This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1312 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 6/29/2020 8:40 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 6/29/2020 8: 40 am Manually prepared cost report use only ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1 Contractor use only number of times reopened = 0-9.

## PART II - CERTIFICATION

(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 the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WHITE HOSPITAL (15-1312) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

[ X ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

TODD WILLIAMS (Si gned) Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.) Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	363, 310	-292, 509	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	22, 563	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	385, 873	-292, 509	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

Health Financial Systems IU HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA In Lieu of Form CMS-2552-10 IU HEALTH WHITE HOSPITAL Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:40 am Provider CCN: 15-1312 Peri od: From 01/01/2019 To 12/31/2019 3. 00 4.00 Hospital and Hospital Health Care Complex Address:
Street: 720 SOUTH SIXTH STREET PO Bo.
City: MONTICELLO State 1. 00 2. 00 1.00 P0 Box: 2.00 State: IN Zip Code: 47960 County: WHITE Component Name 1 00

		1.00	2.00	3. 00	4.00	5. 00	6.00	7. 00	8.00	
	Hospital and Hospital-Based Componer	it Identification:								
. 00	Hospi tal	IU HEALTH WHITE	151312	99915	1	07/01/1966	N	0	0	3.
	i i	HOSPI TAL								
00	Subprovi der - IPF									4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)									6.
	, ,	IU HEALTH WHITE	15Z312	99915		02/16/1990	N	0	N	7.
00	Swing Beds - SNF		152312	99915		02/16/1990	IN	0	IN IN	'.
00	C . D . NE	HOSPI TAL			-					
00	Swing Beds - NF									8.
00	Hospi tal -Based SNF									9.
. 00	Hospi tal -Based NF									10.
. 00	Hospi tal -Based OLTC									11.
. 00	Hospi tal -Based HHA	HOME CARE OF WHITE	157514	99915		03/01/1997	N	N	N	12.
	'	COUNTY								
00	Separately Certified ASC									13.
	Hospi tal -Based Hospi ce									14.
	· ·	-			-					
	· •				l .					15.
. 00	Hospital-Based Health Clinic - FQHC									16.
. 00	Hospital-Based (CMHC) I									17.
. 00	Renal Dialysis									18.
	Other							l		19
	12			I.	1	From:		То	:	
						1. 00		2. (		1
-00	Cost Reporting Period (mm/dd/yyyy)					01/01/2	110	12/31/		20.
	Type of Control (see instructions)				2		317	12/31/	2017	21.
00	Type of control (see mistructions)									21.
					1. 00	2. 00		3. 0	20	+
	Inpatient PPS Information				1.00	2.00		3. (	<i>.</i>	-
00		ourrently receiving n	oumonto for		N	N				1
. 00	Does this facility qualify and is it				IN	IN IN				22
	disproportionate share hospital adju			!						
	§412.106? In column 1, enter "Y" fo	r yes or "N" for no. I	s this							
	facility subject to 42 CFR Section §	412. 106(c)(2)(Pickle a	mendment							
	hospital?) In column 2, enter "Y" fo	r yes or "N" for no.								
. 01	Did this hospital receive interim un	3	nts for thi	s	N	N				22
	cost reporting period? Enter in colu	mn 1 "V" for ves or "	N" for no f	or	• •					
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N		on of the c	ost						
	reporting period occurring on or aft	er October 1 (see ins								
		0. 001000 (000	tructions)							
02	Is this a newly merged hospital that				N	N				22
. 02	3 3 1	requires final uncomp	ensated car	re	N	N				22
. 02	payments to be determined at cost re	requires final uncomp port settlement? (see	ensated car instructior	re	N	N				22
. 02	payments to be determined at cost re Enter in column 1, "Y" for yes or "N	requires final uncomp port settlement? (see " for no, for the port	ensated car instructior ion of the	re is)	N	N				22
. 02	payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob	requires final uncompeport settlement? (see of the portment) for the portment 1. Enter in column	ensated car instructior ion of the 2, "Y" for	re is) yes	N	N				22
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. 03	payments to be determined at cost referred in column 1, "Y" for yes or "N cost reporting period prior to Octobor "N" for no, for the portion of th October 1.  Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in cfor the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.  Which method is used to determine Me below? In column 1, enter 1 if date	requires final uncomp port settlement? (see "for no, for the port er 1. Enter in column he cost reporting perio dic reclassification fr ds for delineating sta folumn 1, "Y" for yes o g period prior to Octo no for the portion of er October 1. (see ins 100 but not more than 2.105)? Enter in colum ddicaid days on lines 2 of admission, 2 if cen	ensated car instruction instruction of the 2, "Y" for d on or aft om urban to tistical ar "N" for r ber 1. Ente the cost tructions) 499 beds (an 3, "Y" for 4 and/or 25 sus days, co	yes eer ceas no er		N		N		22 22 23
. 03	payments to be determined at cost referred in column 1, "Y" for yes or "N cost reporting period prior to October "N" for no, for the portion of the October 1.  Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.  Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method	requires final uncomp port settlement? (see "for no, for the port er 1. Enter in column he cost reporting perio lic reclassification fr ds for delineating sta column 1, "Y" for yes o no for the portion of er October 1. (see ins 100 but not more than 2.105)? Enter in colum ddicaid days on lines 2 of admission, 2 if cen of identifying the day	ensated car instruction ion of the 2, "Y" for d on or aft om urban to tistical ar "N" for reber 1. Ente the cost tructions) 499 beds (an 3, "Y" for 4 and/or 25 sus days, cos in this cost instructions)	yes eer ceas no er		N		N		22
. 03	payments to be determined at cost reenter in column 1, "Y" for yes or "N cost reporting period prior to Octobor "N" for no, for the portion of the October 1.  Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in continuous 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.  Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	requires final uncomp port settlement? (see "for no, for the port her 1. Enter in column he cost reporting perio lic reclassification fr ds for delineating sta column 1, "Y" for yes o no for the portion of er October 1. (see ins 100 but not more than 2.105)? Enter in colum ddicaid days on lines 2 of admission, 2 if cen of identifying the day method used in the pri	ensated car instruction ion of the 2, "Y" for d on or aft om urban to tistical ar "N" for r ber 1. Ente the cost tructions) 499 beds (an 3, "Y" for 4 and/or 25 sus days, cos in this cor cost	yes eer ceas no er		N		N		22
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						6/29/20	<u>) 20 8: 4</u>	0 am		
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	ys Med	ther di cai d days			
	1.00	2. 00	3. 00	4. 00	5. 00	(	5. 00			
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in col 4, Medicaid HMO paid and eligible but unpaid days column 5, and other Medicaid days in column 6.	umn i n					0	C			
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-st Medicaid eligible unpaid days in column 4, Medica HMO paid and eligible but unpaid days in column 5	id	0	0	Urban (F	Rural S	O Data of	Coogn	25. 00		
				1. (		2.0		-		
26.00 Enter your standard geographic classification (no cost reporting period. Enter "1" for urban or "2" Enter your standard geographic classification (no reporting period. Enter in column 1, "1" for urba	for rural. t wage) status n or "2" for r	at the end ural. If ap	of the cos	the	2 2			26. 00 27. 00		
enter the effective date of the geographic reclas 35.00 If this is a sole community hospital (SCH), enter effect in the cost reporting period.			CH status in	ו	0			35. 00		
				Begi ni		Endi		-		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.										
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status  is in effect in the cost reporting period.										
37.01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y instructions)								37. 01		
38.00 If line 37 is 1, enter the beginning and ending of greater than 1, subscript this line for the number enter subsequent dates.								38. 00		
				Υ/		Υ/				
39.00 Does this facility qualify for the inpatient hosp hospitals in accordance with 42 CFR §412.101(b)(2 1 "Y" for yes or "N" for no. Does the facility me accordance with 42 CFR 412.101(b)(2)(i), (ii), or "N" for no. (see instructions)	)(i), (ii), or et the mileage	(iii)? Ent	er in colur nts in	nn		2. ( N		39. 00		
40.00 Is this hospital subject to the HAC program reduce "N" for no in column 1, for discharges prior to 0 no in column 2, for discharges on or after Octobe	ctober 1. Ente	r "Y" for y	or yes on "N" 1	or N For	I	N	I	40. 00		
pro 111 con anni 2, 101 di sondi ges on di ai tei detabe	(300 11131	. 40 (1 0113)			V	XVIII	XIX			
Prospective Payment System (PPS)-Capital					1.00	2. 00	3.00			
45.00 Does this facility qualify and receive Capital pa with 42 CFR Section §412.320? (see instructions)	yment for disp	roporti onat	e share in	accordance	N	N	N	45. 00		
46.00 Is this facility eligible for additional payment pursuant to 42 CFR §412.348(f)? If yes, complete Pt. III.	•		,		N	N	N	46. 00		
47.00 Is this a new hospital under 42 CFR §412.300(b) F 48.00 Is the facility electing full federal capital pay	•		,		N N	N N	N N	47. 00 48. 00		
Teaching Hospitals  56.00 Is this a hospital involved in training residents "N" for no in column 1. If column 1 is "Y", are y  CME payment reduction? Enter "Y" for yes or "N"	ou impacted by	CR 11642 (		,				56. 00		
GME payment reduction? Enter "Y" for yes or "N" 57.00 If line 56 is yes, is this the first cost reporti GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first for yes or "N" for no in column 2. If column 2 i "N", complete Wkst. D, Parts III & IV and D-2, Pt	ng period duri for yes or "N month of this s "Y", complet	ng which re " for no ir cost report e Worksheet	n column 1. ing period1	If column ? PEnter "Y'				57.00		
58.00 If line 56 is yes, did this facility elect cost r defined in CMS Pub. 15-1, chapter 21, §2148? If y	eimbursement f	or physicia	ns' service	es as				58. 00		
59.00 Are costs claimed on line 100 of Worksheet A? If			Pt. I.		N			59. 00		

