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 4, 133, 360 4, 133, 360 4, 133, 360 92.00 92.01 09202 OBSERVATION BEDS (DISTINCT PART) 9, 251, 446 9, 251, 446 9, 251, 446 92.01 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00 95. 00 09500 AMBULANCE SERVICES 0 0 95.00 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 200.00 442, 760, 401 442, 760, 401 442, 859, 058 200. 00 Subtotal (see instructions) 0 98.657 4, 133, 360 201. 00 201.00 Less Observation Beds 4, 133, 360 4, 133, 360 202.00 Total (see instructions) 438, 627, 041 438, 627, 041 98, 657 438, 725, 698 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 1:53 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 173, 367, 868 173, 367, 868 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 23, 729, 391 23, 729, 391 31.00 03200 CORONARY CARE UNIT 32.00 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 13, 253, 909 13, 253, 909 35.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 4, 696, 522 43.00 4, 696, 522 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 227, 418, 848 0.122110 0.000000 50.00 88, 121, 872 315, 540, 720 05001 CV SURGERY 50.01 0.000000 0.000000 50.01 51.00 05100 RECOVERY ROOM 8, 461, 877 48, 200, 845 56, 662, 722 0. 244765 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 37, 714, 301 621, 377 38, 335, 678 0. 238414 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 13, 670, 880 54.00 05400 RADI OLOGY-DI AGNOSTI C 33, 073, 005 46, 743, 885 0.192775 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 257, 605 125, 886, 495 0.057121 0.000000 129, 144, 100 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0.000000 56.00 14, 081, 280 05700 CT SCAN 32, 070, 158 46, 151, 438 0.083079 57 00 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2, 952, 018 11, 241, 130 14, 193, 148 0.162999 0.000000 58.00 05900 CARDIAC CATHETERIZATION 41, 294, 518 61, 935, 920 103, 230, 438 0.074152 59.00 0.000000 59.00 06000 LABORATORY 147, 708, 049 0.000000 60.00 53, 663, 097 94, 044, 952 0.168224 60.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 14, 961, 132 5, 533, 879 20, 495, 011 0.296734 0.000000 65.00 66.00 66.00 06600 PHYSI CAL THERAPY 9, 465, 937 21, 957, 766 31, 423, 703 0.432236 0.000000 41, 109, 770 69 00 06900 ELECTROCARDI OLOGY 16, 382, 318 24, 727, 452 0 074104 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 051, 774 6, 177, 692 7, 229, 466 0.137102 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 34, 793, 256 67, 602, 453 102, 395, 709 0. 181470 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 85, 720, 927 110, 725, 303 196, 446, 230 0.149151 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 355, 192, 809 73.00 82, 425, 035 272, 767, 774 0.176286 0.000000 73.00 73.01 07302 OP PHARMACY 5, 671, 191 5, 671, 191 1. 295222 0.000000 73.01 74.00 07400 RENAL DIALYSIS 4, 572, 414 1, 951, 945 6, 524, 359 0.368976 0.000000 74.00 76 97 07697 CARDIAC REHABILITATION 179, 754 3, 923, 601 4, 103, 355 0 220343 0.000000 76 97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 \cap 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 12.762 1, 443, 881 1, 456, 643 2 602234 0.000000 90 00 09001 OP ONCOLOGY INFUSION CENTER 3, 652, 400 52, 041, 858 90.01 55, 694, 258 0.220299 0.000000 90.01 7, 900, 181 09002 WOUND CARE CENTER 3,737 7, 896, 444 0.223931 0.000000 90.02 90.02 90.03 09003 PAIN CLINIC 6, 401 5, 059, 101 5, 065, 502 0.342686 0.000000 90.03 90 04 09004 OB CLINIC 11,789 3, 025, 319 3.037.108 2 565072 0.000000 90 04 90.05 09005 OP PSYCH CLINIC 2,530 5, 690, 308 5, 692, 838 0.506072 0.000000 90.05 90.06 09006 MULTI SPECIALTY CLINIC 227, 381 4, 573, 774 4, 801, 155 0.878268 0.000000 90.06 09100 EMERGENCY 91.00 59, 588, 151 201, 032, 562 260, 620, 713 0.000000 91.00 0.116037 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,006,855 92.00 15, 125, 232 16, 132, 087 0.256220 0.000000 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 92.01 377, 094 26, 090, 151 26, 467, 245 0.349543 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 94.00 94.00 95. 00 |09500 AMBULANCE SERVICES 0 0 C 0.000000 0.000000 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 792, 706, 785 1, 477, 510, 416 2, 270, 217, 201 200.00

792, 706, 785 1, 477, 510, 416 2, 270, 217, 201

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Date/Time Prepared: 12/31/2023 5/29/2024 1:53 pm Title XIX Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 35.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 122110 50.00 50 01 05001 CV SURGERY 0.000000 50.01 51. 00 05100 RECOVERY ROOM 51 00 0 244765 05200 DELIVERY ROOM & LABOR ROOM 52.00 0. 238414 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0. 192775 54.00 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.057121 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 05700 CT SCAN 0.083079 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0. 162999 58.00 05900 CARDIAC CATHETERIZATION 59 00 0.074152 59 00 60.00 06000 LABORATORY 0. 168224 60.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 64.00 06500 RESPIRATORY THERAPY 0. 296734 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0.432236 66.00 69.00 06900 ELECTROCARDI OLOGY 0.074104 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 137102 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0. 181470 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.149151 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 176286 73.00 73.00 73. 01 07302 OP PHARMACY 1. 295222 73.01 07400 RENAL DIALYSIS 74.00 0.368976 74.00 76.97 07697 CARDIAC REHABILITATION 0. 220343 76.97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 77.00 78 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2. 602234 90.00 09001 OP ONCOLOGY INFUSION CENTER 90.01 0. 220299 90.01 09002 WOUND CARE CENTER 0. 223931 90.02 90.02 0.342686 90.03 09003 PAIN CLINIC 90.03 09004 OB CLINIC 90.04 2. 565072 90.04 90.05 09005 OP PSYCH CLINIC 0.506072 90.05 09006 MULTI SPECIALTY CLINIC 90.06 0.878268 90.06 91.00 09100 EMERGENCY 0. 116037 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 256220 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 0.349543 92.01 92 01 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 95. 00 09500 AMBULANCE SERVICES 0.000000 95.00 100.00 10000 I &R SERVI CES-NOT APPRVD PRGM 100 00 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00

114.00

115.00

116, 00

200. 00

201.00

202.00

114.00 11400 UTILIZATION REVIEW-SNF

116. 00 11600 HOSPI CE

200.00

201.00

202.00

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

Health Financial Systems I U HEALTH BLOG CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0051

					10 12/31/2023	5/29/2024 1:5	
			Ti ti	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost		Operating Cost	
	'	(Wkst. B, Part		Net of Capital		Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
		·		col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	38, 530, 614	3, 648, 707	34, 881, 907			
50. 01	05001 CV SURGERY	0	(0	0	50. 01
51. 00	05100 RECOVERY ROOM	13, 869, 056				0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 139, 777	1, 176, 405	7, 963, 372		0	52.00
53.00	05300 ANESTHESI OLOGY	0	(٦		
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 011, 060				0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	7, 376, 812	1, 134, 479	6, 242, 333	3	0	
56. 00	05600 RADI OI SOTOPE	0	(0	0	56. 00
57. 00	05700 CT SCAN	3, 834, 229	l			0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 313, 475				0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 654, 734				0	
60. 00	06000 LABORATORY	24, 848, 106	896, 436	23, 951, 670		0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	(0	-	
65. 00	06500 RESPI RATORY THERAPY	6, 081, 570				0	65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 582, 444				-	66. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 046, 396					
70. 00	07000 ELECTROENCEPHALOGRAPHY	991, 172		1		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 581, 726					
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	29, 300, 224				0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	62, 615, 592				_	
73. 01	07302 OP PHARMACY	7, 345, 450				0	
74.00	07400 RENAL DIALYSIS	2, 407, 332				0	
76. 97	07697 CARDI AC REHABI LI TATI ON	904, 144		1		0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	•			0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	() (0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS	2 700 504	4 040 044	0.700.40	4		00.00
90.00	09000 CLINIC	3, 790, 526					
90. 01	09001 OP ONCOLOGY INFUSION CENTER	12, 269, 387					
90. 02	09002 WOUND CARE CENTER	1, 769, 098				-	
90. 03	09003 PAIN CLINIC	1, 735, 877				0	90. 03
90. 04 90. 05	O9004 OB CLINIC O9005 OP PSYCH CLINIC	7, 790, 401 2, 880, 985				0	90. 04 90. 05
90.05	l	1 ' '				0	
91.00	09006 MULTI SPECIALTY CLINIC 09100 EMERGENCY	4, 216, 701	l			0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	30, 241, 648 4, 133, 360					
92. 00	09202 OBSERVATION BEDS (NON-DISTINCT PART)	9, 251, 446					
92.01	OTHER REIMBURSABLE COST CENTERS	9, 231, 440	175, 240	0,470,200	<u> </u>	0	92.01
94. 00	09400 HOME PROGRAM DIALYSIS	0				0	94. 00
95. 00	09500 AMBULANCE SERVICES	0				0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0					100.00
	10100 HOME HEALTH AGENCY	0	· ·				101.00
	10200 OPI OI D TREATMENT PROGRAM	0	1				101.00
102.00	SPECIAL PURPOSE COST CENTERS			71	<u> </u>	0	102.00
113 00	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(0	0	115. 00
	11600 HOSPI CE						116. 00
200.00		339, 513, 342	23, 734, 515	315, 778, 82	7		200. 00
201.00	1 1 7	4, 133, 360					201. 00
202.00		335, 379, 982					202. 00
50	, , , , , , , , , , , , , , , , , , , ,		,, /00	/ / / / /	1	'	,

Health Financial Systems I U HEALTH BLO CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm Provi der CCN: 15-0051 REDUCTIONS FOR MEDICALD ONLY

						5/29/2024 1:5	3 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	'	Capital and		Cost to Charge	e		
			Part I, column				
		Reducti on	8)	/ col . 7)			
		6. 00	7.00	8.00			
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00			
50.00	05000 OPERATING ROOM	38, 530, 614	315, 540, 720	0. 122110			50.00
50. 00	05001 CV SURGERY	38, 330, 014		1			50. 00
			_	1			1
51.00	05100 RECOVERY ROOM	13, 869, 056					51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	9, 139, 777					52. 00
53.00	05300 ANESTHESI OLOGY	0	ļ	1 0.00000			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 011, 060		1			54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 376, 812	129, 144, 100				55. 00
56.00	05600 RADI OI SOTOPE	0	0	0. 000000			56. 00
57.00	05700 CT SCAN	3, 834, 229	46, 151, 438	0. 083079	9		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 313, 475	14, 193, 148				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 654, 734		0. 074152	2		59.00
60.00	06000 LABORATORY	24, 848, 106					60.00
64. 00	06400 I NTRAVENOUS THERAPY	0		0. 000000			64.00
65. 00	06500 RESPI RATORY THERAPY	6, 081, 570					65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 582, 444					66. 00
69. 00	06900 ELECTROCARDI OLOGY			1			69. 00
70.00		3, 046, 396					70.00
	07000 ELECTROENCEPHALOGRAPHY	991, 172		1			1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 581, 726					71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	29, 300, 224					72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	62, 615, 592		1			73. 00
73. 01	07302 OP PHARMACY	7, 345, 450					73. 01
74.00	07400 RENAL DI ALYSI S	2, 407, 332	6, 524, 359	0. 36897	6		74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	904, 144	4, 103, 355	0. 220343	3		76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	o		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 000000	0		78. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>		•	<u>'</u>		1
90.00	09000 CLI NI C	3, 790, 526	1, 456, 643	2. 602234	4		90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	12, 269, 387					90. 01
90. 02	09002 WOUND CARE CENTER	1, 769, 098		1			90. 02
90. 03	09003 PAIN CLINIC	1, 735, 877					90. 03
90. 03	09004 OB CLINIC						90.03
90.04		7, 790, 401					
	09005 OP PSYCH CLINIC	2, 880, 985					90. 05
90.06	09006 MULTI SPECIALTY CLINIC	4, 216, 701					90.06
91.00	09100 EMERGENCY	30, 241, 648					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 133, 360					92. 00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	9, 251, 446	26, 467, 245	0. 349543	3		92. 01
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	C				94. 00
95.00	09500 AMBULANCE SERVICES	0	0	0. 000000	0		95. 00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0. 000000	0		100.00
	10100 HOME HEALTH AGENCY	0	0				101.00
	10200 OPIOID TREATMENT PROGRAM	0		l .			102. 00
. 52. 50	SPECIAL PURPOSE COST CENTERS			3. 000000	-		1
113 00	11300 INTEREST EXPENSE						113. 00
	111400 UTI LI ZATI ON REVI EW-SNF			1			114. 00
	1 1						1
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00
	11600 HOSPI CE	0	0	0. 000000	J		116. 00
200.00			2, 055, 169, 511	1			200. 00
201.00		4, 133, 360		1			201. 00
202.00	Total (line 200 minus line 201)	335, 379, 982	2, 055, 169, 511	1			202. 00