resident FTEs attributable to rotations occurring in all nonprovider

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1312 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8: 40 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 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 FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1312	Period: From 01/01/2019 To 12/31/2019		epared:
		1.00	
Long Term Care Hospital PPS  1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  1.00 Is this a LTCH co-located within another hospital for part or all of the cost report "Y" for yes and "N" for no.	ting period? Enter	N N	80. 00 81. 00
TEFRA Providers  .00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for y Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(4)(i) TeFRA? Enter "Y" for your and "Y"		N	85. 0 86. 0
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  1s this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	on	N	87. 0
[1880(d)(1)(b)(v1): Litter 1 for yes of N for ho.	1. 00	XI X 2. 00	
Title V and XIX Services			
.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	or N	Y	90.0
.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	n N	N	91. (
.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.0
instructions) Enter "Y" for yes or "N" for no in the applicable column.  One of this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	er N	N	93. 0
"Y" for yes or "N" for no in the applicable column.  .00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	94.0	
applicable column.  .00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	95. (
.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N N	N N	96. 0
applicable column.  .00   If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	97.0
.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	Y	98. 0	
column 1 for title V, and in column 2 for title XIX.		Y	98.0
.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on WFC, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 i		Ť	90.0
title XIX.  .02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	n N	Υ	98. 0
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	1		
.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CA reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in colum		N	98. 0
for title V, and in column 2 for title XIX.			
.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, a	and N	N	98. 0
in column 2 for title XIX.  .05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance	on N	Y	98. 0
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and column 2 for title XIX.			
.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	N	Y	98. 0
Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			
Rural Providers 5.00 Does this hospital qualify as a CAH?	Y		105. C
6.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of paym			106. 0
for outpatient services? (see instructions) 7.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&F	R N		107. 0
training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an			
approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			
8.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See	42 N		108.0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  Physical Occupation	onal Speech	Respi ratory	
9.00  f this hospital qualifies as a CAH or a cost provider, are N N	3. 00 N	4. 00 N	109. 0
therapy services provided by outside supplier? Enter "Y"	IN.	IN	107.0

	1.00	
110.00Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

		Period: From 01/01/2019 To 12/31/2019	u of Form CMS Worksheet S- Part I Date/Time Pr 6/29/2020 8:	epared
		1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, of integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	N		111. C
	1. 00	2. 00	3.00	$\dashv$
12.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period?  Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	N N	2.00	3.00	112. C
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.  16.00 Is this facility classified as a referral center? Enter "Y" for yes or	N N			0 115. C
"N" for no.				
17.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.  18.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	N	1		117. C
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premiums	Losses	Insurance	
18.01 List amounts of malpractice premiums and paid losses:	1. 00 39, 7	2.00	3.00	0118.0
10. OT LEST dimodrits of marpractice premiums and part 1033es.	37, 1	14 0		0110.0
		1. 00	2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost center other 1		N		118. (
Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y"  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)	' for yes or ne Outpatient		N	119. ( 120. (
Administrative and General? If yes, submit supporting schedule listing count and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless proving S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  21.00 Did this facility incur and report costs for high cost implantable devices	' for yes or ne Outpatient ructions)		N	
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Administrative and General? If yes, submit supporting schedule listing coand amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless proves \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as defined in \$1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.  Transplant Center Information  25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2.  27.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2.  28.00 If this is a Medicare certified liver transplant center, enter the certification of this is a Medicare certified liver transplant center, enter the certification of this is a Medicare certified liver transplant center, enter the certification of this is a Medicare certified liver transplant center, enter the certification of this is a Medicare certified pancreas transplant center, enter the certification of this is a Medicare certified pancreas transplant center, enter the certification of this is a Medicare certified pancreas transplant center, enter the certification of this is a Medicare certified pancreas transplant center, enter the certification of this is a Medicare certified intestinal transplant center, enter the certifica	for yes or ne Outpatient ructions) s charged to (w)(3) of the in column 2 for no. If fication date cation date cation date itification cation date	Y Y		120.

Health Financial Systems IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1312 Peri od: Worksheet S-2 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: To 6/29/2020 8:40 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: INDIANA UNIVERSITY HEALTH | Contractor's Name: WPS 141. 00 Name: INDIANA UNIVERSITY HEALTH Contractor's Number: 08101 141 00 142.00 Street: 340 WEST 10TH STREET PO Box: 142.00 143.00 City: INDIANAPOLIS State: Zip Code: 46202 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 Ν 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in

column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
	-								
		1.00							
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act								
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00						
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the		168. 00						
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	i ilai usiii p		168. 01						
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		0.6	00169. 00						
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)									
	Begi nni ng	Endi ng							
	1.00	2.00							
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00						
	1. 00	2.00							
171.00 ffline 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	10	08 171. 00						

OSPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1312	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Pre 6/29/2020 8:4	epared
				Y/N	Date	+U alli
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ente	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1. (
	reporting period. It yes, enter the date of the change in de	7 (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2. (
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug er or its the board	Y			3. (
	Teratronships: (see Tristructrons)		Y/N	Туре	Date	
			1.00	2.00	3. 00	
. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.0
. 00	Are the cost report total expenses and total revenues differ		N			5. (
	those on the filed financial statements? If yes, submit reco	onciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities	16 !		- I N		١,
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	ir yes, is tr	ne provider is	S N		6.
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a		d during the	N N		7. ( 8. (
. 00	cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved of	graduate medio	cal education	N		9.
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or		the current	N		10.
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
	Bad Debts				Y/N 1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes,				Υ	12.
	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.		-		N	13.
4.00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	its warveur i	yes, see ms	structions.	N	14.
5. 00	Did total beds available change from the prior cost reporting				N	15.
		Y/N	Tt A Date	Y/N Par	t B Date	
		1. 00	2.00	3. 00	4. 00	
	PS&R Data					
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16.
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	04/01/2020	Y	04/01/2020	17.
3. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
9. 00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