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider CO		Period: From 01/01/2023 To 12/31/2023		pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	9, 390, 730	0	9, 390, 73	0 49, 072	191. 37	30.00
31.00 INTENSIVE CARE UNIT	899, 253		899, 25	3 4, 747	189. 44	31.00
32. 00 CORONARY CARE UNIT	0			0	0.00	32.00
35.00 NEONATAL INTENSIVE CARE UNIT	727, 797		727, 79	7 3, 576	203. 52	35. 00
42. 00 SUBPROVI DER	0	0		0	0.00	42.00
43. 00 NURSERY	337, 448		337, 44	8 2, 944	114. 62	43.00
200.00 Total (lines 30 through 199)	11, 355, 228		11, 355, 22	8 60, 339		200.00
Cost Center Description	Inpati ent	Inpati ent		•		
	Program days	Program				
	o ,	Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	14, 853	2, 842, 419				30.00
31.00 INTENSIVE CARE UNIT	1, 439	272, 604				31. 00
32. 00 CORONARY CARE UNIT	0	0				32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	16, 292	3, 115, 023				200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-255						2552-10
Cost Center Description	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C				
Total Charges					From 01/01/2023	Part II	narod:
Cost Center Description					10 12/31/2023	5/29/2024 1:5	pareu. 3 pm
Cost Center Description			Title	e XVIII	Hospi tal		<u> </u>
ANCILLARY SERVICE COST CENTERS	Cost Center Description	Capi tal				Capital Costs	
Part II, col 8		Related Cost	(from Wkst. C,	to Charges	Program	column 3 x	
ANCILLARY SERVICE COST CENTERS		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
ANCILLARY SERVICE COST CENTERS			8)	2)			
ANCILLARY SERVICE COST CENTERS So. 00 So. 00 Openating ROOM So. 01 So. 00 So. 00 Openating ROOM So. 01 So. 00 So. 00 Openating ROOM So. 00 Openating ROOM So. 00 Openating ROOM So. 00 Openating ROOM							
SOO 05000 05000 05000 05000 0 0		1.00	2.00	3. 00	4. 00	5. 00	
SOLITION OSDOT CV SURCERY O		0 (40 707	045 540 700	0.04454	00 000 074	242.022	F0 00
1.972 461 56, 662, 722 0.034811 3,091, 445 107, 616 51 00						· ·	
S2.00 05200 DELIVERY ROOM & LABOR ROOM 1,176,405 38,335,678 0,030687 52,526 1,612 52.00		1	_	1			
53.00 05300 AINSTHESI OLOGY 0 0 0 0 0 0 0 0 0							
54.00 05400 RADI OLOGY-DI ARONSTIC 782, 907 46, 743, 885 0.016/49 5, 065, 269 84, 838 54, 00 055.00 05500 ADDI OLOGY-THERAPEUTIC 1, 134, 479 129, 144, 100 0.008785 1, 345, 953 11, 824 55, 00 057.00		1		1	· ·		
55.00 05500 RADIO LOGY-THERAPEUTIC		1	_				
55.00 05600 RADIO I SOTOPE 0 0 0 0,000000 0 0 50 5							
57. 00 05700 CT SCAN 217, 190 46, 151, 428 0. 004706 5, 247, 406 24, 694 57. 00							
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 286, 694 14, 193, 148 0.020199 967, 716 19, 547 58.00		1	_				
59,00 05900 CARDIAC CATHETERIZATION 1,630,436 103,220,438 0,015794 13,835,045 218,511 59,00						· ·	
60. 00 00000 LABORATORY						· ·	
64. 00 06400 NTRAVENOUS THERAPY 0 0 0.000000 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 74, 329 20, 495, 011 0.003627 4, 262, 758 15, 461 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 355, 724 31, 423, 703 0.043143 3, 584, 262 154, 636 66. 00 69. 00 06900 ELECTROCARDIO LOGY 255, 791 41, 109, 770 0.006222 6, 207, 892 38, 626 69, 00 70. 00 07000 ELECTROCARDIO LOGY 113, 499 7, 229, 466 0.015699 363, 524 5, 707 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 189, 453 102, 395, 709 0.001850 11, 408, 195 21, 105 71, 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 300, 304 196, 446, 230 0.001529 31, 630, 606 48, 363 72, 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 596, 908 355, 192, 809 0.001681 25, 700, 147 43, 202 73, 00 74. 00 07400 RENAL DI ALYSIS 166, 750 6, 524, 359 0.02558 1, 904, 989 48, 688 76. 97 07697 CARDI AC REHABL LITATION 7, 889 4, 103, 355 0.001923 51, 775 100 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0 0 0.000000 0 0 78. 00 07800 CAR T-ECLL I IMBUNDHERAPY 0 0 0.000000 0 0 78. 00 07800 CAR T-ECLL I ACQUI SITION 0 0 0.000000 0 0 78. 00 07800 CAR T-ECLL I ACQUI SITION 0 0 0.000000 0 0 79. 00 07000 CLINIC 1, 570, 528 55, 694, 258 0.028199 1, 286, 715 36, 284 90, 011 90. 01 09001 0P ONCOLOGY INFUSION CENTER 1, 570, 528 55, 694, 258 0.028199 1, 286, 715 36, 284 90, 011 90. 02 09002 WOUND CARE CENTER 250, 717 7, 900, 181 0.031736 3, 701 117 90, 02 90. 03 09003 PAIN CLINIC 1, 700, 643 3, 3037, 108 0.559955 5, 574 3, 121 90, 04 90. 05 09005 0P PSYCH CLINIC 38, 513 4, 801, 155 0.008022 3, 225 26, 60, 90, 60 90. 06 09006 MUSTLOCARE CENTERS 250, 0713 0.008051 20, 928, 012 168, 491 91, 00 91. 00 09000 09500 09500 00500 00500 00500 00500 00500 00500 00500							
65. 00			147, 708, 049				
66. 00 06600 PHYSICAL THERAPY			20 405 011	l .			
69.00 66900 ELECTROCARDI OLOGY 255, 791 41, 109, 770 0. 006222 6, 207, 892 38, 626 69. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 113, 499 7, 229, 466 0. 015699 363, 524 5, 707 70. 00 71						· ·	
70. 00 07000 ELECTROENCEPHALOGRAPHY 113, 499 7, 229, 466 0. 015699 363, 524 5, 707 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 01 73. 01 73. 01 73. 01 73. 01 73. 02 74. 00 7						· ·	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 189, 453 102, 395, 709 0.001850 11, 408, 195 21, 105 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 300, 304 196, 446, 230 0.001529 31, 630, 606 48, 363 72. 00 73. 01 73. 00 07300 DRUGS CHARGED TO PATIENTS 596, 908 355, 192, 809 0.001681 25, 700, 147 43, 202 73. 00 73. 01 74. 00 07400 RENAL DI ALYSI S 166, 750 6, 524, 359 0.025558 1, 904, 989 48, 688 74. 00 76. 97 7697 CARDI AC REHABILITATION 7, 889 4, 103, 355 0.001923 51, 775 100 76. 97 7697 CARDI AC REHABILITATION 0 0 0.000000 0 0 0.77. 00 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 0.000000 0		•					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 300, 304 196, 446, 230 0.001529 31, 630, 606 48, 363 72. 00 73. 00 73.00 DRUGS CHARGED TO PATIENTS 596, 908 355, 192, 809 0.001681 25, 700, 147 43, 202 73. 00 73. 01 73. 01 73. 01 73. 01 73. 01 74. 00 74.							
73. 00		•				· ·	
73. 01 07302 OP PHARMACY 182,007 5,671,191 0.032093 0 0 73. 01 74. 00 07400 RENAL DIALYSIS 166,750 6,524,359 0.025558 1,904,989 48,688 74. 00 76. 97 07697 CARDIAC REHABILITATION 7,889 4,103,355 0.001923 51,775 100 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0.000000 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0.000000 0 0 0 78. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 1,010,042 1,456,643 0.693404 6,677 4,630 90. 00 90. 01 09001 OP ONCOLOGY INFUSION CENTER 1,570,528 55,694,258 0.028199 1,286,715 36,284 90. 01 90. 02 09002 WOUND CARE CENTER 250,717 7,900,181 0.031736 3,701 1117 90. 02 90. 03 09003 PAIN CLINIC 171,475 5,065,502 0.033852 0 0 90. 03 90. 04 09004 OB CLINIC 1770,643 3,037,108 0.559955 5,574 3,121 90. 04 90. 05 09005 OP PSYCH CLINIC 55,065,020 0.033852 0 0 90. 03 90. 06 09006 MULTI SPECIALTY CLINIC 38,513 4,801,155 0.008022 3,225 26 90. 06 90. 06 09006 MULTI SPECIALTY CLINIC 38,513 4,801,155 0.008022 3,225 26 90. 06 91. 00 09100 EMERGENCY 2,098,173 260,620,713 0.008051 20,928,012 168,491 91. 00 92. 01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 775,240 26,467,245 0.029291 254,477 7,454 92. 01 074. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0.000000 0 0 94. 00 95. 00 09500 AMBULANCE SERVICES							
74. 00 07400 RENAL DI ALYSI S 166,750 6,524,359 0.025558 1,904,989 48,688 74. 00 76. 97 07407 CARDI AC REHABI LI TATI ON 7,889 4,103,355 0.001923 51,775 100 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0.000000 0 0 0 0 77. 00 78. 00 07800 CAR T - CELL I MMUNOTHERAPY 0 0 0.000000 0 0 0 78. 00 000000 CAR T - CELL I MMUNOTHERAPY 0 0 0.000000 0 0 0 78. 00 0017PATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 1,010,042 1,456,643 0.693404 6,677 4,630 90. 00 90. 01 09001 OP ONCOLOGY I NFUSI ON CENTER 1,570,528 55,694,258 0.028199 1,286,715 36,284 90. 01 90. 03 09003 PAIN CLI NI C 250,717 7,900,181 0.031736 3,701 1117 90. 02 90. 04 09004 08 CLI NI C 171,475 5,065,502 0.033852 0 0 0 90. 03 90. 04 09004 0B CLI NI C 171,475 5,065,502 0.033852 0 0 0 90. 03 90. 04 09004 0B CLI NI C 171,475 5,065,502 0.033852 0 0 0 90. 03 90. 05 09005 OP PSYCH CLI NI C 659,285 5,692,838 0.115810 0 0 90. 05 90. 06 09006 MULTI SPECI ALTY CLI NI C 3,513 4,801,155 0.008022 3,225 26 91. 00 09100 EMERGENCY 2,098,173 260,620,713 0.008051 20,928,012 168,491 91. 00 92. 01 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 471,530 16,132,087 0.029229 332,861 9,729 92. 00 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0.000000 0 0 94.00 95. 00 09500 AMBULANCE SERVI CES						· ·	
76. 97 07697 CARDI AC REHABILITATION 7,889 4,103,355 0.001923 51,775 100 76.97 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0.000000 0 0 0.77.00 0.000000 0 0 0.000000 0		1					
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0.000000 0 0 0.77. 00 078.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 0 78.00 0000000 0 0 0 0 0 0						· ·	
78. 00		1					
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS				1			
90. 00 09000 CLINIC 1,010,042 1,456,643 0.693404 6,677 4,630 90.00 90.01 09001 0P ONCOLOGY INFUSION CENTER 1,570,528 55,694,258 0.028199 1,286,715 36,284 90.01 90.02 09002 WOUND CARE CENTER 250,717 7,900,181 0.031736 3,701 117 90.02 90.03 09003 PAIN CLINIC 1771,475 5,065,502 0.033852 0 0 90.03 90.05 09005 0P PSYCH CLINIC 659,285 5,692,838 0.115810 0 0 90.05 90.05 09005 0P PSYCH CLINIC 38,513 4,801,155 0.008022 3,225 26 90.06 91.00 09100 EMERGENCY 2,098,173 260,620,713 0.008051 20,928,012 168,491 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 471,530 16,132,087 0.029291 254,477 7,454 92.01 OTHER REIMBURSABLE COST CENTERS 94.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 09500 AMBULANCE SERVICES				0.0000	<u> </u>		70.00
90. 01 09001 0P ONCOLOGY INFUSION CENTER 1,570,528 55,694,258 0.028199 1,286,715 36,284 90. 01 90. 02 09002 WOUND CARE CENTER 250,717 7,900,181 0.031736 3,701 117 90. 02 90. 03 09003 PAIN CLINIC 171,475 5,065,502 0.033852 0 0 90. 03 90. 04 09004 0B CLINIC 1,700,643 3,037,108 0.559955 5,574 3,121 90. 04 90. 05 09005 0P PSYCH CLINIC 659,285 5,692,838 0.115810 0 0 90. 05 90. 06 09006 MULTI SPECIALTY CLINIC 38,513 4,801,155 0.008022 3,225 26 90. 06 91. 00 09100 EMERGENCY 2,098,173 260,620,713 0.008051 20,928,012 168,491 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 471,530 16,132,087 0.029229 332,861 9,729 92. 00 09202 OBSERVATION BEDS (DISTINCT PART) 775,240 26,467,245 0.029291 254,477 7,454 92. 01 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 00 0.000000 0 0 94. 00 95. 00 09500 AMBULANCE SERVICES 90. 01 0 0.000000 0 0 94. 00 95. 00 00 00 00 00 00 00 00		1, 010, 042	1, 456, 643	0. 69340	4 6, 677	4, 630	90.00
90. 02 09002 WOUND CARE CENTER 250, 717 7, 900, 181 0.031736 3, 701 117 90.02 90. 03 09003 PAIN CLINIC 171, 475 5, 065, 502 0.033852 0 0 90.03 90. 04 09004 0B CLINIC 1,700, 643 3,037, 108 0.559955 5,574 3, 121 90.04 90. 05 09005 0P PSYCH CLINIC 659, 285 5,692, 838 0.115810 0 0 90.05 90. 06 09006 MULTI SPECIALTY CLINIC 38,513 4,801, 155 0.008022 3,225 26 90.06 91. 00 09100 EMERGENCY 2,098,173 260,620,713 0.008051 20,928,012 168,491 91.00 92. 01 09202 OBSERVATION BEDS (NON-DISTINCT PART) 471,530 16,132,087 0.029229 332,861 9,729 92.00 92. 01 OP202 OBSERVATION BEDS (DISTINCT PART) 775,240 26,467,245 0.029291 254,477 7,454 92.01 0THER REIMBURSABLE COST CENTERS 0 0 0.000000 0 94.00 95. 00 09500 AMBULANCE SERVICES 95.00						· ·	
90. 03							
90. 04 09004 0B CLINIC 1,700,643 3,037,108 0.559955 5,574 3,121 90.04 90.05 09005 0P PSYCH CLINIC 659,285 5,692,838 0.115810 0 0 90.05 90.06 09006 MULTI SPECIALTY CLINIC 38,513 4,801,155 0.008022 3,225 26 90.06 91.00 09100 EMERGENCY 2,098,173 260,620,713 0.008051 20,928,012 168,491 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 471,530 16,132,087 0.029229 332,861 9,729 92.00 09202 0BSERVATION BEDS (DISTINCT PART) 775,240 26,467,245 0.029291 254,477 7,454 92.01 0THER REIMBURSABLE COST CENTERS 94.00 99500 AMBULANCE SERVICES 95.00 95.00 09500 AMBULANCE SERVICES	90. 03 09003 PAIN CLINIC	171, 475			2 0	0	90. 03
90. 05 09005 0P PSYCH CLINIC 659, 285 5, 692, 838 0. 115810 0 0 90. 05 90. 06 90.						3, 121	90. 04
90. 06 09006 MULTI SPECIALTY CLINIC 38, 513 4, 801, 155 0. 008022 3, 225 26 90. 06 91. 00 09100 EMERGENCY 2, 098, 173 260, 620, 713 0. 008051 20, 928, 012 168, 491 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 471, 530 16, 132, 087 0. 029229 332, 861 9, 729 92. 00 09202 OBSERVATI ON BEDS (DISTINCT PART) 775, 240 26, 467, 245 0. 029291 254, 477 7, 454 92. 01 000000 000000000000000000000000	90. 05 09005 OP PSYCH CLINIC	659, 285			0 0	0	90. 05
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 471,530 16,132,087 0.029229 332,861 9,729 92.00 09202 OBSERVATI ON BEDS (DISTINCT PART) 775,240 26,467,245 0.029291 254,477 7,454 92.01 07 07 07 07 07 07 07						26	90. 06
92. 01 09202 OBSERVATI ON BEDS (DISTINCT PART) 775, 240 26, 467, 245 0.029291 254, 477 7, 454 92. 01	91. 00 09100 EMERGENCY	2, 098, 173	260, 620, 713	0.00805	1 20, 928, 012	168, 491	91.00
92. 01 09202 OBSERVATI ON BEDS (DISTINCT PART) 775, 240 26, 467, 245 0.029291 254, 477 7, 454 92. 01	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	471, 530	16, 132, 087	0. 02922	9 332, 861	9, 729	92. 00
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0000000 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 95. 00		775, 240	26, 467, 245	0. 02929	1 254, 477	7, 454	92. 01
95. 00 09500 AMBULANCE SERVI CES 95. 00							
11.11	94. 00 09400 HOME PROGRAM DI ALYSIS	0	0	0.00000	0 0	0	94.00
200.00 Total (lines 50 through 199) 23,734,515 2,055,169,511 182,729,770 1,514,000 200.00							
	200.00 Total (lines 50 through 199)	23, 734, 515	2, 055, 169, 511		182, 729, 770	1, 514, 000	200. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/29/2024 1:5	epared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	0	0		0 0	0 0	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				0		1
42. 00 04200 SUBPROVI DER				0 0		1
43. 00 04300 NURSERY	0			0 0		
200.00 Total (lines 30 through 199)	0			0 0	ا ا	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	t Per Diem (col.	Inpatient	
· ·	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 CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	49, 07	2 0.00	14, 853	30.00
31.00 03100 INTENSIVE CARE UNIT		0	4, 74			
32. 00 03200 CORONARY CARE UNIT		0	1	0.00		
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	3, 57			00.00
42. 00 04200 SUBPROVI DER	0	0)	0.00	1	1 00
43. 00 04300 NURSERY		0	2, 94			10.00
200.00 Total (lines 30 through 199)		0	60, 33	9	16, 292	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					

9.00

30.00 31.00 32.00 35.00 42.00 43.00 200.00

| INPATIENT ROUTINE SERVICE COST CENTERS | 30.00 | 03000 | ADULTS & PEDIATRICS | 31.00 | 03100 | INTENSIVE CARE UNIT | 32.00 | 03200 | CORONARY CARE UNIT | 02060 | NEONATAL INTENSIVE CARE UNIT | 04200 | SUBPROVIDER | 04300 | 04300 | NURSERY | Total (lines 30 through 199)

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | T Provider CCN: 15-0051 THROUGH COSTS

					10 12/	3172023	5/29/2024 1:5	
			Ti tl e	XVIII	Hosp	i tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied	Heal th	Allied Health	
		Anestheti st	Program	Program	Post-S	tepdown		
		Cost	Post-Stepdown		Adj us	tments		
			Adjustments					
	1	1.00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1	II.	0	0	0	
50. 01	05001 CV SURGERY	0	C	2	0	0	0	00.0.
51.00	05100 RECOVERY ROOM	0		2	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		2	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0		2	0	0	0	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0		(0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		(0	0	0	55. 00 56. 00
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	0		(0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	1	
59.00	05900 CARDIAC CATHETERIZATION	0		()	0	0	0	59.00
60.00	06000 LABORATORY	0			0	0	0	
64. 00	06400 I NTRAVENOUS THERAPY				0	0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	0			0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0			0	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0			0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7		0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ĭ		0	0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ĭ		0	0	783, 632	
73. 01	07302 OP PHARMACY	0			0	0	0	1
74. 00	07400 RENAL DI ALYSI S	0	Č		0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	Č		0	0	l o	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	ĺ		Ö	0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	l c		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	'	<u> </u>				<u>'</u>	
90.00	09000 CLI NI C	0	C)	0	0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	C		0	0	0	90. 01
90. 02	09002 WOUND CARE CENTER	0	C		0	0	0	90. 02
90. 03	09003 PAIN CLINIC	0	C)	0	0	0	90. 03
90. 04	09004 OB CLINIC	0	C)	0	0	0	90. 04
90. 05	09005 OP PSYCH CLINIC	0	C)	0	0	0	90. 05
90.06	09006 MULTI SPECIALTY CLINIC	0	C)	0	0	0	90. 06
91. 00	09100 EMERGENCY	0	C)	0	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0	C)	0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS	ı						
94. 00	09400 HOME PROGRAM DI ALYSI S	0	C		0	0	0	
95. 00	09500 AMBULANCE SERVICES	_	_			_	700 /	95. 00
200.00	Total (lines 50 through 199)	0	[C	ין	0	0	783, 632	J200. 00

Heal th	Financial Systems I	O HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THE COSTS	RVICE OTHER PASS	S Provider C	F	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/29/2024 1:5	pared:
			Ti +l c	xVIII	Hospi tal	PPS	3 piii
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
	oust denter beschiptron	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of	Part I, col.	(col . 5 ÷ col .	
			4)	col s. 2, 3,	8)	7)	
			,	and 4)	,	(see	
				,		instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0					
50. 01	05001 CV SURGERY	0		l .		0. 000000	
51. 00	05100 RECOVERY ROOM	0	0	1		0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(38, 335, 678		
53.00	05300 ANESTHESI OLOGY	0	0	(0	0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(
56.00	05600 RADI 0I SOTOPE	0	0	(-	0. 000000	1
57. 00	05700 CT SCAN	0	0	(0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0. 000000	
60.00	06000 LABORATORY	0	0	(0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(_	0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	0	0	(0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0	(0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0	(
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(., ==.,		
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	(
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(
73.00	07300 DRUGS CHARGED TO PATIENTS	0	783, 632	1		0. 002206	
73. 01	07302 OP PHARMACY	0	0	(-, ,	0. 000000	
74. 00	07400 RENAL DIALYSIS	0	0	(-,,		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(1, 100, 000	0.000000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		1	0.000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0. 000000	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0		1 457 (42	0.000000	00 00
90.00	09001 OP ONCOLOGY INFUSION CENTER	0		1			
90.01	09002 WOUND CARE CENTER	0	0			0. 000000 0. 000000	
90. 02	09003 PALN CLINIC	0	0		5, 065, 502	0. 000000	
90. 03	09004 0B CLINIC	0	0				
90. 04	09005 OP PSYCH CLINIC		0				1
90.05	09006 MULTI SPECIALTY CLINIC	0	0		-,,		
91.00	09100 EMERGENCY						
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0. 000000	1
92. 00 92. 01	09202 OBSERVATION BEDS (NON-DISTINCT PART)			1			
72. U I	OTHER REIMBURSABLE COST CENTERS			1 (20, 407, 245	0.000000	72.01
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0	0. 000000	94. 00
	09500 AMBULANCE SERVICES		١		1	0.00000	95.00
200.00	1	0	783, 632	783 633	2, 055, 169, 511		200.00
200.00	1.0tdi (11103 00 tili 00gii 177)	1	1 ,00,002	1 700,002	_, _, 000, 107, 011	1	1200.00

IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2023 THROUGH COSTS Part IV 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm Title XVIII Hospi tal PPS Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through Pass-Through to Charges Charges Charges (col. 6 ÷ col Costs (col. Costs (col. x col. 12) 13.00 x col. 10) 7) 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0.000000 44, 522, 374 30, 099, 264 0 0 50.01 05001 CV SURGERY 0.000000 0 05100 RECOVERY ROOM 0.000000 3, 091, 445 0 11, 594, 382 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52, 526 4.737 0 0 05300 ANESTHESI OLOGY 0.000000 53.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 5, 065, 269 7, 172, 959 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 1, 345, 953 48, 384, 606 0 05600 RADI OI SOTOPE 0.000000 0 56 00 0 0 05700 CT SCAN 5, 247, 406 57.00 0.000000 7, 284, 156 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 967, 716 1, 900, 761 0 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 13, 835, 045 19, 521, 107 0 06000 LABORATORY 0 0.000000 7, 975, 225 60 00 15, 089, 756 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 06500 RESPIRATORY THERAPY 65.00 0.000000 4, 262, 758 1, 737, 380 0