Heal th	Financial Systems IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1312	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S Part II Date/Time P 6/29/2020 8	repared:
		Descr	i pti on	Y/N	Y/N	. 10
			0	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		_	N	N	20. 00
		Y/N	Date	Y/N	Date	
	III	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 (EXCE	PT CHILDRENS H	HOSPI TALS)		1.00	
	Capital Related Cost		,			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	yes, submit	N	27. 00		
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	reporti ng	N	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	suance of new	debt? If yes	, see	N	31. 00
	instructions.  Purchased Services					_
32. 00	Have changes or new agreements occurred in patient care ser	rvi ces furni she	ed through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	ıcti ons.	•		IV	33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provi der-ba	sed physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35. 00
				Y/N	Date	
	H 066: C+-			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Y		36.00
36.00	If line 36 is yes, has a home office cost statement been pr	enared by the	home office?			37.00
	If yes, see instructions.					
	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	of the home of	offi ce.			38. 00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compor	nents? If yes	, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
	Cost Depart Dropager Contact Information	1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	UTTER		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost	317. 962. 1093		RUTTER@I UHEALTI	H. ORG	43.00
	report preparer in columns 1 and 2, respectively.					13.33

Health Financial Systems		IU HEALTH	WHITE	HOSPI TAL				In Lie	u of Form	CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH	CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN: 15		Peri		Workshee	et S-2	
								01/01/2019		D	
							To	12/31/2019	6/29/202	ne Pre	parea:
							_		0/29/202	20 8:4	U alli
							_				
					3. 00						
Cost Report Preparer Co	ntact Information										
41.00 Enter the first name, I	ast name and the t	itle/position	GO\	VERNMENT F	PROGRAMS	DI RECTOR	7				41.00
held by the cost report	preparer in colum	ns 1. 2. and 3.									
respectively.	1 1										
42.00 Enter the employer/comp	any name of the co	st report									42.00
preparer.	ang name en ene ee	от горог с									12.00
43.00 Enter the telephone num	bor and omail addr	oss of the cost									43.00
											43.00
report preparer in colu	ımns ı and 2, respe	ecti vei y.	ı				1				l

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared:

					[7	Го 12/31/2019	Date/Time Pre	
							I/P Days / 0/P	Jaili
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 125	41, 088. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 125	41, 088. 00	0	7. 00
0.00	beds) (see instructions)							8. 00
8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							9. 00 10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)			25	9, 125	41, 088. 00	0	14. 00
15. 00	CAH visits			23	7, 120	41,000.00	Ö	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21.00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32. 00	Labor & delivery days (see instructions)			0		ן		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33. 00
	LTCH fion-covered days  LTCH si te neutral days and di scharges							33. 00
55. 01	121011 of to floati at days and at scharges		I		ı	1	I	33.01

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: | 6/29/2020 8:40 am

						6/29/2020 8: 4	0 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 014	12	1, 712	!		1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	278	136				2. 00
3. 00	HMO IPF Subprovider	2/0	130				3. 00
4. 00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	152	0	152			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	132	0	376			6. 00
7. 00	Total Adults and Peds. (exclude observation	1, 166	12	2, 240			7. 00
7.00	beds) (see instructions)	1, 100	12	2,210			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	1, 166	12	2, 240	0.00	137. 34	14. 00
15. 00	CAH visits	0	0	C	)		15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0	0	C	0.00	0.00	21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D.P.)	۷	U	U	0.00	0.00	23. 00
24. 00	HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)			1			24. 10
25. 00	CMHC - CMHC			·			25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	ol	0	C	0.00	0.00	
27. 00	Total (sum of lines 14-26)				0.00	137. 34	27. 00
28. 00	Observation Bed Days		17	571			28. 00
29. 00	Ambul ance Tri ps	o					29. 00
30.00	Employee discount days (see instruction)			C	)		30.00
31. 00	Employee discount days - IRF			C	)		31. 00
32.00	Labor & delivery days (see instructions)	0	0	C	)		32. 00
32. 01	Total ancillary labor & delivery room			C			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

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared:

				To	12/31/2019	Date/Time Pre   6/29/2020 8:40	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14.00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	318	5	526	1. 00
2.00	HMO and other (see instructions)			66	45		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				1		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
8.00	INTENSIVE CARE UNIT						9. 00
9.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. 00 10. 00
10. 00 11. 00	· ·						10.00
	SURGICAL INTENSIVE CARE UNIT						
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12. 00 13. 00
14. 00	Total (see instructions)	0. 00	0	318	-	526	14. 00
	,	0.00	U	318	٥	520	15. 00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IPF				+		17. 00
18. 00	SUBPROVI DER - TRF				+		18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23. 00
24. 00	HOSPICE						24. 00
24. 00	HOSPICE (non-distinct part)						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 (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 00	Total ancillary labor & delivery room						32. 00 32. 01
32.01	outpatient days (see instructions)						J2. U1
33. 00	LTCH non-covered days	ł		0	1		33. 00
	LTCH site neutral days and discharges			Ö			33. 01
55. 51	1 =	1		. 9			

INSPI TA	Financial Systems IU HEALTH WHITE HOS AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN	. 15_1312	Peri od:	u of Form CMS-2 Worksheet S-10				
103P1 1 <i>F</i>	AL UNCOMPENSATED AND INDIGENT CARE DATA	TOVI dei CCN		From 01/01/2019	WOLKSHEET 3-10	U			
				To 12/31/2019					
					6/29/2020 8: 4	U am			
				•	1. 00				
	Uncompensated and indigent care cost computation			>					
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line	e 202 column	8)	0. 314386	1. (			
	Medicaid (see instructions for each line) Net revenue from Medicaid				1, 181, 338	2. (			
	Did you receive DSH or supplemental payments from Medicaid?				1, 101, 330 N	3. (			
	If line 3 is yes, does line 2 include all DSH and/or supplemental	l payments	from Medica	i d?	14	4.			
	If line 4 is no, then enter DSH and/or supplemental payments from				0	1			
	Medi cai d charges		13, 761, 177	6.					
	Medicaid cost (line 1 times line 6)				4, 326, 321	7.			
	Difference between net revenue and costs for Medicaid program (I	ine 7 minus	s sum of lin	es 2 and 5; if	3, 144, 983	8.			
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>								
	Net revenue from stand-alone CHIP	each Tille)			0	9. (			
	Stand-al one CHIP charges				0	1			
	Stand-alone CHIP cost (line 1 times line 10)				0				
2. 00	Difference between net revenue and costs for stand-alone CHIP (II	ine 11 minu	ıs line 9; i	f < zero then	0	12.			
-	enter zero)								
	Other state or local government indigent care program (see instru			`		1,0			
	Net revenue from state or local indigent care program (Not include Charges for patients covered under state or local indigent care)					13. 14.			
	10)	program (NC	ot included	in times o or	U	14.			
	State or local indigent care program cost (line 1 times line 14)				0	15.			
	Difference between net revenue and costs for state or local indicates		rogram (lin	e 15 minus line	-	16.			
	13; if < zero then enter zero)								
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/	'local indig	ent care program	is (see				
	Private grants, donations, or endowment income restricted to fund	ding charit	y care		0	17.			
8. 00	Government grants, appropriations or transfers for support of hos	spital oper	ations		0	18.			
	Total unreimbursed cost for Medicaid, CHIP and state and local i	indigent ca	are programs	(sum of lines	3, 144, 983	19.			
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1				
			patients	pati ents	+ col . 2)				
			1.00	2. 00	3. 00				
	Uncompensated Care (see instructions for each line)		0.050.75		0.004.050				
0. 00	Charity care charges and uninsured discounts for the entire facilisee instructions)	IITY	2, 859, 75	71, 297	2, 931, 053	20.			
1. 00	Cost of patients approved for charity care and uninsured discoun	ts (see	899, 06	71, 297	970, 364	21			
	instructions)	(555	3777 33	7.727	7707001				
2. 00	Payments received from patients for amounts previously written or	ff as	1, 21	1 0	1, 211	22.			
1	charity care								
3. 00	Cost of charity care (line 21 minus line 22)		897, 85	6 71, 297	969, 153	23.			
					1. 00				
4. 00	Does the amount on line 20 column 2, include charges for patient	days beyon	nd a Length	of stay limit	N N	24.			
	imposed on patients covered by Medicaid or other indigent care pr		3	,					
	If line 24 is yes, enter the charges for patient days beyond the stay $\mathop{\hbox{limit}}$	indigent c	care program	's length of	0	25.			
	Total bad debt expense for the entire hospital complex (see inst	ructions)			3, 366, 910	26.			
	Medicare reimbursable bad debts for the entire hospital complex	•	,		670, 812	1			
1	Medicare allowable bad debts for the entire hospital complex (see	e instructi	ons)		1, 032, 020	1			
7. 01									
7. 01 8. 00	Non-Medicare bad debt expense (see instructions)					1			
7. 01 8. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expenses	nse (see in	nstructions)		1, 095, 265	29.			
7. 01 8. 00 9. 00 0. 00	·		nstructi ons)			29. 30.			