Heal th	Financial Systems I	U HEALIH BLOOMI	NGION HOSPITAL	-	In Lie	eu of Form CMS-:	2552-10
APP0R1	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0051	Peri od: From 01/01/2023 To 12/31/2023		pared:
						5/29/2024 1:5	3 pm
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.)	(see inst.)	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	0. 122110	44, 522, 374	ı	0 0	5, 436, 627	50.00
50. 01	05001 CV SURGERY	0. 000000	11,022,071		0 0		1
51. 00	05100 RECOVERY ROOM	0. 244765	11, 594, 382	1	0 0	l	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 238414	4, 737	•	0 0	1, 129	
53. 00	05300 ANESTHESI OLOGY	0. 000000	4, 737		0 0		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 192775	7, 172, 959				1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 192773	48, 384, 606				
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0.000000	40, 304, 000		0 0		1
57. 00	05700 CT SCAN	0. 083079	7, 284, 156	<u>'</u>			
58. 00		0. 162999	1, 900, 761]		l	
59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0. 162999	19, 521, 107	,			
60.00	06000 LABORATORY						
64. 00	06400 I NTRAVENOUS THERAPY	0. 168224 0. 000000	7, 975, 225				64. 00
		1	1 727 200	(
65. 00 66. 00	06500 RESPIRATORY THERAPY	0. 296734	1, 737, 380	1			1
	06600 PHYSI CAL THERAPY	0. 432236	157, 823			,	
69. 00	06900 ELECTROCARDI OLOGY	0. 074104	8, 941, 389		0 0		
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 137102	1, 460, 608		0 0	200, 252	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 181470	17, 918, 164	1	0 0		1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 149151	30, 316, 569		0 0	.,,	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 176286	94, 439, 463		0 103, 403	l	
73. 01	07302 OP PHARMACY	1. 295222	050.040	2	0 0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 368976	258, 048	•	0 0		
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 220343	1, 350, 796		0 0		
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	1	0 0		
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	7	0 0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2. 602234	490, 239	J 20	02 36	1, 275, 717	90.00
90.00	09001 OP ONCOLOGY INFUSION CENTER	0. 220299	16, 097, 812			3, 546, 332	
90.01	09001 OP UNCOLOGY THRUSTON CENTER	0. 220299	3, 324, 954				1
90. 02	09002 WOUND CARE CENTER	0. 342686	613, 077	•	0 0		1
		1		l	0 4		
90. 04	09004 OB CLINIC	2. 565072	1, 521, 173		-	3, 901, 918	1
90.05	09005 OP PSYCH CLINIC	0. 506072	358, 928	1	0 0		
90.06	09006 MULTI SPECIALTY CLINIC	0. 878268	320, 272	1	0 6		
91.00	09100 EMERGENCY	0. 116037	29, 300, 253	•	0 105		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 256220	1, 673, 077		0 3		
92. 01	O9202 OBSERVATI ON BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 349543	5, 567, 021		0 11	1, 945, 913	92. 01
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000			0 0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000					95.00
200.00		0.000000	364, 207, 353	3, 5!	-	58, 303, 549	
200.00	,		304, 201, 353	3, 50	0 103, 609	30, 303, 349	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges						201.00
202.00			364, 207, 353	3, 5!	103, 609	58, 303, 549	202 00
202.00	[] [] [] [] [] [] [] [] [] []	1 1	30.,20.,000	1 0,00	.55,007	1 33, 333, 017	1-32.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2023 | Part V | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 | 1:53 pm | Heal th FinancialSystemsI U HEALTH BLOOMAPPORTIONMENT OFMEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0051

Cost Center Description					5/29/2024 1:53 pm
Cost Center Description			Title XVIII	Hospi tal	PPS
Cost Center Description		Costs			
Reinbursed Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. See Inst.) Subject To Ded. & Coins. See Inst.) See Inst. Se	Coot Contar Dogorintian				
Services Subject To Ded. & Coins. See Inst.)	cost center bescription				
Subject To Ded. & Coins. Subject To D					
Ded. & Col ns. (see nst.) (see nst.		Servi ces S	Services Not		
See Inst. (see Inst.)		Subject To	Subject To		
See Inst. (see Inst.)		Ded. & Coins. De	ed. & Coins.		
ANCILLARY SERVICE COST CENTERS					
MACILLARY SERVICE COST CENTERS					
50. 00 05000 0FEATTING ROOM		6.00	7.00		
SO 01 OSOOT OV SIRGERY O					
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 52.00	50.00 05000 OPERATING ROOM	O	0		50.00
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 52.00	50, 01 05001 CV SURGERY	l ol	ol		50.01
S2.00 05200 05200 05200 05200 05200 05200 05200 0530		ام			
S3. 00 05300 ANESTHESI OLOGY 0 0 0 53. 00					
54. 00 05400 RADI DLOGY-DI AGNOSTIC 0 0 0 55. 00 05500 RADI DLOGY-DI AGNOSTIC 0 0 0 55. 00 05500 RADI DLOGY-DI HERAPEUTI C 0 0 0 55. 00 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 0 0 0 0		ا ا	-1		
55. 00 05.00 RADIO LOGY -THERAPEUTIC 0 0 0 0 0 0 0 0 0	53. 00 05300 ANESTHESTOLOGY	0	0		53.00
56.00 05000 RADIO I SOTOPE 0 0 0 57.00 57.	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
56.00 05000 RADIO I SOTOPE 0 0 0 57.00 57.	55 00 05500 RADI OLOGY-THERAPEUTI C	ام	ol		55 00
57.00 05700 CT SCAN 57.00 0 0 0 58.00		ام	-1		
S8. 00 OSBOO MAGNETIC RESONANCE I MAGING (MRI) O O O S9. 00					
59, 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0		l ol			
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58. 00
60.00 06000 LABORATORY 0 0 0 64.00 64.00 65.00 66.00 6	59. 00 05900 CARDI AC CATHETERI ZATI ON	O	ol		59. 00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0		ام	o		60.00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 06600 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 070. 00	1	٥			
66. 00 06600 PHYSICAL THERAPY 0 0 0 690 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		٩	-1		
69. 00 0,00 0,000 ELECTROCARDIOLOGY 0 0 0 0,00 0,00 0,00 0,00 0,00 0,00 0		O			
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 07200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	0	0		66. 00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	o	O		69. 00
71. 00	70 00 07000 ELECTROENCEPHALOGRAPHY		o		70.00
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 18, 229 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 01 73. 00 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 74. 00 74. 00 74. 00 74. 00 74. 00 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 77. 00 76. 97 77. 00 77.		ENTS			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 18, 229 73. 00 7302 OP PHARMACY 0 0 0 73.00 73. 01 73.00 7302 OP PHARMACY 0 0 0 0 73. 01 73. 01 74. 00 7400 RENAL DI ALYSI S 0 0 0 74. 00 7400 RENAL DI ALYSI S 0 0 0 0 74. 00 7400 RENAL DI ALYSI S 0 0 0 0 75. 00 76. 97 77. 00 7700 ALLOGENEIC STEM ELL ACQUISITION 0 0 0 0 77. 00 7700 ALLOGENEIC STEM ELL ACQUISITION 0 0 0 0 77. 00 778. 00 7780 CART -CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		LINIS	- 1		
73. 01 07302 OP PHARMACY 0 0 7400 RENAL DI ALYSIS 0 0 0 7400 RENAL DI ALYSIS 0 0 0 0 7400 RENAL DI ALYSIS 0 0 0 0 75697 CARDI AC REHABI LI TATI ON 0 0 0 776. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 777. 00 07800 CAR T - CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		١	-1		
74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0		0	18, 229		73. 00
76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 0 0 0	73. 01 07302 OP PHARMACY	0	0		73. 01
76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 77. 00 77. 00 77. 00 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0	74 00 07400 RENAL DIALYSIS	ام	ol		74 00
77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0		ام			
78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0		١	-1		
90. 00		١	- 1		
90. 00		0	0		78. 00
90. 01 09001 0P ONCOLOGY INFUSION CENTER 423 9 90. 01 90. 02 09002 WOUND CARE CENTER 320 0 90. 02 90. 03 09003 PAIN CLINIC 0 0 0 90. 04 09004 0B CLINIC 0 10 90. 04 90. 05 09005 0P PSYCH CLINIC 0 0 0 90. 06 09006 MULTI SPECIALTY CLINIC 0 5 90. 06 91. 00 09100 EMERGENCY 0 12 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 1 92. 00 92. 01 09202 0BSERVATION BEDS (DISTINCT PART) 0 4 92. 01 074. 00 09400 HOME PROGRAM DIALYSIS 0 0 95. 00 09500 AMBULANCE SERVICES 0 200. 00 Subtotal (see instructions) 1, 269 18, 364 201. 00 Charges 0 0 001 001 001 001 001 001 001 001 001 001 001 001 002 003 001 001 001 001 003 001 001 001 001 001 003 001 001 001 001 004 007 00	OUTPATIENT SERVICE COST CENTERS				
90. 01 09001 0P ONCOLOGY INFUSION CENTER 423 9 90. 01 90. 02 09002 WOUND CARE CENTER 320 0 90. 02 90. 03 09003 PAIN CLINIC 0 0 0 90. 04 09004 0B CLINIC 0 10 90. 04 90. 05 09005 0P PSYCH CLINIC 0 0 0 90. 06 09006 MULTI SPECIALTY CLINIC 0 5 90. 06 91. 00 09100 EMERGENCY 0 12 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 1 92. 00 92. 01 09202 0BSERVATION BEDS (DISTINCT PART) 0 4 92. 01 074. 00 09400 HOME PROGRAM DIALYSIS 0 0 95. 00 09500 AMBULANCE SERVICES 0 200. 00 Subtotal (see instructions) 1, 269 18, 364 201. 00 Charges 0 0 001 90. 01 0 001 90. 02 0 002 003 004 005 005 005 005 003 005 005 005 005 005 004 006 007	90, 00 09000 CLINIC	526	94		90.00
90. 02 09002 09002 09003 PAIN CLINIC 0 0 0 0 90. 03 90. 04 09004 08 CLINIC 0 0 0 0 0 0 0 0 0					
90. 03		1			
90. 04 09004 0B CLINIC 0 10 90. 04 90. 05 9005 0P PSYCH CLINIC 0 0 0 0 90. 05 90. 06 90. 0					
90. 05 09005 0P PSYCH CLINIC 0 0 0 0 0 0 0 0 0		0	0		90. 03
90. 06 09006 MULTI SPECIALTY CLINIC 0 5 90. 06 91. 00 09100 EMERGENCY 0 12 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 1 92. 00 92. 01 O9202 OBSERVATI ON BEDS (DISTINCT PART) 0 4 92. 01 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSI S 0 0 95. 00 09500 AMBULANCE SERVICES 0 200. 00 Subtotal (see instructions) 1, 269 18, 364 201. 00 Cless PBP Clinic Lab. Services-Program 0 Only Charges	90. 04 09004 0B CLINIC	o	10		90. 04
90. 06 09006 MULTI SPECIALTY CLINIC 0 5 90. 06 91. 00 09100 EMERGENCY 0 12 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 1 92. 00 92. 01 O9202 OBSERVATI ON BEDS (DISTINCT PART) 0 4 92. 01 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSI S 0 0 95. 00 09500 AMBULANCE SERVICES 0 200. 00 Subtotal (see instructions) 1, 269 18, 364 201. 00 Less PBP Clinic Lab. Services-Program 0 Only Charges	90 05 09005 OP PSYCH CLINIC	ام	ol		90.05
91. 00 09100 EMERGENCY 0 12 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 1 92. 00 09202 OBSERVATI ON BEDS (DISTINCT PART) 0 4 92. 01 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 94. 00 09500 AMBULANCE SERVICES 0 95. 00 00 Subtotal (see instructions) 1, 269 18, 364 200. 00 201. 00 Only Charges 0 Only Charges		ام			
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 1 92. 00 09202 0BSERVATI ON BEDS (DISTINCT PART) 0 4 92. 01 07HER REIMBURSABLE COST CENTERS 94. 00 09500 AMBULANCE SERVICES 0 95. 00 09500 AMBULANCE SERVICES 0 95. 00 0 0 0 0 0 0 0 0 0		0			•
92. 01 09202 OBSERVATION BEDS (DISTINCT PART) 0 4 92. 01	1	O O			•
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O	92.00 09200 OBSERVATION BEDS (NON-DISTINCT P.	ART) O	1		92. 00
OTHER REIMBURSABLE COST CENTERS 94.00 95	92.01 09202 OBSERVATION BEDS (DISTINCT PART)	O	4		92. 01
94. 00			- '		
95. 00		ما	0		04.00
200.00 Subtotal (see instructions) 1,269 18,364 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00	1	ا ا	Ч		•
201.00 Less PBP Ĉlinic Lab. Servićes-Program 0 0 201.00	1	0			•
Only Charges	200.00 Subtotal (see instructions)	1, 269	18, 364		200. 00
Only Charges	201.00 Less PBP Clinic Lab. Services-Pr	ogram O			201. 00
202.00		1 269	18 364		202 00
		, , , , , , , , , , , , , , , , , , , ,	. 5, 55 .		1232.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA		NGTON HOSPITAL		III LI C	u of Form CMS-2	2002-10
	PITAL COSTS	Provider Co		Period: From 01/01/2023 To 12/31/2023		pared: 3 pm
			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	9, 390, 730	0	9, 390, 73	0 49, 072	191. 37	30.00
31.00 INTENSIVE CARE UNIT	899, 253		899, 25	3 4, 747	189. 44	31. 00
32.00 CORONARY CARE UNIT	0			0	0.00	32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	727, 797		727, 79	7 3, 576	203. 52	35. 00
42. 00 SUBPROVI DER	0	0		0	0.00	42.00
43. 00 NURSERY	337, 448		337, 44	2, 944	114. 62	43.00
200.00 Total (lines 30 through 199)	11, 355, 228		11, 355, 22	8 60, 339		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 455	278, 443				30.00
31.00 INTENSIVE CARE UNIT	169	32, 015				31. 00
32.00 CORONARY CARE UNIT	0	0				32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	372	75, 709				35. 00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	1, 499	171, 815				43.00
200.00 Total (lines 30 through 199)	3, 495	557, 982				200. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	narod:
				10 12/31/2023	5/29/2024 1:5	pareu. 3 pm
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		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)					
ANOLILIA DIVI OFFICIA CONT. OFFITEDO	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	2 (40 707	215 540 720	0.0115/	1 0// 504	10 222	F0 00
50. 00	3, 648, 707	315, 540, 720			12, 333	50.00
50. 01 05001 CV SURGERY	1 072 4/1	1	0.00000		0	50. 01
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 972, 461	56, 662, 722			2, 480	51. 00 52. 00
53. 00 05200 DELI VERY ROOM & LABUR ROOM 53. 00 05300 ANESTHESI OLOGY	1, 176, 405 0			· ·	11, 171 0	52.00
54. 00 05400 RADI OLOGY	_		0. 00000 0. 01674			54. 00
55. 00 05500 RADI OLOGY - DI AGNOSTI C	782, 907				4, 601 110	55.00
56. 00 05600 RADI 0LOGY - THERAPEUTI C	1, 134, 479		0.00000		0	56. 00
57. 00 05700 CT SCAN	217, 190	1			1, 197	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	286, 694				1, 177	58.00
59. 00 05900 CARDIAC CATHETERIZATION	1, 630, 436				6, 395	59.00
60. 00 06000 LABORATORY	896, 436				8, 036	60.00
64. 00 06400 NTRAVENOUS THERAPY	070, 430	147, 700, 049	0.00000		0, 030	64. 00
65. 00 06500 RESPIRATORY THERAPY	74, 329	20, 495, 011	0.00362		2, 312	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 355, 724			· ·	8, 370	66.00
69. 00 06900 ELECTROCARDI OLOGY	255, 791	41, 109, 770		· ·	1, 524	69. 00
70. 00 07000 ELECTROCARD OLOGT	113, 499				215	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	189, 453				914	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	300, 304			· ·	1, 386	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	596, 908				4, 207	73. 00
73. 01 07302 OP PHARMACY	182, 007		0. 03209		0	73. 01
74. 00 07400 RENAL DI ALYSI S	166, 750				5, 441	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	7, 889				1	76. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		1		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 010, 042				72	90. 00
90.01 09001 OP ONCOLOGY INFUSION CENTER	1, 570, 528	55, 694, 258	0. 02819	9 111, 927	3, 156	90. 01
90. 02 09002 WOUND CARE CENTER	250, 717		0. 03173		0	90. 02
90. 03 09003 PAIN CLINIC	171, 475				0	90. 03
90. 04 09004 0B CLINIC	1, 700, 643				74	90. 04
90. 05 09005 OP PSYCH CLINIC	659, 285				0	90. 05
90.06 09006 MULTI SPECIALTY CLINIC	38, 513				13	90. 06
91. 00 09100 EMERGENCY	2, 098, 173				10, 087	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	471, 530				470	92. 00
92. 01 09202 OBSERVATI ON BEDS (DI STI NCT PART)	775, 240	26, 467, 245	0. 02929	1 3, 948	116	92. 01
OTHER REIMBURSABLE COST CENTERS			0.00000			04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000		0	94.00
95.00 09500 AMBULANCE SERVICES 200.00 Total (Lines 50 through 199)	22 724 515	2, 055, 169, 511		10, 423, 942	85, 860	95. 00
200.00 Total (Titles 50 till ough 199)	23, /34, 515	Z, USS, 109, 511	I	10, 423, 942	აა, 800	200.00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Li∈	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER			CN: 15-0051	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III	pared:
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	0	0		0 0	0 0	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 42. 00 04200 SUBPROVI DER	0	0		0 0	0	35. 00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0		0 0		43. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	0	0	49, 07 4, 74		169	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 42. 00 04200 SUBPROVI DER	0	0	3, 57		372	35. 00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)		0	2, 94 60, 33			43. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					

30.00

31. 00 32. 00 35. 00 42. 00

43. 00 200. 00

MCRI F32 - 22. 2. 178. 3

30. 00 03000 ADULTS & PEDIATRICS
31. 00 03100 INTENSIVE CARE UNIT
32. 00 03200 CORONARY CARE UNIT
35. 00 02060 NEONATAL INTENSIVE CARE UNIT
42. 00 04200 SUBPROVIDER

43. 00 | 04300 | NURSERY | Total (lines 30 through 199)

| Period: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time | Prepared: Provider CCN: 15-0051 THROUGH COSTS

Timodon ood					To 12/31/2023	Date/Time Pre 5/29/2024 1:5	
			Ti tI	e XIX	Hospi tal	PPS	о рііі
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	LARV OFRIGO SOCT OFFITTING	1.00	2A	2. 00	3A	3. 00	
	LARY SERVICE COST CENTERS						F0 00
	OPERATING ROOM	0	0	2	0	0	
	CV SURGERY	0	0)	0 0	0	50. 01
	RECOVERY ROOM	0	0	2	0	0	51.00
	D DELIVERY ROOM & LABOR ROOM	0	0	2	0	0	52.00
	ANESTHESI OLOGY	0			0	0	53.00
	RADI OLOGY - DI AGNOSTI C	0		(0	0	54.00
	RADI OLOGY-THERAPEUTI C	0		(0	0	55. 00
	RADI OI SOTOPE CT SCAN	0		(0	0	56.00
		0		1	0 0	0	57. 00
	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0		1	0 0	0	58. 00 59. 00
	LABORATORY	0		1	0	0	60.00
	INTRAVENOUS THERAPY	0		1	0 0	0	64.00
	RESPIRATORY THERAPY	0		•		0	65.00
	PHYSI CAL THERAPY	0		1	0 0	0	66.00
	ELECTROCARDI OLOGY	0		1		0	69.00
	D ELECTROCARDI OLOGI D ELECTROENCEPHALOGRAPHY	0		1		0	1
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	0		1		0	
	D DRUGS CHARGED TO PATTENTS	0				783, 632	
	OP PHARMACY	0		1		0 703,032	73. 00
	RENAL DIALYSIS	0				0	1
	CARDI AC REHABI LI TATI ON	0				0	76. 97
	ALLOGENEIC STEM CELL ACQUISITION	0		1	0 0	0	1
	CAR T-CELL IMMUNOTHERAPY	0	Ö	1	0 0	Ö	78. 00
	ATIENT SERVICE COST CENTERS			1	<u> </u>		70.00
	CLINIC	0	C)	0 0	0	90. 00
90. 01 0900	OP ONCOLOGY INFUSION CENTER	0	Ó		0 0	0	90. 01
	WOUND CARE CENTER	0	O		0 0	0	90. 02
90. 03 09003	PAIN CLINIC	0	o		0 0	0	90. 03
90. 04 09004	OB CLINIC	0	o		0 0	0	90. 04
90. 05 09005	OP PSYCH CLINIC	0	o		0 0	0	90. 05
90.06 09006	MULTI SPECIALTY CLINIC	0	o		0 0	0	90.06
	EMERGENCY	0	o		0 0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
92. 01 09202	OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92. 01
OTHER	R REIMBURSABLE COST CENTERS						
94. 00 09400	HOME PROGRAM DIALYSIS	0	C		0 0	0	94. 00
	AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50 through 199)	0	0)	0 0	783, 632	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 THROUGH COSTS Part IV Date/Time Prepared: 5/29/2024 1:53 pm Title XIX Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 8) 4) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 315, 540, 720 0.000000 50.00 50.01 05001 CV SURGERY 0 0 0 0.000000 50.01 51.00 05100 RECOVERY ROOM 00000000000000000000000 0 0 56, 662, 722 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 38, 335, 678 0.000000 52 00 52 00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 46, 743, 885 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 129, 144, 100 0.000000 55 00 0 56.00 05600 RADI OI SOTOPE 0 0.000000 56.00 57.00 05700 CT SCAN 46, 151, 438 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 14, 193, 148 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0 103, 230, 438 0.000000 59 00 59 00 60.00 06000 LABORATORY 147, 708, 049 0.000000 60.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 20, 495, 011 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY O Ω 31, 423, 703 0.000000 66 00 69.00 06900 ELECTROCARDI OLOGY 0 0 41, 109, 770 0.000000 69.00 0.000000 07000 ELECTROENCEPHALOGRAPHY 7, 229, 466 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 102, 395, 709 0.000000 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 196, 446, 230 72 00 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 783, 632 783, 632 355, 192, 809 0.002206 73.00 07302 OP PHARMACY 5, 671, 191 73.01 0 0.000000 73.01 07400 RENAL DIALYSIS 6, 524, 359 74.00 0 0.000000 74.00 0 07697 CARDIAC REHABILITATION 0 4, 103, 355 76.97 Ω 0.000000 76.97 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0.000000 77.00 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 1, 456, 643 0.000000 90.00 0.000000 09001 OP ONCOLOGY INFUSION CENTER 55, 694, 258 90.01 0 0 0 90.01 90.02 09002 WOUND CARE CENTER 0 0 7, 900, 181 0.000000 90.02 09003 PAIN CLINIC 0 5, 065, 502 90 03 0 0.000000 90.03 90.04 09004 OB CLINIC 3, 037, 108 0.000000 90.04 09005 OP PSYCH CLINIC 90. 05 0 0 0 0 5, 692, 838 0.000000 90.05 09006 MULTI SPECIALTY CLINIC 0 4, 801, 155 90.06 0.000000 90.06 0 0 91.00 09100 EMERGENCY 0 260, 620, 713 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 16, 132, 087 0.000000 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 26, 467, 245 0.000000 92.01 92.01 OTHER REIMBURSABLE COST CENTERS

0

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Ω

783, 632

0

783, 632 2, 055, 169, 511

0.000000

94.00

95.00

200. 00

94.00

200.00

09400 HOME PROGRAM DIALYSIS

Total (lines 50 through 199)

95. 00 09500 AMBULANCE SERVICES

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared:
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

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

					To 12/31/2023	Date/Time Prep 5/29/2024 1:5:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11. 00	12.00	13.00	
ANG	CILLARY SERVICE COST CENTERS						
50.00 050	000 OPERATING ROOM	0. 000000	1, 066, 594		0	0	50. 00
50. 01 050	001 CV SURGERY	0. 000000	0		0	0	50. 01
51.00 05	100 RECOVERY ROOM	0. 000000	71, 228		0 0	0	51.00
52.00 05:	200 DELIVERY ROOM & LABOR ROOM	0. 000000	364, 040		0 0	0	52.00
53.00 05	300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0. 000000	274, 723		0 0	0	54.00
55. 00 05!	500 RADI OLOGY-THERAPEUTI C	0. 000000	12, 466		0 0	0	55. 00
56.00 050	600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00 05	700 CT SCAN	0. 000000	254, 417		0 0	0	57. 00
58.00 058	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	58, 353		0 0	0	58. 00
59.00 059	900 CARDI AC CATHETERI ZATI ON	0. 000000	404, 892		0 0	0	59. 00
60.00 060	000 LABORATORY	0. 000000	1, 324, 131		0 0	0	60.00
64. 00 064	400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65. 00 06!	500 RESPI RATORY THERAPY	0. 000000	637, 468		0 0	0	65. 00
66.00 066	600 PHYSI CAL THERAPY	0. 000000	194, 001		0 0	0	66. 00
69. 00 069	900 ELECTROCARDI OLOGY	0. 000000	244, 933		0 0	0	69. 00
70.00 070	000 ELECTROENCEPHALOGRAPHY	0. 000000	13, 668		0 0	0	70. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	493, 872		0 0	0	71. 00
72. 00 07:	200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	906, 295		0 0	0	72. 00
73. 00 07:	300 DRUGS CHARGED TO PATIENTS	0. 002206	2, 502, 889	5, 52	1 0	0	73. 00
	302 OP PHARMACY	0. 000000	0		0 0	0	73. 01
74. 00 074	400 RENAL DIALYSIS	0. 000000	212, 892		0 0	0	74. 00
76. 97 076	697 CARDI AC REHABI LI TATI ON	0. 000000	372		0 0	0	76. 97
77. 00 07	700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77. 00
1	800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OU	TPATIENT SERVICE COST CENTERS	<u>'</u>			*		
90.00 090	000 CLI NI C	0. 000000	104		0 0	0	90. 00
90. 01 090	001 OP ONCOLOGY INFUSION CENTER	0. 000000	111, 927		0 0	0	90. 01
90. 02 090	002 WOUND CARE CENTER	0. 000000	0		0 0	0	90. 02
90. 03 090	003 PAIN CLINIC	0. 000000	0		0 0	0	90. 03
90. 04 090	004 OB CLINIC	0. 000000	133		0 0	0	90. 04
90. 05 090	005 OP PSYCH CLINIC	0. 000000	0		0 0	0	90. 05
90.06 090	006 MULTI SPECIALTY CLINIC	0. 000000	1, 682		0 0	0	90. 06
91. 00 09	100 EMERGENCY	0. 000000	1, 252, 840		0 0	0	91. 00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	16, 074		0 0	0	92.00
92. 01 09:	202 OBSERVATION BEDS (DISTINCT PART)	0. 000000	3, 948		0 0	0	92. 01
	HER REIMBURSABLE COST CENTERS			•	•		
94. 00 094	400 HOME PROGRAM DIALYSIS	0.000000	0		0 0	0	94. 00
95. 00 09!	500 AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50 through 199)		10, 423, 942	5, 52	1 0	0	200. 00
		·					

	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		Provi der Co		Peri od:	Worksheet D	
						From 01/01/2023 To 12/31/2023	Part V Date/Time Pre 5/29/2024 1:5	pared:
				Ti +1	e XIX	Hospi tal	5/29/2024 1: 5 PPS	3 pm
				11 (1	Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge	PPS	Rei mbursed		Cost	PPS Services	
	5051 50Htol 505011 pt 10H	Ratio From		vices (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,		inst.)	Servi ces	Services Not	(, , , , , , , , , , , , , , , , , , ,	
		Part I, col. 9		Í	Subject To	Subject To		
					Ded. & Coins.	Ded. & Coins.		
					(see inst.)	(see inst.)		
	TANGLEL ADV. OFDVI OF COOT OFNITTED	1. 00		2. 00	3. 00	4. 00	5. 00	
50. 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	0. 122110			1 000 70	5 0	0	50. 00
50. 00	05001 CV SURGERY	0. 000000		0	,	0 0		50.00
51. 00	05100 RECOVERY ROOM	0. 244765		0	340, 45	-		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 238414		0	6, 17		0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000		0	0, 17	0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 192775		0	480, 26	-	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 172773		0	1, 410, 40		0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	1	0	1, 410, 40	0 0	o n	56. 00
57. 00	05700 CT SCAN	0. 083079		0	440, 97	-	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 162999		0	91, 45		-	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 074152		0	325, 69		0	59. 00
60.00	06000 LABORATORY	0. 168224		0	1, 101, 11		o o	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000		0	, , ,	o	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 296734		0	91, 90	4 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 432236		0	656, 91	7 0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 074104	ı	0	219, 20	5 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 137102		0	111, 87	4 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 181470		0	387, 03	6 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 149151		0	949, 44		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 176286		0	3, 020, 01	6 0	0	73. 00
73. 01	07302 OP PHARMACY	1. 295222		0		0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0. 368976		0	76, 07		0	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 220343		0	44, 84		0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000		0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000)	0		0 0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS	2 (02224	1		11 02	4 0	0	00.00
90. 00 90. 01	O9000 CLINIC O9001 OP ONCOLOGY INFUSION CENTER	2. 602234 0. 220299		0	11, 82 675, 52			90. 00 90. 01
90.01	09002 WOUND CARE CENTER	0. 223931		0	89, 43			90.01
90. 02	09003 PAIN CLINIC	0. 342686		0	40, 34		0	90.02
90. 03	09004 0B CLINIC	2. 565072		0	17, 32		0	90.03
90. 05	09005 OP PSYCH CLINIC	0. 506072		0	35, 53		0	90.04
90. 06	09006 MULTI SPECIALTY CLINIC	0. 878268		0	71, 23		0	90.06
91. 00	09100 EMERGENCY	0. 116037	1	0	4, 103, 03		0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 256220	1	0	572, 82		Ö	1
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0. 349543		0	625, 37			92. 01
	OTHER REIMBURSABLE COST CENTERS					=1		
94.00	09400 HOME PROGRAM DI ALYSIS	0. 000000				0 0		94. 00
95.00	09500 AMBULANCE SERVI CES	0. 000000		0		o		95. 00
200.00	Subtotal (see instructions)			0	17, 979, 07	8 0	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)			0	17, 979, 07	8 0	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2023 | Part V | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 | 1:53 pm | Heal th FinancialSystemsI U HEALTH BLOOMAPPORTIONMENT OFMEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0051

				5/29/2024 1:53 pm
		Title XIX	Hospi tal	PPS
	Cos	sts		
Cost Center Description	Cost	Cost		
	Rei mbursed	Rei mbursed		
	Servi ces	Servi ces Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
	6.00	7.00		
ANCILLARY CERVICE COCT CENTERS	0.00	7.00		
ANCI LLARY SERVI CE COST CENTERS	0.40 4.40			
50. 00 05000 OPERATI NG ROOM	242, 118	0		50. 0
50. 01 05001 CV SURGERY	0	0		50. 0
51.00 05100 RECOVERY ROOM	83, 331	0		51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 473	0		52.0
53. 00 05300 ANESTHESI OLOGY	0	0		53. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	92, 582	o		54. 0
55. 00 05500 RADI OLOGY-THERAPEUTI C	80, 564	0		55. 0
56. 00 05600 RADI 0I SOTOPE	0	ol		56. 0
57. 00 05700 CT SCAN	36, 635	o o		57. 0
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	14, 907	Ö		58. 0
		o o		
59. 00 05900 CARDI AC CATHETERI ZATI ON	24, 151			59. 0
60. 00 06000 LABORATORY	185, 234	0		60. 0
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64. 0
65. 00 06500 RESPIRATORY THERAPY	27, 271	0		65. 0
66. 00 06600 PHYSI CAL THERAPY	283, 943	0		66. 0
69. 00 06900 ELECTROCARDI OLOGY	16, 244	O		69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY	15, 338	o		70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	70, 235	ol		71. 0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	141, 611	ol		72. 0
73. 00 07300 DRUGS CHARGED TO PATIENTS	532, 387	o o		73. 0
73. 01 07302 OP PHARMACY	0	o o		73. 0
		o o		74. 0
	28, 071			
76. 97 07697 CARDI AC REHABI LI TATI ON	9, 880	0		76. 9
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77. 0
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 0
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	30, 769	0		90.0
90. 01 09001 OP ONCOLOGY INFUSION CENTER	148, 817	0		90. 0
90. 02 09002 WOUND CARE CENTER	20, 026	o		90. 0
90. 03 09003 PAIN CLINIC	13, 826	ol		90. 0
90. 04 09004 0B CLINIC	44, 427	ol		90. 0
90. 05 09005 OP PSYCH CLINIC	17, 985	o o		90. 0
		o o		90.0
	62, 560			
91. 00 09100 EMERGENCY	476, 104	0		91. 0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	146, 769	0		92. 0
92.01 09202 OBSERVATION BEDS (DISTINCT PART)	218, 594	0		92. 0
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 0
95. 00 09500 AMBULANCE SERVICES	0			95. 0
200.00 Subtotal (see instructions)	3, 065, 852	o		200. 0
201.00 Less PBP Clinic Lab. Services-Program	0			201. 0
Only Charges				[231.0
202.00 Net Charges (line 200 - line 201)	3, 065, 852	o		202. 0
	3,000,002	ا		1232. 0

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/29/2024 1:5	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1 00	

		T: +1 o W// 1 1	Heeni tel	5/29/2024 1: 5 PPS	3 pm
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	oost ochter beschiptron			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			49, 072 49, 072	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-le Private room days (excluding swing-bed and observation bed day		ivato room dave	49,072	2. 00 3. 00
3.00	do not complete this line.	ys). It you have only pr	i vate i ooiii days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		46, 608	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n daya) through Dagambar	21 of the cost	0	7 00
7. 00	reporting period	ii days) through beceiliber	31 Of the Cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	m davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	,			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	14, 853	9. 00
	newborn days) (see instructions)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		dom days) arter		11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period		-		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	1
	SWI NG BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	s through becember 31 or	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			82, 318, 100	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	a period (line 6	0	23. 00
20.00	x line 18)	or or the dost roper tri	g period (iiie o	· ·	20.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		82, 318, 100	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIII III 20)		02, 010, 100	27.00
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
	Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus lina 33)(saa instruc	tions)	0. 00 0. 00	ı
35. 00	Average per diem private room cost differential (line 34 x lin		ti ons)	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 a	and private room cost di	fferential (line	82, 318, 100	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTHENTO.			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 (77 50	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 677. 50 24, 915, 908	1
40. 00	Medically necessary private room cost applicable to the Progra	•		24, 915, 908	40.00
	Total Program general inpatient routine service cost (line 39	•		24, 915, 908	1
	1	,_,		, , , ,	