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		Provi der CC	CN: 15-1312	Peri od:	Worksheet A	
			-	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
					6/29/2020 8: 4	
Cost Center Description	Sal ari es	0ther	lotal (col. 1   + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
			+ (01. 2)	ons (see A-6)	(col. 3 +-	
					col . 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS		4 500 /50	4 500 /5	0 4 500 075	44 577	4 00
1.00   00100   CAP REL COSTS-BLDG & FIXT 1.01   00101   CAP REL COSTS-BLDG & FIXT - HOSPITAL		1, 599, 652 0		2 -1, 588, 075 0 2, 466, 396	11, 577 2, 466, 396	1. 00 1. 01
1.02 O0101 CAP REL COSTS-BLDG & FIXT - HOSPITAL  1.02 O0102 CAP REL COSTS-BLDG & FIXT - TLMOB		0		0 2, 466, 396	2, 400, 390	1. 01
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT	93	50, 930			1, 579, 332	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	615, 168	7, 359, 972			7, 520, 352	5. 00
7.00   OO700 OPERATION OF PLANT	353, 809	1, 907, 976	2, 261, 78	5 -1, 865, 791	395, 994	7. 00
7.01   OO701   OPERATION OF PLANT - HOSPITAL	0	0		0 1, 689, 350	1, 689, 350	7. 01
7. 02   00702   OPERATION OF PLANT - TLMOB	0	0	•	0 330, 942	330, 942	7. 02
8. 00   00800   LAUNDRY & LI NEN SERVI CE	0	0		0 68, 164	68, 164	8. 00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY	311, 032 483, 191	267, 561 356, 031	578, 59 839, 22		385, 463 527, 679	9. 00 10. 00
11. 00   01100   CAFETERI A	403, 191	330, 031		0 149, 825	149, 825	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	678, 286	219, 941	898, 22		1, 003, 907	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	40, 786			659, 916	14. 00
15. 00 01500 PHARMACY	366, 989	3, 027, 645	3, 394, 63	4 -2, 727, 103	667, 531	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1 222 252			1 001 110	
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	1, 346, 846	1, 003, 250	2, 350, 09	6 -458, 677	1, 891, 419	30. 00
50. 00 05000 OPERATING ROOM	459, 387	881, 252	1, 340, 63	9 -328, 481	1, 012, 158	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	314, 533	384, 618			434, 081	54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	80, 994	61, 253			106, 399	55. 00
56. 00   05600   RADI 01 SOTOPE	125, 439	52, 158	177, 59		134, 286	56. 00
57. 00   05700   CT   SCAN	361, 752	256, 364			395, 112	57. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	127, 789	84, 102			144, 073	58. 00
60. 00   06000   LABORATORY 66. 00   06600   PHYSI CAL THERAPY	0 385, 631	1, 259, 696 112, 988			1, 259, 706 420, 488	60. 00 66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	117, 917	30, 427			129, 523	67. 00
68. 00 06800 SPEECH PATHOLOGY	68, 545	20, 194			74, 221	
69. 00 06900 ELECTROCARDI OLOGY	110, 960	38, 816			123, 170	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 22, 870	22, 870	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		9, 056	9, 056	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 389, 094	389, 094	73. 00
73. 01   07301   0NCOLOGY DRUGS	0	0		0 2, 306, 631	2, 306, 631	73. 01
76. 00   03160   CARDI OPULMONARY 76. 97   07697   CARDI AC   REHABI LI TATI ON	467, 921 21, 760	262, 162 159, 262			567, 225 180, 067	76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	21,700	137, 202	101, 02.	2  -900	180, 007	70. 77
90. 00 09000 CLINIC	117, 832	87, 094	204, 92	6 -40, 570	164, 356	90. 00
91. 00 09100 EMERGENCY	1, 134, 144	1, 803, 742			2, 505, 850	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92.01 O9201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS	0	0			0	101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 050, 018	21, 327, 872	29, 377, 89	0 572, 679	29, 950, 569	118. 00
NONREI MBURSABLE COST CENTERS	0,000,010	21,021,012	27/07/107	0,2,0,,	27,700,007	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	79, 349	24, 510			86, 458	
192. 02 19202 MOB	0	555, 277	555, 27	7 -555, 278		192. 02
192. 03 19203 ARNETT SURGERY OFFICE 192. 04 19201 OCCUPATI ONAL MEDICINE	0	0				192. 03 192. 04
193. 00 19300 NONPALD WORKERS	0	0				192. 04
200.00 TOTAL (SUM OF LINES 118 through 199)	8, 129, 367	21, 907, 659	30, 037, 02	6 0	30, 037, 026	
. ,	• •		•			•

| Period: | Worksheet A | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8: 40 am

				6/29/2020 8: 40	o am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	26, 225	37, 802		1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	206, 340	2, 672, 736		1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB	293, 636	517, 992		1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	282, 819	1, 862, 151		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-697, 898	6, 822, 454		5. 00
7.00	00700 OPERATION OF PLANT	0	395, 994		7. 00
7.01	00701 OPERATION OF PLANT - HOSPITAL	36, 780	1, 726, 130		7. 01
7.02	00702 OPERATION OF PLANT - TLMOB	0			7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0			9. 00
10.00	01000 DI ETARY	-136, 934			10. 00
11. 00	01100 CAFETERI A	-59, 461	90, 364		11. 00
13. 00	01300 NURSING ADMINISTRATION	23, 223		l l	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-16, 893		l l	14. 00
15. 00	01500 PHARMACY	202, 114	869, 645	l l	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	202, 114	l	1	16. 00
16.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				16.00
30. 00	03000 ADULTS & PEDIATRICS	-219, 866	1, 671, 553		30. 00
30.00	ANCILLARY SERVICE COST CENTERS	-217,000	1,071,555		30.00
50. 00	05000 OPERATING ROOM	-217, 930	794, 228		50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-217, 750			54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	-232	l		55. 00
56. 00	05600 RADI OLOGY-THERAPEUTI C	0			56. 00
					56.00
57. 00 58. 00	05700 CT SCAN				58.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)				
60.00	06000 LABORATORY	0			60.00
66.00	06600 PHYSI CAL THERAPY	0			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0			67. 00
68. 00	06800 SPEECH PATHOLOGY	0			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71. 00
72. 00		0			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	,		73.00
73. 01	07301 ONCOLOGY DRUGS	0	_, _,		73. 01
76.00	03160 CARDI OPULMONARY	99, 894			76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	180, 067		76. 97
	OUTPAȚIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	164, 356		90.00
91.00	09100 EMERGENCY	18, 230	2, 524, 080		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92. 01
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
	SPECIAL PURPOSE COST CENTERS				
118.00		-159, 973	29, 790, 596		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191.00	19100 RESEARCH	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	86, 458		192. 00
192. 02	2 19202 MOB	0	-1		192. 02
	19203 ARNETT SURGERY OFFICE	0	0		192. 03
	4 19201 OCCUPATIONAL MEDICINE	0	O		192. 04
	19300 NONPALD WORKERS	0	0		193. 00
200.00		-159, 973	29, 877, 053		200. 00
	1 23			1	

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: | 6/29/2020 8: 40 am Provider CCN: 15-1312

					10 127	6/29/2020 8: 40 am	
		Increases					
	Cost Center	Li ne #	Sal ary	Other 5			
	2.00	3. 00	4. 00	5. 00	<u> </u>		
1. 00	A - CAFETERIA CAFETERIA	11.00	102, 981	46, 844		1. C	00
1.00	CAFETERIA		102, 981	4 <u>6, 844</u> 46, 844		1.0	JU
	B - DRUGS EXPENSE		102, 701	40, 044			
1.00	DRUGS CHARGED TO PATIENTS	73.00	ol	389, 094		1. 0	00
2.00	ONCOLOGY DRUGS	73. 01	o	2, 306, 631		2.0	
3.00		0.00	o	0		3. C	
4.00		0.00	O	0		4. C	00
5.00		0.00	0	0		5. C	00
6.00		0.00	0	0		6. C	00
7.00		0.00	0	0		7. C	
8.00		0.00	0	0		8.0	
9.00		0.00	0	0		9. 0	
10.00		0.00	0	0		10.0	
11.00		0.00	0	0		11.0	
12. 00 13. 00		0. 00 0. 00	0	0		12. C	
14. 00	1	0.00	0	0		14. 0	
15. 00		0.00	o	0		15. 0	
10.00		— — <del>••••</del>	<del> </del>	2, 695, 725		10.0	00
	C - MEDICAL SUPPLIES AND REBA	ATES	<u> </u>	270707720			
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	623, 592		1. C	00
2.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	22, 870		2. 0	00
	PATI ENTS						
3.00	I MPL. DEV. CHARGED TO	72. 00	0	9, 056		3. C	00
4 00	PATI ENTS			, ,			00
4. 00 5. 00	ADMINISTRATIVE & GENERAL	5. 00 60. 00	0	61		4. C 5. C	
6. 00	LABORATORY MOB	192. 02	0	10 20		•	
7. 00	INIOB	0.00	0	0		6. C	
8. 00		0.00	Ö	0		8. 0	
9. 00		0.00	ő	o		9. 0	
10. 00		0.00	o	0		10. 0	
11. 00		0.00	o	0		11. 0	
12.00		0.00	O	0		12.0	00
13.00		0.00	o	0		13. C	00
14.00		0.00	O	0		14. C	00
15.00		0.00	0	0		15. C	
16.00		0.00	0	0		16. C	
17. 00		0.00	0	0		17. C	
18. 00		0.00	0	0		18. C	
19. 00		0.00	0	0		19. 0	
20.00		0.00	0	0		20.0	
21. 00		0.00	0	0 655, 609		21.0	JU
	D - LAUNDRY		U	033, 009			
1.00	LAUNDRY & LINEN SERVICE	8.00	0	68, 164		1. C	00
2. 00		0.00	Ö	0		2. 0	
3.00		0.00	o	0		3. C	00
	0		0	68, 164			
	E - DEPRECIATION						
1. 00	CAP REL COSTS-BLDG & FIXT -	1. 01	0	1, 412, 682		1.0	00
2. 00	HOSPITAL CAP REL COSTS-BLDG & FIXT -	1. 02	0	248, 594		2.0	$\cap \cap$
∠. ∪∪	TLMOB	1.02	٩	240, 374		2.0	JU
3.00		0.00	o	0		3.0	00
4. 00		0.00	ő	o		4. 0	
5.00		0.00	O	0		5. C	
6.00		0.00	ō	0		6.0	
7.00		0.00	O	0		7. C	00
8.00		0.00	0	0		8. C	
9.00		0.00	0	0		9. 0	
10.00		0.00	0	0		10.0	
11.00	1	0.00	0	0		11. 0	
12.00		0.00	0	0		12. 0	
13.00		0.00	0	0		13.0	
14.00		0.00	0	0		14.0	
15. 00 16. 00		0. 00 0. 00	0	0		15. C 16. C	
16.00	1	0.00	0	0		17. 0	
18. 00		0.00	0	0		18.0	
19. 00		0.00	o	0		19. 0	
20. 00		0.00	Ö	Ö		20.0	
21. 00		0.00	Ō	0		21. 0	
	•		<u>'</u>	<u> </u>		 !	—

Provider CCN: 15-1312 Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					пе Ргерагеа: 20 8:40 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
00.00	2. 00	3.00	4.00	5. 00	 00.00
22. 00			0	0 0 1,661,276	22. 00
	F - OTHER CAPITAL EXPENSES		U	1,001,270	
1.00	CAP REL COSTS-BLDG & FIXT -	1. 01	O	1, 029, 475	1.00
1.00	HOSPI TAL	1.01	Ĭ	1,027,170	1.00
2.00	CAP REL COSTS-BLDG & FIXT -	1. 01	О	24, 239	2. 00
	HOSPI TAL				
3.00	MOB	<u> </u>	0_	<u>24, 2</u> 38	3. 00
	TOTALS		0	1, 077, 952	
1 00	G - OPERATION OF PLANT	7 01	O	1 (00 250	1 00
1. 00	OPERATION OF PLANT - HOSPITAL	7. 01	۷	1, 689, 350	1. 00
2.00	OPERATION OF PLANT - TLMOB	7. 02	o	330, 942	2. 00
2.00	0		-	2,020,292	2.00
	H - EMPLOYEE BENEFITS		-1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 530, 149	1.00
2.00		0.00	0	0	2. 00
3.00		0.00	0	0	3. 00
4.00		0.00	0	0	4. 00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6. 00
7.00		0.00	0	0	7. 00
8. 00 9. 00		0. 00 0. 00	0	0	8. 00 9. 00
9. 00 10. 00	+	0.00	0	0	10.00
11. 00		0.00	0	0	11. 00
12. 00		0.00	ő	0	12.00
13. 00		0.00	ol	Ö	13. 00
14. 00		0.00	ō	0	14. 00
15.00		0.00	О	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	001,530,149	22. 00
	I - HOUSEKEEPING SUPPLIES		U	1, 530, 149	
1. 00	HOUSEKEEPI NG	9.00	0	6, 355	1.00
2.00		0.00	ő	0, 333	2. 00
3.00		0.00	ō	0	3. 00
4.00		0.00	o	0	4. 00
5.00		0.00	O	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. 00	0	0	10.00
11. 00			0	<u>0</u> 6, 355	11.00
	J - NON-CAPITAL EXPENSES		U <sub>I</sub>	0, 333	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	71	1.00
50	TOTALS	— — <del></del>	<del>-</del> - <del>-</del>	— — <u></u> 7 <u>1</u>	1.30
	K - CNO		<u> </u>		
1.00	NURSING ADMINISTRATION	13.00	198, 876	0	1. 00
	TOTALS		198, 876		
500.00	Grand Total: Increases		301, 857	9, 762, 437	500.00