Intensive Care Type Input ent. Hospital Unit 5 11.744,678 4.747 2.474,111 1.439 3.560,244 44.00 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 44.40 0 0 0 0 0 0 0 0 0		Financial Systems II ATION OF INPATIENT OPERATING COST	U HEALTH BLOOMI	Provi der C		Peri od:	worksheet D-1	
Cost Center Description							Date/Time Pre	
Impact ent Local June Col. 1		Cook Contain D					1	
42 00		Cost Center Description						
1.00 2.00 3.00 4.00 5.00 0.00			Impatrent cost	impatrent bays		Ŧ		
Titleries for Care Type Inpatient, Hospitul Unit 12 11,744,578 4,747 2,474.11 1,459 3,560,244 44 400 (MRDMARY CARE UNIT			1.00	2.00		4. 00		
	42. 00			O	0.	00 0	0	42. 00
44.00 CREATER VARIES WIT							0.5/0.0//	
45.00 DIRRO INTENSIVE CARE UNIT			11, /44, 5/8					
46.00 SMRCICAL INTERSIVE CARE INUIT			٩	U	0.	00	0	44. 00 45. 00
## ROMATAL INTERSIVE CARE UNIT 6.978, 410 3.576 1.951.66 0 47 ## ROMATAL INTERSIVE CARE UNIT 1.00 27 ## ROMATAL INTERSIVE CARE UNIT 1.00								46. 00
48. 00 Program Inpatient and Illary service cost (WKSt. D.3. col. 3, Iline 200) Program Inpatient cell ullar therapy acquisition cost (Worksheet D-6, Part III, Iline 10, column 1) 9. 07 Total Program Inpatient costs (wan of Ilines 31 through 48.01)(see instructions) 9. 08. 10 Total Program Inpatient costs (wan of Ilines 31 through 48.01)(see instructions) 9. 09. 10 Total Program inpatient costs (wan of Ilines 31 through 48.01)(see instructions) 9. 10 Pass through costs applicable to Program Inpatient routine services (from Wkst. D. sum of Parts I and 3, 115, 023 soliday) 9. 10 Total Program excludable cost (sum of Ilines 50 and 51) 9. 10 Total Program excludable cost (sum of Ilines 50 and 51) 9. 10 Total Program excludable cost (sum of Ilines 50 and 51) 9. 10 Total Program excludable cost (sum of Ilines 50 and 51) 9. 10 Total Program excludable cost (sum of Ilines 50 and 51) 9. 10 Total Program excludable cost (sum of Ilines 50 and 51) 9. 10 Total Program inpatient operating cost excluding capital related, non-physician amesthetist, and 51,724,776 9. 10 Total Program inpatient operating cost excluding capital related, non-physician amesthetist, and 51,724,776 9. 10 Total Program inpatient amount per discharge (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 190) 9. 10 Program of Ischarges (sum of Iline 50 and 1			6, 978, 410	3, 576	1, 951.	46 0	0	47. 00
### 18.00 Program inpatient ancil lary service cost (Whst. D-3, col. 3, line 200) 27,934,342 48 48.01 Program inpatient collium r therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 50,404,494 49 49 49 49 49 49 49		Cost Center Description						
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	10.00							40.00
75.00 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 75.00 Pass through costs applicable to Program inpatient routine services (from Wast. D. sum of Parts II and 1,1570, 695 to and 1) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 50 and 51) 75.00 Total Program excludable cost (sum of lines 1) 75.00 Total Program excludable cost (sum of lines 1) 75.00 Total Program excludable cost (sum of lines 1) 75.00 Total Program excludable cost (sum of lines 1) 75.00 Total Program excludable cost (sum of lines 1) 75.00 Total Program excludable cost (sum of lines 1) 75.00 Total Program excludable cost (sum of lines 1) 75.00 Total Program excludable cost (sum of lines 1) 75.00 Total Program excludable cost (sum of lines 55 sol on 1) 75.00 Total Program excludable cost (sum of lines 55 sol on 1) 75.00 Total Program excludable cost (sum of lines 55 sol on 1) 75.00 Total Program excludable cost (sum of lines 55 sol on 1) 75.00 Total Program excludable cost (sum of lines 55 sol on 1) 75.00 Total Program excludable cost (sum of lines 55 sol on 1) 75.00 Total Modern from the program (sol on 1) 75.00 Total Program excludable cost (sol on 1) 75.00 Total Program (sol on 1) 75.00 Total					III lina 10	column 1)	27, 934, 342	1
PASS IHROGEN LOST ADJUSTMENTS 10 08 Past through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II and 3.115,023 50 11) 11 08 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 1,570,695 51 11) 12 08 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 1,570,695 51 11) 13 08 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 1,570,695 51 11) 14 09 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 51,724,776 52 140 Program inpatient on costs (fine 49 minus line 52) 14 09 Program discharges 15 00 Program discharges 15 01 Program adventures (ischarge (contractor use only) 15 02 Adjustment amount per discharge (contractor use only) 15 03 Program adventure in discharge (contractor use only) 15 04 Dischard amount (ine 54 sum of lines 55,501, and 55,02) 16 05 Program and ischarges 16 06 Program and ischarges 17 10 Program discharges 18 08 Bouss payment (see instructions) 18 08 Bouss payment (see instructions) 18 09 Bouss payment (see instructions) 19 00 Program and ischarge (contractor use only) 10 00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report; updated by the arket basket) 10 00 Continuous Impresent bouse payment (r line 33 + line 54 is less than the lowest of lines 55 gius continuous Impresent bouse payment (r line 33 + line 54 is less than the lowest of lines 55 gius continuous Impresent bouse payment (r line 33 + line 54 is less than the lowest of lines 55 gius continuous Impresent lowes instructions) 10 08 Program and lines instructions 10 09 Program and lines payment (see instructions) 10 09 Program and lines payment (see ins						, corumn r)	56 410 494	48. 01
9.0.00 Pass through costs applicable to Program inpatient routine services (From West. D. sum of Parts I and 11, 15, 023 50 111) 11.00 Pass through costs applicable to Program inpatient ancillary services (From West. D. sum of Parts II 1, 1570, 695 51 110) 15.00 Total Program excludable cost (sum of lines 50 and 51) 15.01 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 15, 724, 776 53 110, 12	+7.00		+1 till odgir +0. 0	1) (300 111311 40			30, 410, 474	47.00
1.570,695 51 Pars through costs applicable to Program inpatient ancillary services (from Wisst. D. sum of Parts II 1.570,695 51 and IV) 4.685,718 52 53 10 Total Program excludable cost (sum of lines 50 and 51) 4.685,718 52 53 10 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (file 40 minus line 52) 5.724,776 5.	50. 00		atient routine	services (from	ı Wkst. D, su	m of Parts I and	3, 115, 023	50.00
19.00 Total Program excludable cost (sum of lines 50 and 51) 10.10 10.		*						
Total Program excludable cost (sum of lines 50 and 51) 5.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) FIREFORMADIAT AMD LINET COMPUTATION 5.00 Program discharges 5.01 Tagest amount per discharge 5.02 Adjustment amount per discharge 5.03 Adjustment amount per discharge (contractor use only) 5.04 Adjustment amount per discharge (contractor use only) 5.05 Adjustment amount per discharge (contractor use only) 6.06 Target amount (line 54 xum of lines 55, 55.01, and 55.02) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 1996, updated and compounded by the merets basket) 7.00 Difference between adjusted in patient operating cost and target amount (line 56 minus line 1990, updated and compounded by the merets basket) 7.00 Difference between adjusted to perating cost and t	51. 00		atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	1, 570, 695	51.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (Irine 49 minus Irine 52) FARKET AMOUNT AND LINIT COMPUTATION 54.00 Program discharges 55.01 Permanent adjustment amount per discharge 55.02 Adjustment amount per discharge (contractor use only) 55.02 Adjustment amount per discharge (contractor use only) 56.02 Adjustment amount per discharge (contractor use only) 57.00 Effective on the stem education of the stem	52 00		50 and 51)				/ AQE 710	52 00
medical education costs (tine 49" minus line 52)		•	,	lated non-phy	sician anestl	hetist and		1
55.00 Program discharges 0.05	00.00			. a tou, p		notrot, and	01,721,770	00.00
1			,					
Permanent adjustment amount per discharge 0.00 55.02 Adjustment amount per discharge (contractor use only) 0.00 55.02 Adjustment amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 59.00 0.		3						54.00
55.02 Adjustment amount per discharge (contractor use only) 0.00 55.00 Terest amount (line 54 x sum of lines 55, 55.01 and 55.02) 0.56								
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PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 ÷ line 2) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 01 O Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost per diem limitation 83. 00 Reasonable inpatient routine service (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	69. 00		routine costs (line 67 + line	: 68)		0	69. 00
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72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.10 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 73 74 75 76 77 78 79 79 70 70 72 74 74 75 74 75 74 75 76 77 78 78 79 79 79 79 79 80 80 81 82 83 84 85 86 87 87 87 87 87 87 87 88 88		9 9	-		•)		70. 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70 Total Program inpatient operating costs (sum of lines 83 through 85) 86 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 88.00 Total observation bed days (see instructions) 89.00 Total observation bed days (see instructions)		,		ine 70 ÷ line	2)			71.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 2, 464 87		•		(line 1/ v li	ne 35)			72.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Total Program inpatient ancillary services (see instructions) 84.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 2, 464 87								74.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 76.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77.00 Total observation bed days (see instructions) 78.00 Total observation bed days (see instructions) 79.00 Total observation bed days (see instructions)		3 3 1	•	,		Part II, column		75. 00
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2, 464 87		26, line 45)		·				
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2, 464 87			. *					76. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2,464 87								77.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2, 464 87		•		rovi der record	le)			78. 00 79. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 7.00 Total observation bed days (see instructions) 2,464 87			, ,		*	nus line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 83.84 84.00 Program inpatient routine service costs (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		· ·			-	,		81. 00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 84.85 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.86 88.86		Inpatient routine service cost limitation (I	ine 9 x line 81	•				82. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2,464 87		·		s)				83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Total observation bed days (see instructions)				nc)				84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2,464 87		. , , .	•	•				85. 00 86. 00
87.00 Total observation bed days (see instructions) 2,464 87				. 54gii 65 <i>j</i>			1	1 30.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		Total observation bed days (see instructions)					1
89.00 Observation bed cost (line 87 x line 88) (see instructions) 4,133,360 89	88. 00	,	•	line 2)				1

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 1:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	9, 390, 730	82, 318, 100	0. 11407	9 4, 133, 360	471, 530	90.00
91.00 Nursing Program cost	0	82, 318, 100	0.00000	4, 133, 360	0	91.00
92.00 Allied health cost	0	82, 318, 100	0.00000	4, 133, 360	0	92.00
93.00 All other Medical Education	0	82, 318, 100	0. 000000	4, 133, 360	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0051	Peri od: From 01/01/2023	Worksheet D-1	
		To 12/31/2023	Date/Time Pre 5/29/2024 1:5	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	

		Title XIX	Hospi tal	5/29/2024 1:5 PPS	3 pm
	Cost Center Description	TI LIE XIX	nospi tai	113	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	s. excluding newborn)		49, 072	1.00
2.00	Inpatient days (including private room days, excluding swing-			49, 072	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ad days)		46, 608	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	40, 000	5. 00
	reporting period	3 /			
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December :	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
7.00	reporting period	adys) im odgii becember	01 01 110 0031	Ü	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	l of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eyeluding	swing had and	1, 455	9. 00
9.00	newborn days) (see instructions)	The Frogram (excluding	swifig-bed and	1, 455	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instructions had SNE toward instructions and instructions to the cost reporting period (see instructions to the cost reporting period (see instructions)).			0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)		,	2, 944	
16. 00	Nursery days (title V or XIX only)			1, 499	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	the cost	0.00	17. 00
17.00	reporting period	es through becember 51 0	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
17.00	reporting period	s through becember 31 or	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00
21 00	reporting period	-)		02 210 100	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		na period (line	82, 318, 100 0	1
	5 x line 17)		9		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	- 31 of the cost reportion	na period (line	0	24. 00
24.00	7 x line 19)	or the cost reporting	ig perrod (Trile	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		82, 318, 100	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	1
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)	==,		0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		tions)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	IC 31)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	82, 318, 100	•
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 677. 50	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 440, 763	1
40.00	Medically necessary private room cost applicable to the Progra	,		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 40)		2, 440, 763	41.00

Hoal th	Financial Systems	U HEALTH BLOOMING	TON HOSDITAL		In Lie	eu of Form CMS-2	2552 10
	Financial Systems I ATION OF INPATIENT OPERATING COST	U HEALTH BLOOMING	Provider CCN: 1	15-0051	Peri od:	Worksheet D-1	2552-10
00 0.	AND SI THE SITE OF ENVIRONMENT SEED.				From 01/01/2023		
					To 12/31/2023	Date/Time Prep 5/29/2024 1:53	
			Title XI		Hospi tal	PPS	
	Cost Center Description	Total	Total Av pati ent Days Di er	verage Per	Program Days	Program Cost (col. 3 x col.	
		Impatrent costini		col. 2)	-	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	2, 304, 628	2, 944	782. 8	1, 499	1, 173, 447	42.00
43. 00	INTENSIVE CARE UNIT	11, 744, 578	4, 747	2, 474. 1	1 169	418, 125	43.00
44.00	CORONARY CARE UNIT	0	0	0.0	00 0	0	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	6, 978, 410	3, 576	1, 951. 4	372	725, 943	46.00
17.00	Cost Center Description	0, 770, 110	0, 070	1, 701. 1	372	720, 710	17.00
10.00	10					1.00	10.00
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			line 10	column 1)	1, 786, 876 0	48. 00
49. 00	Total Program inpatient costs (sum of lines				cordiiir 1)	6, 545, 154	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from Wks	st. D, sum	of Parts I and	557, 982	50. 00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (from V	Wkst. D, s	um of Parts II	91, 381	51.00
F0 00	and IV)	FO 1 54)				/ 40 0/ 5	F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ited. non-physici	ian anesth	etist, and	649, 363 5, 895, 791	
55.50	medical education costs (line 49 minus line	9 1				3, 3, 3, 7, 71	33.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					l .	54. 00 55. 00
55. 01	Permanent adjustment amount per discharge					l .	55. 01
55. 02	Adjustment amount per discharge (contractor						55. 02
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		et amount (line	56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ring cost and targ	jet allourit (Trile	50 IIII IIUS	111le 53)	0	1
59.00	Trended costs (lesser of line 53 ÷ line 54,		he cost reportir	ng period	endi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		prior year cost	roport u	indated by the	0.00	60.00
00.00	market basket)	or true 55 from	piroi yeai cost	report, u	puated by the	0.00	00.00
61. 00	Continuous improvement bonus payment (if lin					0	61. 00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	. 00), 01 1 % 01 1	ine target amount	(11110 00	y, otherwise		
62.00	Relief payment (see instructions)		.:>			0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see mstruct	.1 0115)			. 0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the cos	st reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only)	ts often December	21 of the cost	roportina	pariod (Sac		45 00
65.00	<pre>Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	its after becember	31 Of the Cost	reporting	perrou (see	ا	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65)(1	title XVII	I only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	ne costs through Γ	Accembar 31 of th	na cost ra	norting period	o	67. 00
67.00	(line 12 x line 19)	le costs till ough L	ecember 31 of th	ie cost re	por tring perrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of the	cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 68)		ol	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N					_	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	•		(line 37)			70. 00 71. 00
71.00	Program routine service cost (line 9 x line		ie 70 ÷ TTNe 2)				72.00
	Medically necessary private room cost applic	able to Program (35)			73. 00
74.00	Total Program general inpatient routine serv	•		ahaa+ D. D	lowt II oolumn		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	COSTS (Trom Works	sneet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	•					76. 00
77.00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	ovi der records)				78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the cos	· .	ine 78 min	us line 79)		80. 00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
05 00	Utilization review - physician compensation						85.00
85.00	Total Program inpatient operating costs (sum	i ui iines 83 t n ro	uull 00)			i	86. 00
86. 00		S THROUGH COST	J /				
86. 00 87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions	5)	· ·			2, 464	
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS	diem (line 27 ÷ l	· ·			2, 464 1, 677. 50 4, 133, 360	88. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 1:53	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	9, 390, 730	82, 318, 100	0. 11407	9 4, 133, 360	471, 530	90.00
91.00 Nursing Program cost	0	82, 318, 100	0.00000	4, 133, 360	0	91.00
92.00 Allied health cost	0	82, 318, 100	0.00000	4, 133, 360	0	92.00
93.00 All other Medical Education	0	82, 318, 100	0. 000000	4, 133, 360	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0051	Period: Worksheet D-3