RECLASSI FI CATIONS

Provider CCN: 15-1312

Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Ti me Prepared:

6/29/2020 8:40 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA 1.00 DI ETARY 10.00 102, 981 46, 844 0 1.00 46, 844 102, 981 B - DRUGS EXPENSE 1.00 CENTRAL SERVICES & SUPPLY 14.00 1, 790 0 1.00 PHARMACY 0 2, 640, 637 0 2.00 15.00 2.00 3.00 ADULTS & PEDIATRICS 30.00 ol 6.886 0 3.00 0 0 4.00 OPERATING ROOM 50.00 4,770 4.00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 0 2, 465 0 5.00 RADI OLOGY-THERAPEUTI C 17, 212 6.00 55.00 0 0 6.00 7 00 RADI OI SOTOPE 56 00 0 0 7 00 210 0 8.00 CT SCAN 57.00 0 5, 293 8.00 9.00 MAGNETIC RESONANCE IMAGING 58.00 0 0 9.00 11 (MRI) 10.00 PHYSICAL THERAPY 0 10.00 66, 00 0 ELECTROCARDI OLOGY 0 0 11.00 69.00 11.00 12.00 CARDI OPULMONARY 76.00 0 2, 187 0 12.00 90.00 0 0 13.00 CLINIC 4, 197 13.00 0 10, 050 0 14.00 EMERGENCY 91.00 14.00 PHYSICIANS' PRIVATE OFFICES 15.00 192.00 11 0 15.00 0 2, 695, 725 - MEDICAL SUPPLIES AND REBATES 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 426 0 1.00 2.00 OPERATION OF PLANT 7.00 0 24.938 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 18, 654 0 3.00 0 1, 292 0 DI ETARY 10.00 4.00 4.00 0 NURSING ADMINISTRATION 0 5.00 13.00 38 5.00 6.00 PHARMACY 15.00 0 10, 514 0 6.00 o 97, 849 0 7.00 ADULTS & PEDIATRICS 30.00 7.00 o 0 OPERATING ROOM 50.00 8.00 168, 266 8.00 RADI OLOGY-DI AGNOSTI C 0 0 9.00 54.00 4, 302 9.00 10.00 RADI OLOGY-THERAPEUTI C 55.00 0 86 0 10.00 9, 405 0 11.00 RADI OI SOTOPE 56.00 0 11.00 0 12 00 CT SCAN 57 00 65 560 0 12 00 MAGNETIC RESONANCE I MAGING 0 13.00 58.00 0 10, 447 13.00 (MRI) PHYSICAL THERAPY 0 14.00 66.00 4,620 14.00 15.00 OCCUPATIONAL THERAPY 67.00 0 0 15.00 224 9,640 ELECTROCARDI OLOGY 0 0 16.00 69.00 16.00 17.00 CARDI OPULMONARY 76.00 0 47, 860 0 17.00 18.00 CARDIAC REHABILITATION 76.97 0 60 0 18.00 90.00 0 0 19.00 19.00 ICLI NI C 7.660 0 20.00 EMERGENCY 91.00 0 172, 197 20.00 21.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 1, 571 0 21.00 655, 609 D - LAUNDRY 1.00 HOUSEKEEPI NG 9.00 0 62, 293 0 1.00 2.00 DI ETARY 10.00 0 5,846 0 2.00 50.00 3.00 OPERATING ROOM o 25 0 3.00 Ō 68, 164 - DEPRECIATION 1.00 CAP REL COSTS-BLDG & FIXT 1. 00 0 558, 529 9 1.00 EMPLOYEE BENEFITS DEPARTMENT 2.00 4.00 0 1.414 2.00 3.00 ADMINISTRATIVE & GENERAL 5.00 0 164, 736 0 3.00 4.00 OPERATION OF PLANT 7.00 0 67, 577 0 4.00 0 DI ETARY 10.00 0 39, 658 5.00 5.00 0| CENTRAL SERVICES & SUPPLY 0 6.00 14.00 2,672 6.00 7.00 PHARMACY 15.00 0 35, 123 0 7.00 o 0 8.00 ADULTS & PEDIATRICS 30.00 69, 788 8.00 0 0 OPERATING ROOM 50.00 79. 954 9.00 9.00 RADI OLOGY-DI AGNOSTI C 0 0 10.00 54.00 186, 938 10.00 11.00 RADI OLOGY-THERAPEUTI C 55.00 0 3, 494 0 11.00 RADI OI SOTOPE 0 0 12.00 56.00 17,047 12.00 13 00 CT SCAN 57 00 0 86 549 0 13 00 0 14.00 MAGNETIC RESONANCE I MAGING 58.00 0 40, 443 14.00 (MRI) PHYSICAL THERAPY 66.00 0 15.00 0 262 15.00 OCCUPATIONAL THERAPY 67.00 0 0 16,00 16,00 60 17.00 ELECTROCARDI OLOGY 69.00 0 3.895 0 17.00 18.00 CARDI OPULMONARY 76.00 0 4, 385 0 18.00 19.00 CLINIC 90.00 0 14 0 19.00 0 47, 704 EMERGENCY 0 20.00 91.00 20.00 PHYSICIANS' PRIVATE OFFICES 0 0 21.00 192.00 2.440 21.00 22.00 MOB 192.02 248, 594 0 22.00

Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 8:40 am

Cost Center			Decreases				
O   1, 661, 276		Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
Comparison   Com		6. 00	7. 00	8. 00	9. 00	10. 00	
1.00   CAP REL COSTS-BLOG & FIXT   1.00   0   1.029, 475   11   2   2.00   2.00   ADMINISTRATIVE & GENERAL   5.00   0   24, 238   13   3.00   TILLINGE		0		0	1, 661, 276		
2.00   AMM IN STRATU VE & GENERAL   5.00   0   24, 239   12   3.00   CAP REL COSTS-BLOG & FIXT -   1.02   0   24, 238   13   3.00   TILNOR   TILN		F - OTHER CAPITAL EXPENSES					
CAP REL COSTS-BLOG & FIXT -   1.02	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 029, 475	11	1. 00
CAP REL COSTS-BLOG & FIXT -   1.02	2.00	ADMINISTRATIVE & GENERAL	5.00	O	24, 239	12	2. 00
TLAUGE	3.00	CAP REL COSTS-BLDG & FIXT -	1. 02	o			3. 00
Comparation					.,		
Color   Colo		TOTALS			1. 077. 952		
1.00   OPERATION OF PLANT		G - OPERATION OF PLANT					
2.00 MOB	1.00		7. 00	0	1, 689, 350	0	1. 00
Name		•					
- EMPLOYEE BENEFITS	2.00		— ···				2.00
1.00		H _ EMDLOVEE RENEELTS		<u> </u>	2,020,272		
2.00   OPERATION OF PLANT	1 00		5 00	٥	67.060	0	1 00
3.00 HOUSEKEEPING 9.00 0 118,538 0 3.00 3.00 4.00 bit Tarky 10.00 0 109,658 0 4.00 bit Tarky 10.00 0 109,658 0 5.00 5.00 0 8.00 0 8.00 0 93,158 0 5.00 6.00 pit Tarky 15.00 0 40,236 0 7.00 8.00 0 9.0					•		
4. 00   DIETRAPY   10. 00   0   109,658   0   4. 00   5. 00   6. 00   PHABMACY   15. 00   0   40,236   0   6. 00   PHABMACY   15. 00   0   40,236   0   7. 00   0   0   0   0   0   0   0   0   0				-1	•		
S. 0.0   NURSING ADMINI STRATION   13. 0.0   0   93.158   0   6. 00					•		
6. 00 PHARMACY		•			•		
7.00				-			
8.00   OPERATING ROOM   50.00   0   75,450   0   9.00				~			
9.00 RADI OLOGY-DI AGNOSTIC 0.00 RADIOLOGY-THERAPEUTIC 55.00 0.00 11.00 RADIOLOGY-THERAPEUTIC 55.00 0.00 11.00 RADIOLOGY-THERAPEUTIC 55.00 0.00 11.00 CT SCAN 57.00 0.00 0.16.602 0.00 11.00 CT SCAN 11.00 12.00 0.00 CMRDI 13.00 MORETIC RESONANCE IMAGING 58.00 0.00 0.16.977 0.00 13.00 MORETIC RESONANCE IMAGING 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.							1
10. 00				٩			
11. 00				9	•		
12. 00   CT SCAN				9	•		4
13.00   MAGNETIC RESONANCE I MAGING (MRI)				-	•		
MRI				0			
14.00   PHYSICAL THERAPY	13.00	MAGNETIC RESONANCE IMAGING	58. 00	0	16, 917	0	13. 00
15.00   OCCUPATIONAL THERAPY   67.00   0   18.537   0   15.00     16.00   SPECH PATHOLOGY   68.00   0   14.515   0   17.00     17.00   ELECTROCARDIOLOGY   69.00   0   13.066   0   17.00     18.00   CARDI OPULMONARY   76.00   0   108.417   0   18.00     19.00   CARDI OPULMONARY   76.97   0   895   0   19.00     20.00   CLINIC   90.00   0   28.672   0   20.00     21.00   EMERGENCY   91.00   0   202.064   0   21.00     22.00   EMERGENCY   91.00   0   13.379   0   0     1 - HOUSEKEEPING SUPPLIES   192.00   0   1,530,149     1 - HOUSEKEEPING SUPPLIES   10.00   0   5.264   0   2.00     2.00   DIETARY   10.00   0   5.264   0   2.00     3.00   PHARMACY   15.00   0   5.264   0   2.00     5.00   OPERATING ROOM   50.00   0   16   0   4.00     5.00   OPERATING ROOM   50.00   0   16   0   5.00     6.00   RADI OLOGY-DI AGNOSTIC   54.00   0   83   0   6.00     8.00   SPECCH PATHOLOGY   68.00   0   3   0   9   0     9.00   CARDI ACRO ACRO ACRO ACRO ACRO ACRO ACRO ACRO							
16. 00   SPEECH PATHOLOGY   68. 00   0   14, 515   0   16. 00     17. 00   ELECTROCARDI OLOGY   69. 00   0   13, 066   0     18. 00   CARDI AC REHABI LI TATI ON   76. 97   0   895   0     19. 00   CARDI AC REHABI LI TATI ON   76. 97   0   895   0     20. 00   CLI NI C   90. 00   0   28, 672   0     21. 00   EMERGENCY   91. 00   0   202, 064   0     22. 00   PHYSI CILANS' PRI VATE OFFICES   192. 00   0   13, 379   0     1 - HOUSEKEEPI NG SUPPLIES   10. 00   0   1, 530, 149     1 - HOUSEKEEPI NG SUPPLIES   10. 00   0   5, 264   0     20. 00   DI ETARY   10. 00   0   5, 264   0     20. 00   DI ETARY   10. 00   0   593   0     3. 00   PHARMACY   15. 00   0   16   0     5. 00   OPERATI NG ROOM   50. 00   0   16   0     6. 00   RADI OLOGY-DI AGNOSTI C   54. 00   0   83   0     6. 00   RADI OLOGY-DI AGNOSTI C   54. 00   0   47   0     7. 00   RADI OLOGY-DI AGNOSTI C   54. 00   0   47   0     8. 00   SPEECH PATHOLOGY   68. 00   0   27   0     10. 00   CLINI C   90. 00   0   27   0     11. 00   DI ETARY   10. 00   0   71     12   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   CLINI C   90. 00   0   27   0     11. 00   CLINI C   90. 00   0   27   0     11. 00   CLINI C   90. 00   0   27   0     11. 00   CLINI C   90. 00   0   71     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   0   27   0     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   90. 00   90. 00     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   90. 00   90. 00   90. 00     11. 00   OR OLOGY-DI AGNOSTI C   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00   90. 00				0	73, 248		
17. 00			67.00	0	18, 537	0	15. 00
18. 00   CARDI OPULMONARY   76. 00   0   108, 417   0   18. 00     19. 00   CARDI AC REHABI LITATI ON   76. 97   0   895   0   20. 00     20. 00   CLINI C   90. 00   0   28, 672   0   20. 00     21. 00   EMERGENCY   91. 00   0   202, 064   0   21. 00     22. 00   PHYSI CIANS' PRI VATE OFFI CES   192. 00   0   1, 530, 149	16.00	SPEECH PATHOLOGY	68.00	0	14, 515	0	16. 00
19. 00   CARDI AC REHABI LITATI ON   76. 97   0   895   0   19. 00	17.00	ELECTROCARDI OLOGY	69.00	0	13, 066	0	17. 00
20. 00   CLINIC   90. 00   0   28,672   0   20. 00     21. 00   EMERGENCY   91. 00   0   202,064   0     22. 00   PHYSICIANS' PRIVATE OFFICES   192. 00   0   13,379   0	18. 00	CARDI OPULMONARY	76.00	0	108, 417	0	18. 00
21.00   EMERGENCY	19.00	CARDIAC REHABILITATION	76. 97	o	895	0	19. 00
22.00   PHYSICIANS' PRIVATE OFFICES   192.00   0   13,379   0   22.00   0   1,530,149	20.00	CLINIC	90.00	o	28, 672	0	20.00
22.00   PHYSICIANS' PRIVATE OFFICES   192.00   0   13,379   0   0   1.530,149	21.00	EMERGENCY	91.00	O	202, 064	0	21. 00
1 - HOUSEKEEPING SUPPLIES   1 - HOUSEKEEPING SUPPLIES   1 - ON	22. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0			22. 00
1 - HOUSEKEEPING SUPPLIES   1 0							
1.00   ADMI NI STRATI VE & GENERAL   5.00   0   1   0   1.00   2.00   3.00   DI ETARY   10.00   0   5,264   0   2.00   3.00   PHARMACY   15.00   0   593   0   3.00   3.00   4.00   ADULTS & PEDI ATRI CS   30.00   0   291   0   0   4.00   5.00   6.00   7.00   83   0   6.00   6.00   7.00   RADI OLOGY-DI AGNOSTI C   54.00   0   83   0   6.00   7.00   RADI OLOGY-DI AGNOSTI C   56.00   0   47   0   7.00   8.00   7.00   8.00   8.00   9.00   0   47   0   7.00   8.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   9.00   11		I - HOUSEKEEPING SUPPLIES	,				