	I NPATI EI	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0051	Peri od:	Worksheet D-3	
NPATI ENT ROUTINE SERVICE COST CENTERS					From 01/01/2023 To 12/31/2023		pared:
NINATELENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00			Ti tl e	: XVIII	Hospi tal		o piii
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00		Cost Center Description					
INPATIENT ROUTINE SERVICE COST CENTERS 1,00 2,00 3,00				To Charges	9		
IMPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00					Charges		
IMPATI ENT ROUTINE SERVICE COST CENTERS \$3,566,280 30,00 310,00 3000 3000 3000 3000 3000 3000 3000 3000 3000 3100 32,00				1.00	2. 00		
31.00	I	NPATIENT ROUTINE SERVICE COST CENTERS					
32 00					53, 566, 280		
35. 00							•
42 00 04200 SURPROVI DER							•
3. 00 04300 NURSERY							•
MOCILLARY SERVICE COST CENTERS					0		
50.00 0500							43.00
				0, 1221	0 30, 099, 264	3, 675, 421	50.00
1.0 0.510 0.500				l .		0	
53.00 0S300 ANESTHESI OLOGY 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000						756, 678	51.00
SA 00 ORADIO RADIO LOGY-DIAGNOSTIC 0. 192775 5. 055, 269 976, 457 54. 00	52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 23841	4 52, 526	12, 523	52.00
55.00 05500 RADI DLOGY-THERAPEUTIC 0.05712 1, 345, 953 76, 882 55.00 65.00 65.00 056.00 056.00 056.00 056.00 056.00 056.00 056.00 056.00 056.00 056.00 056.00 056.00 050.00 05				0.00000	00		53. 00
56. 00							1
57.00 05700 CT SCAN 0.083079 5.247, 406 435, 949 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.162999 967, 716 157, 737 58.00 05900 CARDIAC CATHETERIZATION 0.074152 13, 835, 045 1, 025, 896 59.00 05900 CARDIAC CATHETERIZATION 0.074152 13, 835, 045 1, 025, 896 59.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000							1
S8. 00 05900 05900 CARDIA CC ATHETERI ZATI ON 0.162999 9.67, 71.6 157, 737 58. 00 05900 CARDIA CC ATHETERI ZATI ON 0.074152 13, 835, 045 1, 025, 896 59. 00 0.00000 0.0000000 0.000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000						-	l .
S9.00 05900 CARDIAC CATHETERIZATION 0.074152 13,835,045 1.025,896 59.00							
60.00					· ·		
64.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0.296734 4.262,758 1,264,905 65.00 66.00 06600 PHYSI CAL THERAPY 0.432236 3,584,262 1,549,247 66.00 67.00 07000 07000 ELECTROCARDI OLOGY 0.074104 6.207,892 460,030 69.00 67.00 07000 ELECTROCARDI OLOGY 0.137102 363,524 49,840 70.00 67.00 07000 ELECTROCROEPHALGGRAPHY 0.137102 363,524 49,840 70.00 67.00 07000 ELECTROCARDI OLOGY 0.137102 363,524 49,840 70.00 67.00 07000 ELECTROCROEPHALGGRAPHY 0.181470 11,408,195 2,070,245 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.181470 11,408,195 2,070,245 71.00 71.00 0700 0700 DEVERAGED TO PATI ENTS 0.149151 31,630,606 4,717,737 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.149151 31,630,606 4,717,737 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.149151 31,630,606 4,717,737 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.149151 31,630,606 4,717,737 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.149151 31,630,606 4,717,737 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.149151 31,630,606 4,717,737 72.00 73.00 07400 CARGE CHARGED TO PATI ENTS 0.149151 31,630,606 4,717,737 72.00 73.00 07400 CARGE CHARGED TO PATI ENTS 0.295222 0 0 72.00 74.00 07400 CARGE CHARGED TO PATI ENTS 0.295222 0 0 72.00 75.00 07400 CARGE CHARGED TO PATI ENTS 0.000000 0 0 77.00 75.00 07500 CARGE CHARGED TO PATI ENTS 0.000000 0 0 77.00 75.00 07000 CARGE CENTER 0.223931 3,701 829 90.00 75.00 07000 CARGE CENTER 0.22393							
65.00 06500 RESPI RATORY THERAPY 0.432236 3,584,262 1,549,905 65.00 66.00 06600 PHYSI CAL THERAPY 0.432236 3,584,262 1,549,247 66.00 66.00 06900 ELECTROCARDI OLOGY 0.074104 6,207,892 460,030 69.00 70.00 07000 ELECTROENCEPHAL GORAPHY 0.137102 363,524 49,840 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.181470 11,408,195 2,070,245 71.00 72.00 1MPL. DEV. CHARGED TO PATIENTS 0.149151 31,630,606 4,717,737 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.176286 25,700,147 4,530,576 73.00 73.01 07302 DP PHRAMCY 1.295222 0 0 7.3.01 07300 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000							•
66. 00 06600 PHYSICAL THERAPY 0. 432236 3. 584, 262 1. 549, 247 66. 00 69. 00 06900 ELECTROCARDIOLOGY 0. 074104 6. 207, 892 460, 303 69. 00 70. 00 07000 ELECTROCARDIOLOGY 0. 074104 6. 207, 892 460, 303 69. 00 70.							l
69.00 06900 ELECTROCARDI OLOGY 0.074104 6,207,892 460,030 69.00 70.00	1						1
71. 00	69.00	06900 ELECTROCARDI OLOGY					69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 149151 31, 630, 606 4, 717, 737 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 176286 25, 700, 147 4, 530, 576 73. 00 73. 01 73. 01 07302 DP PHARMACY 1. 295222 0 0 0 73. 01 73. 01 73. 01 07302 DP PHARMACY 1. 295222 0 0 0 73. 01 73. 01	70.00	77000 ELECTROENCEPHALOGRAPHY		0. 13710	363, 524	49, 840	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 176286 25, 700, 147 4, 530, 576 73. 00 73. 01 73. 01 73. 02 OP PHARMACY 1. 295222 0 0 73. 01							ł
73. 01 07302 OP PHARMACY 1. 295222 0 0 73. 01 74. 00 O7400 RENAL DI ALYSIS 0. 368976 1, 904, 989 702, 895 74. 00 70. 67. 970 O7500 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 0 0 0 77. 00 O7800 CAR T-CELL I IMUINOTHERAPY 0. 000000 0 0 0 78. 00 O7800 CAR T-CELL I IMUINOTHERAPY 0. 000000 0 0 0 79. 00 O7800 CAR T-CELL I IMUINOTHERAPY 0. 000000 0 0 0 79. 00 O7800 CAR T-CELL I IMUINOTHERAPY 0. 000000 0 0 0 90. 01 O9001 OP ONCOLOGY INFUSION CENTER 0. 220299 1, 286, 715 283, 462 90. 01 90. 02 O9002 WOUND CARE CENTER 0. 223931 3, 701 829 90. 02 90. 03 O9003 PAIN CLINIC 0. 342686 0 0 0 0. 0342686 0 0 90. 03 90. 04 O9004 OB CLINIC 0. 566072 0 0 90. 03 90. 05 O9005 OP PSYCH CLINIC 0. 878268 3, 225 2, 832 90. 06 90. 06 O9006 MULTI SPECIALTY CLINIC 0. 878268 3, 225 2, 832 90. 06 90. 07 O9100 DERROGENCY 0. 116037 20, 928, 012 2, 428, 424 90. 01 90. 02 O9202 OBSERVATION BEDS (NON-DISTINCT PART) 0. 256220 332, 861 85, 286 92. 00 90. 01 O9400 HOME PROGRAM DI ALYSIS 0. 000000 0 0 94. 00 90. 02 O9500 AMBULANCE SERVICES 0. 000000 0 0 95. 00 90. 00 O9500 AMBULANCE SERVICES 0. 000000 0 0 95. 00 90. 00 O9500 AMBULANCE SERVICES 0. 000000 0 0 0 90. 00 O9500 DESERVATION BEDS (DISTINCT PART) 0. 24900 0 0 0 90. 00 O9500 AMBULANCE SERVICES 0. 000000 0 0 0 90. 00 O9500 AMBULANCE SERVICES 0. 000000 0 0 0 90. 00 O9500 AMBULANCE SERVICES 0. 000000 0 0 0 90. 00 O9500 O000000000000000000000000000000000							
74. 00 07400 RENAL DIALYSIS 76. 97 07697 CARDI AC REHABILITATION 76. 97 07697 CARDI AC REHABILITATION 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 2000000 0 0 0 76. 97 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 0. 0000000 0 0 0 78. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 90. 01 09001 0P ONCOLOGY INFUSION CENTER 90. 02 09002 WOUND CARE CENTER 90. 03 09003 PAIN CLINIC 90. 04 09004 0B CLINIC 90. 05 09005 OP PSYCH CLINIC 90. 06 09006 MULTI SPECIALTY CLINIC 90. 06 09006 MULTI SPECIALTY CLINIC 90. 07 09000 MULTI SPECIALTY CLINIC 90. 08 09006 DESERVATION BEDS (NON-DISTINCT PART) 90. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 90. 00 09400 HOME PROGRAM DIALYSIS 90. 00 09500 AMBULANCE SERVICES 90. 00 09500 CLINIC SERVICES 90. 00 09500 AMBULANCE SERVICES 90. 00 09500 CLINIC SERVICES 90. 00 09500 AMBULANCE SERVICES							ł
76. 97 07697 CARDI AC REHABILITATION 0.220343 51,775 11,408 76.97 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0 0 0 77.00 0.000000 0 0 0 0 0 0							ł
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78. 00 078.00 079.00 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 78. 00 090.00 CLINIC 0.000000 0 0 0 0 0 0 0							
78. 00	77 00 0	17700 ALLOGENEIC STEM CELL ACOLLSITION					ł
OUTPATIENT SERVICE COST CENTERS O90.00							ł
90. 00				0.0000			70.00
90. 02	90.00	99000 CLI NI C		2. 60223	6, 677	17, 375	90. 00
90. 03							
90. 04				l .			1
90. 05							1
90. 06 09006 MULTI SPECIALTY CLINIC 0. 878268 3, 225 2, 832 90. 06 91. 00 09100 EMERGENCY 0. 116037 20, 928, 012 2, 428, 424 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 256220 332, 861 85, 286 92. 00 09200 OSSERVATION BEDS (DISTINCT PART) 0. 349543 254, 477 88, 951 92. 01 07400 OTHER REIMBURSABLE COST CENTERS 0. 000000 0 0 09400 OMBE PROGRAM DIALYSIS 0. 000000 0 0 94. 00 09500 AMBULANCE SERVICES 95. 00 200. 00 201. 00 00000 0 0 0 0 0 0 0							
91. 00						-	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 256220 332, 861 85, 286 92. 00 92. 01 09202 0BSERVATI ON BEDS (DISTINCT PART) 0. 349543 254, 477 88, 951 92. 01 07 07 07 07 07 07 07							
92. 01 09202 0BSERVATI ON BEDS (DISTINCT PART) 0. 349543 254, 477 88, 951 92. 01 0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0. 0000000 0 94. 00 95. 00 09500 AMBULANCE SERVICES 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 182, 729, 770 27, 934, 342 200. 00 201. 00 201. 00 201. 00							
OTHER REIMBURSABLE COST CENTERS O. 0000000 O 94. 00					· ·		
95. 00							
200.00 Total (sum of lines 50 through 94 and 96 through 98) 182,729,770 27,934,342 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				0.00000	00 0	0	94. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 182,729,770 27,934,342 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	95.00	9500 AMBULANCE SERVICES					
	200.00	Total (sum of lines 50 through 94 and 96 through 98)			182, 729, 770	27, 934, 342	
202.00 Net charges (line 200 minus line 201) 182,729,770 202.00	1		(line 61)		0		1
	202. 00	Net charges (line 200 minus line 201)		l	182, 729, 770	1	202. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	eu of Form CMS-2552-10
INDATIENT ANCILLARY SERVICE COST ADDODTIONMENT	Provider CCN: 15 0051	Pori od:	Workshoot D 2

Health Financial Systems IU HEALTH BLOOMING	ON HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0051	Peri od:	Worksheet D-3	
			From 01/01/2023		
			To 12/31/2023		
				5/29/2024 1:5	3 pm
	li tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			4, 130, 852		30.00
31. 00 03100 NTENSI VE CARE UNI T			630, 583		31.00
32. 00 03200 CORONARY CARE UNIT			000,000		32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			1, 224, 497		35.00
42. 00 04200 SUBPROVI DER			1, 224, 477		42.00
			201 240		
43. 00 04300 NURSERY			201, 348		43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 12211		130, 242	50.00
50. 01 05001 CV SURGERY		0.00000		0	50. 01
51.00 05100 RECOVERY ROOM		0. 24476		17, 434	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 23841	4 364, 040	86, 792	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19277	75 274, 723	52, 960	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 05712		712	55. 00
56. 00 05600 RADI OI SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0. 08307		21, 137	
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)		0. 16299		9, 511	58.00
		0.07415		30, 024	59.00
60. 00 06000 LABORATORY		0. 16822		222, 751	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 29673		189, 158	
66. 00 06600 PHYSI CAL THERAPY		0. 43223	194, 001	83, 854	66. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 07410	244, 933	18, 151	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 13710	13, 668	1, 874	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18147	0 493, 872	89, 623	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14915	906, 295	135, 175	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 17628	2, 502, 889	441, 224	73. 00
73. 01 07302 OP PHARMACY		1. 29522		0	73. 01
74. 00 07400 RENAL DI ALYSI S		0. 36897		78, 552	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 22034		82	76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000		0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000		0	78.00
OUTPATIENT SERVICE COST CENTERS		0.00000	,0 0	0	70.00
		2 (022	104	271	00.00
		2. 60223		271	90.00
		0. 22029		24, 657	
90. 02 09002 WOUND CARE CENTER		0. 22393		0	90. 02
90. 03 09003 PAIN CLINIC		0. 34268		0	90. 03
90. 04 09004 0B CLI NI C		2. 56507		341	90. 04
90. 05 09005 OP PSYCH CLINIC		0. 50607	[2] 0	0	90. 05
90.06 09006 MULTI SPECIALTY CLINIC		0. 87826	1, 682	1, 477	90. 06
91. 00 09100 EMERGENCY		0. 11603	1, 252, 840	145, 376	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 25622	16, 074	4, 118	92.00
92. 01 09202 OBSERVATION BEDS (DISTINCT PART)		0. 34954		1, 380	92. 01
OTHER REIMBURSABLE COST CENTERS		0.0170	0/ / 10	1,000	72.0.
94. 00 09400 HOME PROGRAM DIALYSIS		0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0.00000	.5		95.00
		1	10 400 040	1 70/ 07/	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(line (1)		10, 423, 942	1, 786, 876	1
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IIne 61)		10 100 010		201. 00
202.00 Net charges (line 200 minus line 201)		I	10, 423, 942		202. 00

MMILE - IMPAILISE PROPERTY ALL SERVICES UNDER 1995 1.00 1.0		Title XVIII Hospital	5/29/2024 1: 5: PPS	3 pm
Next Next How Title How Title How Title Power				
1.00 100 1.00 1		DADT A LABATIENT HOODITAL CERVILORG INDER LODG	1. 00	
1.01 Bick amounts other than outlier payments for discharges occurring prior to declober 1 (see 9,597,277 1.02	1 00		0	1 00
Disc amounts other than outlier payment for discharges occurring on or after October 1 (see 9,997,277 1.02		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see		
1.030 1.03	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	9, 597, 277	1. 02
1.04 Scriptor Geoinstructions 1.04 Scriptor 1.04 Scr	1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0	1. 03
2.00 Out-life payments for discharges (see instructions)	1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
0.00		Outlier payments for discharges. (see instructions)		
2.03 Outlier payments for discharges accurring prior to October 1 (see instructions) 2.04 2.04 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 7.05 2.04 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 7.05 2.05 2.05 Outlier payments for discharges occurring on or after October 1 (see instructions) 7.05 2.05 2.05 Outlier payments for disded by number of days in the cost reporting period (see instructions) 7.05 2.05 0			-	
2.04 Dutil er payments for di schariges occurring on or after October 1 (see instructions) 9.041 2.04			-	
Managed Care Simulated Payments				
Indirect Medical Education Adjustment				
FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions) 5.00 FTE cap adjustment for qualifing hospitals under \$131 or the CAA 2021 (see instructions) 0.00 5.01	4.00		195. 02	4. 00
or befrore 12/31/1996, (see instructions) 5. 01 FTE count for quali Fing hospitals under \$131 of the CAA 2021 (see instructions) 5. 01 FTE count for all opathic and oxteopathic programs that need the criteria for an add-on to the cap for 0.00 6.00 new programs in accordance with 42 CFR 413-706 (7) (1) (1) (8) (1) 0.00 7.00 7.00 MAR Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105 (7) (1) (1) (8) (1) 0.00 7.00 7.00 cost report straddles July 1, 2011 then see instructions. 7. 02 Adjustment (increase or decrease) to the hospital 's rural track program FTE Illmitation(s) for rural track programs in a rural track for Medicare (8le affiliated programs in accordance with 413.75(b) ard 87 FR 49075 (August 1, 2022) (see instructions) 8. 00 FR 49075 (August 1, 2022) (see instructions) 8. 01 The amount of increase in the hospital was awarded FTE cap slots under \$5030 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 8. 03 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 8. 04 The count for all opathic and osteopathic programs in the current year form a closed teaching hospital under \$1000 of ACA. See instructions instructions. 8. 05 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 8. 07 The instructions in the programs in the current year from your records 8. 08 The count for all opathic and osteopathic programs in the current year from your records 9. 00 The count for all opathic and osteopathic programs in the current year from your records 9. 00 The count for all opathic and osteopathic programs in the current year from your records 9. 00 The count for all opathic and osteopathic programs in the current year from your records 9. 00 The count for all opathic and osteopathic programs in the current year from your reco	F 00		0.00	F 00
FTE cap adjustment for qualifying hospitals under \$131 of the CAA 2021 (see instructions) 0.00 5.00	5.00		0.00	5.00
FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413-796 and 42 CFR 412-105 (T)(1)(1)(8)(2) If the control of the CAA 2021 (see Instructions) and 42 CFR 412-105 (T)(1)(1)(8)(2) If the control of the CAR 2021 (see Instructions) and 42 CFR 412-105 (T)(1)(1)(8)(2) If the control of the CAR 2021 (see Instructions) and 87 FR 49075 (August 10, 2022) (see Instructions) and 87 FR 49075 (August 10, 2022) (see Instructions) and 87 FR 49075 (August 10, 2022) (see Instructions) and 87 FR 49075 (August 10, 2022) (see Instructions) and 87 FR 49075 (August 10, 2022) (see Instructions) and 87 FR 49075 (August 10, 2022) (see Instructions) and 87 FR 49075 (August 10, 2022) (see Instructions) and 87 FR 49075 (August 10, 2022) (see Instructions) and 57 FR 50067 (August 1, 2002). 8.01 The amount of Increase If the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost under \$ 5506 of ACA. (see Instructions) and FTE cap slots under \$ 5505 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of the CAA 2021 (see Instructions) and FTE cap slots under \$ 5506 of	5. 01		0.00	5. 01
Advantage Processes Proc	6.00		0.00	6. 00
the CAA 2021 (see Instructions) 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 7.02 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 7.03 CACA § 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 7.04 Adjustment (increase or decrease) to the hospital's rural track programs fire Imit ation(s) for rural track programs in a coordance with 43.75(b) 8.09 and \$FR #40F6 (August 10.2022) (see Instructions) 8.00 artifluated programs in a accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12.1998), and 67 FR 55069 (August 1.2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost under § 5500 of ACA. (see instructions). 8.02 The amount of increase if the hospital was awarded FTE cap slots where \$1500 of the ACA. If the cost under § 5500 of ACA. (see instructions). 8.11 The amount of increase if the hospital was awarded FTE cap slots where \$126 of the CAA.2021 (see 1) instructions and 5.01, plus line 6, plus lines 6.25 through 6.49 minus lines 7 and 7.01, plus or Sum of II in 3.02, plus minus lines 8.01 through 8.27 (see Instructions) 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA.2021 (see 1) instructions and 5.01, plus line 6, plus lines 6.25 through 8.27 (see Instructions) 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA.2021 (see 1) instructions and 5.01, plus line 6, plus lines 8.01 through 8.27 (see Instructions) 8.02 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA.2021 (see 1) instructions and 5.01 plus lines 6.25 through 6.49 minus lines 7 and 7.01, plus or \$100.00 minus 10.00 min			0.00	
MAA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(8)(8)(1) 0.00 7.01 ACA §5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see instructions.	6. 26		0.00	6. 26
cost report straddle sully 1, 2011 then see instructions. 1.02 Adjustment (Increase or decrease) to the hospital's rural track programs FTE IImitation(s) for rural track programs with a rural track for Wedicare (ME affiliated programs in accordance with 413,75(b) and 87 FE 49075 (August 10, 2002) (see instructions) 8.00 Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 FER 413,75(b), 413,79(c)(2)(1)), 64 FER 2630 (MBy 12, 1998), and 67 FE 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 8.10 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see instructions) 9.02 Sum of lines and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line, 702, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 Test count for allopathic and osteopathic programs in the current year from your records. 10.01 The allomable FTE count for the prior year. 10.02 Current year allomable FTE count for the prior year. 10.03 Total allomable FTE count for the prior year. 10.04 Total allomable FTE count for the prior year. 10.05 Total allomable FTE count for the prior year. 10.06 Total allomable FTE count for the prior year. 10.07 Total allomable FTE count for the prior year. 10.08 Total allomable FTE count for the prior year. 10.09 Total allomable FTE count for the prior year. 10.00 Total allomable FTE count for the prior year. 10.00 Total allomable FTE count for the prior year. 10.00 Total allomable FTE count for the prior year. 10.00 Total allomable FTE c	7. 00		0. 00	7. 00
Adjustment (Increase or decrease) to the hospital's rural track program FTE Ilimitation(s) for rural track for Medicare (ME aFTILITIATE PROPERTION) Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 413.75(b), and 87 FR 49075 (August 10, 2022) (see instructions) 4.00	7. 01		0.00	7. 01
track programs with a rural track for Medicare (ME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost under § 5506 of ACA. (see instructions) 8.11 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 9.00 Sun of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 FTE count for or lapathic and osteopathic programs. 10.01 FTE count for residents in dental and podiatric programs. 10.02 Courrent year all osable FTE count for the perior year. 10.03 Italial osable FTE count for the perior year. 10.04 Courrent year all osable FTE count for the perior year. 10.05 Italial osable FTE count for the perior year. 10.06 Courrent year all osable FTE count for the perior year. 10.07 Courrent year all osable FTE count for the perior year if that year ended on or after September 30, 1997, conditions of the perior year in the year of the year year year year year year year yea	7.00		0.00	7 00
and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Algustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413, 75(b), 413, 79(c)(2)(iv), 64 FR 26340 (Way 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots under § 100 of the ACA. If the cost under § 5506 of ACA. (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see Instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see Instructions) 9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 9.00 11.00 FTE count for allowable FTE (see instructions) 9.00 Current year allowable FTE (see instructions) 9.00 12.00 Current year allowable FTE count for the programs 9.00 12.00 Current year allowable FTE count for the program (see instructions) 9.00 13.00 Total allowable FTE count for the program (see instructions) 9.00 14.00 Total allowable FTE count for the program (see instructions) 9.00 15.00 Current year residents in initial years of the program (see instructions) 9.00 16.00 Algustment for residents displaced by program or hospital closure 9.00 17.00 Algustment for residents in sintial years of the program (see instructions) 9.00 18.00 Current year resident to bed ratio (see instructions) 9.00 19.00 Current year resident to bed ratio (see instructions) 9.00 19.00 Current year resident to bed ratio (see instructions) 9.00 19.00 Current year resident to increase instructions) 9.00 19.00 Current year resident to inc	7.02		0.00	7. 02
affiliated programs in accordance with 42 CFR 413, 75(b), 413, 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50099 (August 1, 2002).				
1998), and of FR 50069 (August 1, 2002).	8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				
report straddles July 1, 2011, see instructions.	8 01		0.00	8 01
R. 02	0.01		0.00	0.01
Section The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)	8. 02		0.00	8. 02
Instructions	0.01		0.00	0.01
minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 0.00 10.00	0. 21		0.00	0. 21
10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00	9.00		0.00	9. 00
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 14.00 15.00 15.00 14.00 15.00 1	40.00		0.00	10.00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.10				
13.00 Total allowable FTE count for the prior year 0.00 13.00 Total allowable FTE count for the prior year 0.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 14.00 14.00 14.00 15.00 15.00 16.00 18.				
Otherwi se enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 17.00 Adj ustment for residents in initial years of the program (see instructions) 0.00 16.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 18.00 18.00 18.00 Adj ustdent for residents displaced by program or hospital closure 0.00 17.00 18.00 19.00 10.		, ,	0.00	13. 00
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 18.00 18.00 18.00 18.00 18.00 19	14.00		0.00	14. 00
16.00 Adjustment for residents in initial years of the program (see instructions) 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 19.0	15 00		0.00	15 00
17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjusted rolling average FTE count 0.00 18.00 19.00				
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adjustment (see instructions) 0.000000 22.00 18.00 IME payment adjustment - Managed Care (see instructions) 0.000000 22.01 19.00 Indirect Medical Education Adjustment For the Add-on For § 422 of the MMA 0.000000 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 23.00 25.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 28.01 IME add-on adjustment factor. (see instructions) 0.000000 28.00 29.00 <td></td> <td></td> <td></td> <td></td>				
20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 0.000000 21. 00 0.000000 21. 00 0.000000 21. 00 0.000000 22. 00 0.000000 22. 00 0.000000 22. 00 0.000000 0.000000 0.000000 0.000000 22. 00 0.0000000 0.0000000 0.0000000 0.00000000				
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 24.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 25.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 26.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 27.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 28.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 28.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 28.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 29.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 29.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 29.00 Indirect Medical Indirect Medical Part A patient days (see instructions) 29.00 Indirect Medical Part Indirect Medical Part A patient days (see instructions) 20.00 Indirect Medical Part Indirect Part A patient days (see instructions) 20.00 Indirect Medical Part Indirect Part A patient days (see instructions) 20.00 Indirect Medical Part Indirect Part A patient days (see instructions) 20.00 Indirect Medical Part Indirect Part A patient days (see instructions) 20.00 Indirect Medical Part Indirect Part A patient days (see instructions) 20.00 Indirect Medical Education Adjustment 20.00 Indirect Medical Education Adjustment 20.00 Indirect				
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see occurrent instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 17.22 33.00				
22. 01 IME payment adjustment - Managed Care (see instructions) 0 1 1 1 1 1 1 1 1 1				
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 1 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 0.29.00 Total IME payment (sum of lines 22 and 28) 0.29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 5.23 30.00 Sum of lines 30 and 31 33.94 32.00 Allowable disproportionate share percentage (see instructions) 17.22 33.00			0	
(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.94 32.00 34.10 wable disproportionate share percentage (see instructions) 17.22 33.00				
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Sum of lines 30 and 31 33.94 32.00 33.00 Allowable disproportionate share percentage (see instructions) 17.22 33.00	23. 00		0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.94 32.00 34.10 wable disproportionate share percentage (see instructions) 17.22 33.00	24. 00		0.00	24. 00
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment 0 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 5. 23 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 28. 71 31. 00 32. 00 Sum of lines 30 and 31 33. 94 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 17. 22 33. 00				
27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 5. 23 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 28. 71 31. 00 32. 00 Sum of lines 30 and 31 33. 94 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 17. 22 33. 00				
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 17.22 33.00				
28.01 IME add-on adjustment amount - Managed Care (see instructions) 7				
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 32. 01 Disproportionate Share Adjustment 30. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Percentage of Medicaid patient days (see instructions) 34. 00 Sum of lines 30 and 31 35. 00 Percentage of Medicaid patient days (see instructions)				
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Sum of lines 30 and 31				
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 5.23 30.00 28.71 31.00 32.00 31.00 32.00 33.00 31.00 33.00 31.00 33.00 33.00 31.00 33.00 31.00 33.00 31	29. 01		0	29. 01
31.00 Percentage of Medicaid patient days (see instructions) 28.71 31.00 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 28.71 31.00 32.00 33.00	30 00		F 22	30 00
32.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 33.94 32.00 17.22 33.00				
34.00 pulsproportionate share adjustment (see instructions) 1,545,984 34.00		, , , , , , , , , , , , , , , , , , , ,		
	34.00	United to unate share adjustment (see Instructions)	1, 545, 984	34.00

ALCULATI ON	OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0051	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre	naro
			10 12/31/2023	5/29/2024 1:5	pared 3 pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
Uncor	pensated Care Payment Adjustment		1.00	2.00	
	uncompensated care amount (see instructions)		6, 874, 403, 459	5, 938, 006, 757	35.
1	r 3 (see instructions)		0. 000283200	0. 000282346	•
	tal UCP, including supplemental UCP (see instructions)		1, 946, 832	1, 676, 570	
	ata share of the hospital UCP, including supplemental UC	P (see instructions)	1, 456, 123		•
	UCP adjustment (sum of columns 1 and 2 on line 35.03) onal payment for high percentage of ESRD beneficiary di	scharges (Lines 40 throu	1, 877, 556		36.
	Medicare discharges (see instructions)	scharges (Titles 40 till ou	0		40.
1	ESRD Medicare discharges (see instructions)		0		41.
1	ESRD Medicare covered and paid discharges (see instruct	ions)	0		41.
	e line 41 by line 40 (if less than 10%, you do not quali		0.00		42.
3. 00 Tota	Medicare ESRD inpatient days (see instructions)		0		43.
	of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
days 5.00 Aver			0.00		45
1	ge weekly cost for dialysis treatments (see instructions additional payment (line 45 times line 44 times line 41		0.00		46
1	tal (see instructions)	. 01)	40, 049, 404		47
1	tal specific payments (to be completed by SCH and MDH, s	mall rural hospitals	0		48
onl y	(see instructions)	·			
				Amount 1.00	
.00 Tota	payment for inpatient operating costs (see instructions			40, 049, 404	49
	nt for inpatient program capital (from Wkst. L, Pt. I an			2, 949, 226	
.00 Exce	tion payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51
. 00 Di re	t graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	52
	ng and Allied Health Managed Care payment			51, 008	
1 .	al add-on payments for new technologies			60, 691	54
1	isolation add-on payment	0)		0	54
	rgan acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	19)		0	55
1	lar therapy acquisition cost (see instructions) of physicians' services in a teaching hospital (see intr	auctions)		0	55 56
	ne service other pass through costs (from Wkst. D, Pt. I	•	hrough 35)	0	57
	lary service other pass through costs from Wkst. D, Pt.		in ough 55).	56, 695	
	(sum of amounts on lines 49 through 58)	,		43, 167, 024	
.00 Prim	ry payer payments			13, 400	60
.00 Tota	amount payable for program beneficiaries (line 59 minus	line 60)		43, 153, 624	61
	tibles billed to program beneficiaries			3, 452, 928	
1	urance billed to program beneficiaries			192, 000	
1	able bad debts (see instructions)			187, 226	
1 -	ted reimbursable bad debts (see instructions)	ructions)		121, 697	
	able bad debts for dual eligible beneficiaries (see inst tal (line 61 plus line 65 minus lines 62 and 63)	i ucti uis)		62, 886 39, 630, 393	
	ts received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	39, 630, 393	
	er payments reconciliation (sum of lines 93, 95 and 96).	11	· /	0	69
1	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		•	0	70
. 50 Rura	Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70
. 75 N95	espirator payment adjustment amount (see instructions)			0	70
	stration payment adjustment amount before sequestration			0	70
1	r MDH volume decrease adjustment (contractor use only)			0	
	er ACO demonstration payment adjustment amount (see inst	ructions)			70
1	onus payment HVBP adjustment amount (see instructions)			0	
1	onus payment HRR adjustment amount (see instructions)			0	70
	ed Model 1 discount amount (see instructions) payment adjustment amount (see instructions)			-28, 755	70 70
	djustment amount (see instructions)			-26, 755 0	
				U	, , ,

Health Financial Systems	IU HEALTH BLOOMINGTO	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	§	Provider CC	CN: 15-0051	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prep 5/29/2024 1:53	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				Λ	1 00	

		-	To 12/31/2023	Date/Time Pre	
	Title	e XVIII	Hospi tal	5/29/2024 1: 5: PPS	3 PIII
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
the corresponding federal year for the period prior to 10/1) 70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 97
the corresponding federal year for the period ending on or a			U	U	70. 77
70. 98 Low Volume Payment-3	,		0	0	70. 98
70.99 HAC adjustment amount (see instructions)				0	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			39, 601, 638	
71. 01 Sequestration adjustment (see instructions)				792, 033	
71.02 Demonstration payment adjustment amount after sequestration 71.03 Sequestration adjustment-PARHM pass-throughs		-		0	71. 02 71. 03
72. 00 Interim payments				38, 461, 404	
72.01 Interim payments-PARHM				55, 151, 151	72. 01
73.00 Tentative settlement (for contractor use only)				0	73. 00
73.01 Tentative settlement-PARHM (for contractor use only)					73. 01
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.0)2, 72, and			348, 201	74. 00
73) 74.01 Balance due provider/program-PARHM (see instructions)					74. 01
75. 00 Protested amounts (nonallowable cost report items) in accordance	ance with			1, 008, 084	75. 00
CMS Pub. 15-2, chapter 1, §115.2				,	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90. 00
plus 2.04 (see instructions) 91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00 Operating outlier reconciliation adjustment amount (see insti	ructions)			0	92. 00
93.00 Capital outlier reconciliation adjustment amount (see instruc				0	93. 00
94.00 The rate used to calculate the time value of money (see insti				0.00	94. 00
95.00 Time value of money for operating expenses (see instructions)				0	95. 00
96.00 Time value of money for capital related expenses (see instruc	ctions)		Prior to 10/1	0n/After 10/1	96. 00
				OII/AI LEI TO/T	
			1. 00	2. 00	
HSP Bonus Payment Amount				2. 00	
100.00 HSP bonus amount (see instructions)			1.00		100. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions)	ns)		0. 0000000000	0. 0000000000	101. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0. 0000000000	
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions)	ns)		0. 0000000000	0. 0000000000	101. 00 102. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions)	5)		0. 0000000000	0. 0000000000 0 0. 00000	101. 00 102. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst	s) ration) Adju		0. 0000000000	0. 0000000000 0 0. 0000 0 0. 0000	101. 00 102. 00 103. 00 104. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstrat	s) ration) Adju		0. 0000000000	0. 0000000000 0 0. 0000 0 0. 0000	101. 00 102. 00 103. 00
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100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§4	s) ration) Adju eriod under t		0. 0000000000	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Cost Reimbursement 101.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iii 202.00 Medicare discharges (see instructions) 103.00 Case-mix adjustment factor (see instructions)	s) ration) Adju eriod under t ne 49)	the 21st	0. 0000000000 0 0. 00000000000 0 0	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) 105.00 Lis this the first year of the current 5-year demonstration project (See instructions) 106.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iii 202.00 Medicare discharges (see instructions) 107.00 Computation of Demonstration Target Amount Limitation (N/A instructions)	s) ration) Adju eriod under t ne 49)	the 21st	0. 0000000000 0 0. 00000000000 0 0	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
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100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) 105.00 Is this the first year of the current 5-year demonstration project (See instructions) 107.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iii 207.00 Medicare discharges (see instructions) 108.00 Case-mix adjustment factor (see instructions) 109.00 Medicare target amount 109.00 Medicare target amount 109.00 Medicare target amount 109.00 Medicare inpatient routine cost cap (line 202 times line 204) 109.00 Medicare inpatient routine cost cap (line 202 times line 205) 109.00 Adjustment to Medicare Part A Inpatient Reimbursement 109.00 Program reimbursement under the \$410A Demonstration (see instructions)	ration) Adju ration) Adju eriod under t ne 49) i first year	the 21st	0. 0000000000 0 0. 00000000000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
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100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) 105.00 Is this the first year of the current 5-year demonstration project (See instructions) 107.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iii 207.00 Medicare discharges (see instructions) 108.00 Case-mix adjustment factor (see instructions) 109.00 Medicare target amount 109.00 Medicare target amount 109.00 Medicare target amount 109.00 Medicare inpatient routine cost cap (line 202 times line 204) 109.00 Medicare inpatient routine cost cap (line 202 times line 205) 109.00 Adjustment to Medicare Part A Inpatient Reimbursement 109.00 Program reimbursement under the \$410A Demonstration (see instructions)	ration) Adju ration) Adju eriod under t ne 49) i first year	the 21st	0. 0000000000 0 0. 00000000000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
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100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) 200.00 Is this the first year of the current 5-year demonstration project (See instructions) Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iii (See instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instance) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use 211.00 Total adjustment to Medicare Part A IPPS payments (from line Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 213.00 Low-volume adjustment (see instructions)	ration) Adjuration) Adjuration Adjuration Adjuration to the 49) a first year ructions) line 59)	of the curren	0. 0000000000 0 0. 00000000000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 212. 00 213. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) 200.00 Is this the first year of the current 5-year demonstration project (See instructions) Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iii 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use 211.00 Total adjustment to Medicare Part A IPPS payments (from line	ration) Adjuration) Adjuration Adjuration Adjuration to the 49) a first year ructions) line 59)	of the curren	0. 0000000000 0 0. 00000000000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2023 | Part A Exhibit 4 | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 1:53 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0051

						0 12/31/2023	5/29/2024 1:5	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	1.00	1.00	2. 00	3.00	4. 00	5. 00	1. 00
1.00	payments	1.00	١	0	0	O	U	1.00
1. 01	DRG amounts other than outlier	1. 01	26, 314, 082	0	26, 314, 082		26, 314, 082	1. 01
	payments for discharges		20,011,002	· ·	20,011,002		20,011,002	
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	9, 597, 277	0		9, 597, 277	9, 597, 277	1. 02
	payments for discharges							
	occurring on or after October							
	1							
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to							
1 04	October 1	1. 04		0		0	0	1 04
1. 04	DRG for Federal specific operating payment for Model 4	1.04	٩	Ü		U	0	1. 04
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
	discharges (see instructions)							
2.01	Outlier payments for	2. 02	o	0	0	0	0	2. 01
	discharges for Model 4 BPCI							
2.02	Outlier payments for	2. 03	622, 464	0	622, 464		622, 464	2. 02
	discharges occurring prior to							
0.00	October 1 (see instructions)	0.01	22.2	=		00.00	22.2	0.00
2. 03	Outlier payments for	2. 04	92, 041	0		92, 041	92, 041	2. 03
	discharges occurring on or							
	after October 1 (see instructions)							
3.00	Operating outlier	2. 01	٥	0	0	0	0	3. 00
3.00	reconciliation	2.01	l	0		O	O	3.00
4.00	Managed care simulated	3. 00	ol	0	0	0	0	4. 00
	payments		آ ا					
	Indirect Medical Education Adj	ustment						
5.00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
	A, line 21 (see instructions)							
6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
	instructions)	00.04						
6. 01	IME payment adjustment for	22. 01	U	0	0	Ü	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adj	l ustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0.000000		0. 000000		7. 00
7.00	(see instructions)	27.00	0.000000	0.00000	0.00000	0.000000		7.00
8.00	IME adjustment (see	28. 00	o	0	0	0	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
	for managed care (see							
	instructions)							
9.00	Total IME payment (sum of	29. 00	이	0	0	0	0	9. 00
0.01	lines 6 and 8)	20.01		^	_	_	_ ا	0.01
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01		0		U	0	9. 01
	8. 01)							
	Disproportionate Share Adjustm	ent						
10. 00	Allowable disproportionate	33.00	0. 1722	0. 1722	0. 1722	0. 1722		10. 00
	share percentage (see					- · · ·		
	instructions)							
11. 00	Di sproporti onate share	34.00	1, 545, 984	0	1, 132, 821	413, 163	1, 545, 984	11. 00
	adjustment (see instructions)							
11. 01	Uncompensated care payments	36.00	1, 877, 556		1, 456, 123	421, 433	1, 877, 556	11. 01
40.00	Additional payment for high pe		RD beneficiary					40.00
12. 00	Total ESRD additional payment	46. 00	0	0	0	0	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	40, 049, 404	0	29, 525, 490	10, 523, 914	40, 049, 404	13 00
14. 00	Hospital specific payments	48.00	70, 047, 404	0	27, 323, 470	10, 523, 714 N	70, 047, 404 N	14. 00
17.00	(completed by SCH and MDH,	10.00		0		U		1 7. 00
	small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	40, 049, 404	0	29, 525, 490	10, 523, 914	40, 049, 404	15. 00
	operating costs (see							
	instructions)							
16. 00	Payment for inpatient program	50.00	2, 949, 226	0	2, 146, 286	802, 940	2, 949, 226	16. 00
	capital (from Wkst. L, Pt. I,							
	if applicable)	I	ı l		I			

LOW VO	ILUME CALCULATION EXHIBIT 4			Provi der CC		Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 5/29/2024 1:5	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54. 00	60, 691	0	60, 69	0	60, 691	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced	68. 00	0	0	1	0	0	
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0		0 0	0	18. 00
	adjustment amount (see instructions)							
19.00	SUBTOTAL			0	31, 732, 46	7 11, 326, 854	43, 059, 321	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	2, 725, 641	0	1, 984, 86	4 740, 777	2, 725, 641	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	29, 792	0	20, 29	9, 494	29, 792	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see	10. 00	0. 0711	0. 0711	0. 071	0. 0711		24. 00
	instructions)							
25. 00	Disproportionate share adjustment (see instructions)	11. 00	193, 793	0	141, 12	52, 669	193, 793	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	2, 949, 226	0	2, 146, 28	802, 940	2, 949, 226	26. 00
	,,	W/S E, Part A	(Amounts to E.					
		line	Part A)					
		0	1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.00000	0.000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96			1	D	0	28. 00
29. 00	Pt. A, line) Low volume adjustment	70. 97				0	0	29. 00
27.00	(transfer amount to Wkst. E, Pt. A, line)	70. 77						27.00
100.00	Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.	I	ı l	ļ	I	I		I

Provider CCN: 15-0051

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 12/31/2023 5/29/2024 1:53 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 26, 314, 082 26, 314, 082 26, 314, 082 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 9.597.277 9. 597. 277 9.597.277 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 622, 464 622 464 622 464 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 92, 041 92,041 92, 041 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1722 0.1722 0.1722 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1.545.984 1, 132, 821 413, 163 1.545.984 11.00 instructions) 11.01 1, 877, 556 Uncompensated care payments 36, 00 1, 456, 123 421, 433 1,877,556 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 40, 049, 404 29, 525, 490 10, 523, 914 40, 049, 404 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 40, 049, 404 29, 525, 490 10, 523, 914 40, 049, 404 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 2, 949, 226 2, 146, 286 802 940 2, 949, 226 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 60, 691 60, 691 60, 691 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions) 19.00 SUBTOTAL 31, 732, 467 11, 326, 854 43, 059, 321 19. 00

	U HEALTH BLOOMI			In Lie	eu of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 1:5	pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	2, 725, 641	1, 984, 86	4 740, 777	2, 725, 641	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	29, 792	20, 29	9, 494	29, 792	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0.0000		22. 00
23.00 Indirect medical education adjustment (see	6. 00	0		0 0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0711	0. 071	0. 0711		24. 00
25.00 Disproportionate share adjustment (see instructions)	11.00	193, 793	141, 12	4 52, 669	193, 793	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	2, 949, 226	2, 146, 28	6 802, 940	2, 949, 226	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3. 00	4.00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	-28, 755		0 -28, 755	-28, 755	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	0		0	0	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	Ö	31. 01
Triati deti dila)					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3. 00	4.00	
32.00 HAC Reduction Program adjustment (see	70. 99			0 0		32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared:

		5/29/2024 1:5	3 pm
		PPS	
		1.00	\vdash
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	_
1. 00	Medical and other services (see instructions)	19, 633	1.
2.00	Medical and other services reimbursed under OPPS (see instructions)	58, 095, 216	
3.00	OPPS or REH payments	45, 201, 570	1
4.00	Outlier payment (see instructions)	252, 351	1
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	0.000	1
6. 00	Line 2 times line 5	0.000	1
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	1
3. 00	Transitional corridor payment (see instructions)	0	8.
9. 00	Ancillary service other pass through costs including REH direct graduate medical education costs fro	m 208, 333	9.
	Wkst. D, Pt. IV, col. 13, line 200		1.0
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	19, 633	1
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	19,033	' ' '
	Reasonable charges		t
12.00	Ancillary service charges	107, 164	12.
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.
14.00	Total reasonable charges (sum of lines 12 and 13)	107, 164	14.
	Customary charges	1 -	4
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	1
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.
	Total customary charges (see instructions)	107, 164	1
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	87, 531	19.
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.
21 00	instructions) Lesser of cost or charges (see instructions)	19, 633	21.
	Interns and residents (see instructions)	17,033	1
	Cost of physicians' services in a teaching hospital (see instructions)	Ö	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	45, 662, 254	24.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	1
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	7, 859, 125	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	37, 822, 762	27.
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.
28. 50	REH facility payment amount (see instructions)		28.
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.
	Subtotal (sum of lines 27, 28, 28.50 and 29)	37, 822, 762	1
31. 00	Primary payer payments	1, 413	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	37, 821, 349	32.
3. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.
	Allowable bad debts (see instructions)	439, 731	34.
35. 00	Adjusted reimbursable bad debts (see instructions)	285, 825	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	299, 830	
	Subtotal (see instructions)	38, 107, 174	1
8. 00	MSP-LCC reconciliation amount from PS&R	-77	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	39. 39.
	N95 respirator payment adjustment (see instructions)	0	1
	Demonstration payment adjustment amount (see instructions)		1
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	Ö	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	1
	Subtotal (see instructions)	38, 107, 251	
10. 01	Sequestration adjustment (see instructions)	762, 145	
	Demonstration payment adjustment amount after sequestration	0	
0.03	Sequestration adjustment-PARHM pass-throughs Interim payments	37, 343, 176	40
	Interim payments Interim payments-PARHM	31, 343, 1/0	41
2. 00	Tentative settlement (for contractors use only)	0	
2. 01	Tentative settlement-PARHM (for contractor use only)		42.
3. 00	Balance due provider/program (see instructions)	1, 930	
13. 01	Balance due provider/program-PARHM (see instructions)		43.
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	109, 725	44.
	§115. 2 TO BE COMPLETED BY CONTRACTOR		-
	IU DE LUMPLETEU DY LUMIKALIUK		90.
90 OO		ا ۱	
	Original outlier amount (see instructions)	0	
			91.

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2023	Worksheet E Part B	
			Date/Time Pre 5/29/2024 1:5	
	Title XVIII	Hospi tal	PPS	
			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

Health Financial Systems

IU HEALTH BLOOMINGTON HOSPITAL

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0051

From 01/01/2023
To 12/31/2023

To 12/31/2023

To 12/31/2024 1:53 pm

Financial Systems

From 01/01/2023
To 12/31/2023

From 01/01/2023

		Title	XVIII	Hospi tal	PPS	5 piii
			t Part A		t B	
		i iipati eii	c . ui c A	i di		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		38, 461, 404		37, 343, 176	1. 00
2.00	Interim payments payable on individual bills, either		0		o	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
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		0		0	3. 01
3.02			0		0	3. 02
3.03			0		o	3. 03
3.04			0		o	3. 04
3.05			0		o	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		o	3. 52
3.53			0		ol	3. 53
3.54			0		ol	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		38, 461, 404		37, 343, 176	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	I				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Drawit dans to Drawnson		0		0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM		0		0	E E0
5. 50 5. 51	TENTATIVE TO PROGRAM		0		0	5. 50 5. 51
			0		0	
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 52 5. 99
5. 99	· ·		0		ا	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
6.00	the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		348, 201		1, 930	6. 01
6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		346, 201		1, 730	6. 02
7. 00	Total Medicare program liability (see instructions)		38, 809, 605		37, 345, 106	7. 00
7.00	Total mearcare program frability (see instructions)		30, 007, 003	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	·	•		•	. '	

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0051	Peri od:	Worksheet E-1	
			From 01/01/2023		
			To 12/31/2023		
		T: +1 o V/// / /	Hooni tol	5/29/2024 1:5	3 PM
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	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 l	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168	33			
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	(see instructions)			10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	(555 11.51. 451. 51.5)			1 .0.00
30. 00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
31.00	1 37	ine 21) (coo inctmuntion	٥)		31.00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Heal th	Financial Systems IU HEAL	TH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0051 Period: Worksheet E-			Worksheet E-5		
			1/2023	Date/Time Prep 5/29/2024 1:53	
		Title XVIII		PPS	
			Ī	1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line	2, or sum of 2.03 plus 2.04 (see instructions	s)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount	(see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	İ	0	4.00
5.00	The rate used to calculate the time value of money	(see instructions)	İ	0.00	5.00
6.00	Time value of money for operating expenses (see in	structions)	İ	0	6.00
7.00	Time value of money for capital related expenses (see instructions)		o	7.00

Health Financial Systems

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

Provider CCN: 15-0051 Period: From 01

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 1:53 pm

onl y)			''	0 12/31/2023	5/29/2024 1:5	
		General Fund	Speci fi c	Endowment Fund		
		1 00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1.00	Cash on hand in banks	334, 937, 913	0	0	0	1.00
2.00	Temporary investments	0	Ō	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	52, 650, 499	0	0	0	4. 00
5.00	Other recei vable	16, 363, 083	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	12, 788, 363	1	0	0	7. 00
8. 00 9. 00	Prepaid expenses Other current assets	7, 930, 660	1	0	0	8. 00 9. 00
10.00	Due from other funds		0	0	0	
11. 00	Total current assets (sum of lines 1-10)	424, 670, 518			0	1
	FIXED ASSETS	,,	-	-		
12.00	Land	17, 958, 398	0	0	0	12. 00
13.00	Land improvements	74, 851	1	0	0	13. 00
14. 00	Accumulated depreciation	-74, 851	1	0	0	14. 00
15.00	Buildings	408, 190, 862	1	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-47, 114, 326 7, 157, 560	1	0	0	16. 00 17. 00
18. 00	Accumulated depreciation	-6, 328, 562		0	0	
19. 00	Fi xed equipment	0, 020, 002	Ö	0	0	19. 00
20. 00	Accumulated depreciation	Ö	ō	0	0	20. 00
21.00	Automobiles and trucks	494, 591	0	0	0	21. 00
22. 00	Accumulated depreciation	-389, 017		0	0	22. 00
23. 00	Major movable equipment	127, 784, 304		0	0	23. 00
24. 00	Accumulated depreciation	-60, 805, 299	0	0	0	24. 00
25. 00 26. 00	Minor equipment depreciable		0	0	0	25. 00 26. 00
27. 00	Accumulated depreciation HIT designated Assets		0	0	0	27.00
28. 00	Accumulated depreciation	ĺ	Ö	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	Ö	Ō	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	446, 948, 511	0	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	233, 081, 857	1	0	0	
32.00	Deposits on Leases	0	0	0	0	
33. 00 34. 00	Due from owners/officers Other assets	7, 350, 705	0	0	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	240, 432, 562	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	1, 112, 051, 591	1	0	0	36.00
	CURRENT LIABILITIES	, , , , , , , , , , , , , , , , , , , ,		-		
37.00	Accounts payable	35, 585, 247	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	8, 260, 762	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	
40.00	Notes and Loans payable (short term)	104 510	0	0	0	
41. 00 42. 00	Deferred income Accelerated payments	-184, 519 I 0	1	U	0	41. 00 42. 00
43. 00	Due to other funds		o	0	0	•
	Other current liabilities	6, 695, 137	1	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	50, 356, 627		0	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0		0	0	
47. 00	Notes payable	0		0	0	ł
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	0 3, 272, 128	_	0	0	
50. 00	Total long term liabilities (sum of lines 46 thru 49)	3, 272, 128	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	53, 628, 755	1	-	0	
	CAPI TAL ACCOUNTS					
52.00	General fund balance	1, 058, 422, 836	1			52. 00
53. 00	Specific purpose fund		0	_		53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
56.00	Plant fund balance - invested in plant			ا	0	•
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					""
59. 00	Total fund balances (sum of lines 52 thru 58)	1, 058, 422, 836	1	0	0	ł
60. 00	Total liabilities and fund balances (sum of lines 51 and	1, 112, 051, 591	0	0	0	60. 00
	[59]	I	I		l	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0051

					То	12/31/2023	Date/Time Prep 5/29/2024 1:5	
		Genera	I Fund	Speci al	Pur	pose Fund	Endowment Fund	, p
				·		·		
		1. 00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		927, 263, 821			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		131, 146, 117	•				2.00
3.00	Total (sum of line 1 and line 2)		1, 058, 409, 938			0		3. 00
4.00	ROUNDI NG	1			0		0	4.00
5.00		0			0		0	5. 00
6.00		0			0		0	6. 00
7. 00 8. 00		0			0		0	7. 00
9. 00		0			0		0	8. 00
10.00	Total additions (sum of line 4-9)	U	1		U	0	U	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		1, 058, 409, 939			0		11. 00
12.00	TEMPORARILY RESTRICTED	-12, 897	1, 058, 409, 939		0	U	o	12.00
13. 00	TEMPORARILI RESTRICTED	-12,097			0			13. 00
14. 00		0			0		0	14. 00
15. 00		0			0			15. 00
16. 00		0			0		l ől	16. 00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)	J	-12, 897		J	0		18. 00
19. 00	Fund balance at end of period per balance		1, 058, 422, 836			0		19. 00
	sheet (line 11 minus line 18)		.,,,			_		
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)	_			_			2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	ROUNDI NG		0					4.00
5.00			0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00 9. 00
9.00	Total additions (our of line 4.0)	0	U		0			9. 00 10. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	TEMPORARILY RESTRICTED	U	0		U			12.00
13. 00	TEMPORARILI RESTRICTED		0					13. 00
14. 00			0					14. 00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)	n	J		0			18. 00
19. 00	Fund balance at end of period per balance				0			19. 00
	sheet (line 11 minus line 18)				Ĭ			
	, , , , , , , , , , , , , , , , , , , ,	'	'		'		'	

Health Financial Systems 100 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0051

		T	o 12/31/2023	Date/Time Pre 5/29/2024 1:5	
	Cost Center Description	Inpatient	Outpati ent	Total	<u>р</u>
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	178, 064, 390		178, 064, 390	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER	0		0	4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	170 0/4 200		170 044 200	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	178, 064, 390		178, 064, 390	10. 00
11. 00	INTENSIVE CARE UNIT	23, 729, 391		23, 729, 391	11. 00
12. 00	CORONARY CARE UNIT	23, 729, 391		23, 729, 391	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	13, 253, 909		13, 253, 909	
	Total intensive care type inpatient hospital services (sum of lines	36, 983, 300		36, 983, 300	
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	215, 047, 690		215, 047, 690	17. 00
18.00	Ancillary services	512, 769, 996	1, 149, 860, 594	1, 662, 630, 590	18. 00
19.00	Outpatient services	64, 889, 101	327, 649, 821	392, 538, 922	19. 00
20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23.00	AMBULANCE SERVICES	0	0	0	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	25. 00
26. 00	HOSPI CE	0	0	0	26. 00
27. 00	OTHER NRCC	0	5, 675, 822		27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	/92, /06, /8/	1, 483, 186, 237	2, 275, 893, 024	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		491, 803, 525		29. 00
30. 00	ADD (SPECIFY)	0			30.00
31. 00	ADD (SECTED)	0			31.00
32. 00		0			32. 00
33. 00		0			33. 00
34. 00		0			34. 00
35. 00		0			35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)	0			37. 00
38. 00		0			38. 00
39.00		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)(transfer		491, 803, 525		43. 00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems	IU HEALTH BLOOMINGTON H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Pro	vi der CCN: 15-0051	Peri od:	Worksheet G-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Prep 5/29/2024 1:53	
					37 2 77 2024 1. 3	J PIII
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Par	t I, column 3, line 28))		2, 275, 893, 024	1. 00
2.00	Less contractual allowances and discounts of	n patients' accounts			1, 712, 288, 265	2.00
3.00	Net patient revenues (line 1 minus line 2)	•			563, 604, 759	3.00
4.00	Less total operating expenses (from Wkst. (i-2, Part II, line 43)			491, 803, 525	4.00
5.00	Net income from service to patients (line 3	minus line 4)			71, 801, 234	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellar	eous communication serv	/i ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking Lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gu	ests			0	14.00
15. 00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical s	supplies to other than p	oati ents		0	16.00
17. 00	Revenue from sale of drugs to other than pa	tients			0	17.00
18. 00	Revenue from sale of medical records and al	stracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22. 00	Rental of hospital space				0	22. 00
23. 00	Governmental appropriations				0	23.00
	MI SCELLANEOUS I NCOME				59, 344, 883	
04 50	00/// D 40 DUE E 1'				<u> </u>	04 50

24. 50 25. 00 26. 00

0

0 27. 00 0 28. 00 131, 146, 117 29. 00

59, 344, 883 131, 146, 117

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

	Financial Systems IU HEALTH BLOOMINGTO ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0051	Peri od:	eu of Form CMS-2 Worksheet L	
			From 01/01/2023 To 12/31/2023	Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	3 PIII
		TI LIE XVIII	1103pi tai	113	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT			0.705 / / /	
1.00	Capital DRG other than outlier			2, 725, 641	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			29, 792 0	2. 00 2. 01
3. 00				154. 74	3.00
4. 00				0.00	4.00
5. 00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01	L. columns 1 and	0.00	6.00
	1.01) (see instructions)		,		
7. 00	Percentage of SSI recipient patient days to Medicare Part A pa 30) (see instructions)	tient days (Worksheet E	E, part A line	5. 23	7. 00
8.00	Percentage of Medicaid patient days to total days (see instruc	tions)		28. 71	8.00
9. 00	Sum of lines 7 and 8	11 0113)		33. 94	9.00
10.00	Allowable disproportionate share percentage (see instructions)			7. 11	10.00
11. 00	Disproportionate share adjustment (see instructions)			193, 793	
12.00	' '			2, 949, 226	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
- 00	Total inpatient program capital cost (line 3 x line 4)			0	I - 00
5.00	, and the second program of the second progr			U	5.00
5.00	,			1.00	5.00
5.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				5.00
1. 00					
1. 00 2. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	s (see instructions)		1.00	1. 00 2. 00
1. 00 2. 00 3. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2)	s (see instructions)		1.00	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	s (see instructions)		1.00 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	,		1.00 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins	tructions)		1.00 0 0 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary	tructions)	(line 6)	1.00 0 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	tructions) circumstances (line 2)	(line 6)	1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic	tructions) circumstances (line 2) able)	ŕ	1.00 0 0 0.00 0 0.00 0	1. 000 2. 000 3. 000 4. 000 5. 000 6. 000 7. 000 8. 000 9. 000
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca	tructions) circumstances (line 2 x able) pital payments (line 8	less line 9)	1.00 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic	tructions) circumstances (line 2 x able) pital payments (line 8	less line 9)	1.00 0 0 0.00 0.00 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)	tructions) circumstances (line 2 x able) pital payments (line 8 pital payment (from pri	less line 9) or year	1.00 0 0 0.00 0.00 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level over ca Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter	tructions) circumstances (line 2) able) pital payments (line 8 pital payment (from pri ments (line 10 plus line the amount on this line	less line 9) or year ne 11)	1.00 0 0 0.00 0.00 0.00 0 0	1. 00 2. 00 3. 00 4. 000 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay	tructions) circumstances (line 2) able) pital payments (line 8 pital payment (from pri ments (line 10 plus line the amount on this line	less line 9) or year ne 11)	0 0 0 0 0.00 0 0.00 0 0 0	11 22 33 44 55 66 77 88 99 100 111

15.00 0 16.00 0 17.00

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

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