2. 00 DI ETARY  10. 00 0 5, 264 0 3. 00 PHARMACY 15. 00 0 593 0 4. 00 ADULTS & PEDI ATRI CS 30. 00 0 291 0 5. 00 OPERATI NG ROOM 50. 00 0 16 0 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 83 0 6. 00 7. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 0 47 0 6. 00 SPEECH PATHOLOGY 68. 00 0 0 47 0 0 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 0 3 0 0 8. 00 9. 00 CARDI OPULMONARY 76. 00 0 0 9 0 0 9 0 0 9 0 0 9 0 11. 00 CLI NI C 90. 00 0 0 27 0 10. 00 11. 00 EMERGENCY 91. 00 0 0 21 0 0 6, 355  J - NON-CAPI TAL EXPENSES 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 198, 876 0 1. 00  ADMI NI STRATI VE & GENERAL 1. 00 TOTALS 198, 876 0 1. 00 1 10.	1.00		5, 00	0	1	0	1. 00
3. 00 PHARMACY 15. 00 0 593 0 4. 00 4. 00 4. 00 4. 00 4. 00 6. 00 PERATING ROOM 50. 00 0 16 0 5. 00 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 83 0 6. 00 6. 00 7. 00 RADI OLOGY-DI AGNOSTI C 56. 00 0 47 0 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 3 0 8. 00 9. 00 CARDI OPULMONARY 76. 00 0 9 0 9 0 9. 00 9. 00 0 11. 00 CLI NI C 90. 00 0 27 0 10. 00 11. 00				0	5. 264	0	2.00
4. 00 ADULTS & PEDIATRICS 30. 00 0 291 0 5. 00 9PERATING ROOM 50. 00 0 16 0 5. 00 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 83 0 6. 00 7. 00 RADI OLOGY-DI AGNOSTI C 56. 00 0 47 0 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 3 0 8. 00 8. 00 9. 00 CARDI OPULMONARY 76. 00 0 9 0 0 9. 00 9. 00 10. 00 CLI NI C 90. 00 0 27 0 10. 00 11. 00 EMERGENCY 91. 00 0 21 0 0 11. 00 11					•		
5. 00     OPERATI NG ROOM     50. 00     0     16     0     5. 00       6. 00     RADI OLOGY-DI AGNOSTI C     54. 00     0     83     0     6. 00       7. 00     RADI OLOGY-DI AGNOSTI C     56. 00     0     47     0     7. 00       8. 00     RADI OLOGY     68. 00     0     3     0     8. 00       9. 00     CARDI OPULMONARY     76. 00     0     9     0     9. 00       10. 00     CLI NI C     90. 00     0     27     0     10. 00       11. 00     EMERGENCY     91. 00     0     21     0     11. 00       0     J - NON-CAPI TAL EXPENSES       1. 00     CAP REL COSTS-BLDG & FIXT     1. 00     0     71     12     1. 00       TOTALS     0     71     12     1. 00       ADMI NI STRATI VE & GENERAL     5. 00     198, 876     0     0     0       1. 00     198, 876     0     0     0     1. 00							
6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 83 0 6. 00 7. 00 RADI OLOGY-DI AGNOSTI C 56. 00 0 47 0 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 3 0 8. 00 9. 00 CARDI OPULMONARY 76. 00 0 9 0 9. 00 10. 00 CLI NI C 90. 00 0 27 0 10. 00 11. 00 EMERGENCY 91. 00 0 21 0 11. 00 0 0 0 6, 355  J - NON-CAPITAL EXPENSES  1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 71 12 12 1. 00 TOTALS 0 71 12 12 1. 00 TOTALS 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 198, 876 0 0 1. 00 TOTALS 1. 00 TOT				0			1
7. 00 RADI OI SOTOPE 56. 00 0 47 0 8. 00 9PECH PATHOLOGY 68. 00 0 3 0 8. 00 9. 00 CARDI OPULMONARY 76. 00 9. 00 9 0 9. 00 10. 00 CLI NI C 90. 00 0 27 0 10. 00 11. 00 EMERGENCY 91. 00 0 6, 355 1 1. 00 CAP REL COSTS-BLDG & FI XT 1. 00 0 71 12 12 1. 00 TOTALS 0 71 12 12 1. 00 TOTALS 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 198, 876 0 198, 876 0 1. 00 TOTALS				٩			1
8. 00 SPEECH PATHOLOGY 68. 00 0 3 0 8. 00 9. 00 CARDI OPULMONARY 76. 00 0 9 0 9. 00 10. 00 CLI NI C 90. 00 0 27 0 10. 00 11. 00 EMERGENCY 91. 00 0 21 0 11. 00 0 0 0 0 6, 355  J - NON-CAPI TAL EXPENSES  1. 00 CAP REL COSTS-BLDG & FI XT 1. 00 0 71 12 12 1. 00 K - CNO 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 198, 876 0 0 1. 00 TOTALS 198, 876 0 1. 00			l I	0			1
9. 00 CARDI OPULMONARY 76. 00 0 9 0 10. 00 10. 00 CLI NI C 90. 00 0 27 0 10. 00 11. 00 EMERGENCY 91. 00 0 21 0 11. 00 0 0 0 0 6, 355  J - NON-CAPI TAL EXPENSES  1. 00 CAP REL COSTS-BLDG & FI XT 1. 00 0 71 12 12 1. 00 K - CNO  1. 00 ADMI NI STRATI VE & GENERAL 5. 00 198, 876 0 1. 00 TOTALS 198, 876 0 1 1. 00				0			
10. 00   CLINI C   90. 00   0   27   0   10. 00   11. 00     EMERGENCY   91. 00   0   21   0   0   11. 00				0		-	
11. 00 EMERGENCY 91. 00 0 21 0 11. 00    O				0		_	
O   O   6,355     J - NON-CAPITAL EXPENSES     TOTALS   O   71   12   1.00   TOTALS   O   71   12   1.00   O   71   12   1.00   O   71   1.00   O   71   O   O   O   O   O   O   O   O   O				0			
1. 00     CAP REL COSTS-BLDG & FIXT     1. 00     0     71     12     1. 00       TOTALS     0     71     12     1. 00       K - CNO       1. 00     ADMI NI STRATI VE & GENERAL     5. 00     198, 876     0     0     0       TOTALS     198, 876     0     0     0	11.00	EINIERGEINCY	<u> </u>	— — — ‡			11.00
1. 00   CAP REL COSTS-BLDG & FLXT   1. 00   0   71   12   1. 00   1. 0		U NON CARLEAU EVENINGE		0	6, 355		-
TOTALS 0 71  K - CNO  1. 00 ADMI NI STRATI VE & GENERAL 5. 00 198, 876 0 0 1. 00  TOTALS 198, 876 0 1. 00							
K - CNO	1.00			•			1.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 198, 876 0 1. 00 1. 00 1. 00 1. 00				0	71		
	1.00				0	0	1. 00
500.00   Grand Total : Decreases   301, 857   9, 762, 437   500.00							
	500.00	Grand Total: Decreases		301, 857	9, 762, 437		500.00

					To 12/31/2019	Date/Time Pre 6/29/2020 8:4	
				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 ASSE						
1.00	Land	954, 570	0		0	0	1. 00
2.00	Land Improvements	891, 287	0		0	77, 727	2. 00
3.00	Buildings and Fixtures	0	0		0	0	3. 00
4.00	Building Improvements	38, 596, 503	0		0	137, 041	4. 00
5.00	Fi xed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	6, 190, 027	816, 080		0 816, 080	14, 936	6. 00
7.00	HIT designated Assets	15, 000	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	46, 647, 387	816, 080		0 816, 080	229, 704	8. 00
9.00	Reconciling Items	0	0		0 0	0	9. 00
10.00	Total (line 8 minus line 9)	46, 647, 387	816, 080		0 816, 080	229, 704	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	954, 570	0				1. 00
2.00	Land Improvements	813, 560	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	38, 459, 462	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	6, 991, 171	2, 260, 869				6. 00
7.00	HIT designated Assets	15, 000	15, 000				7. 00
8.00	Subtotal (sum of lines 1-7)	47, 233, 763	2, 275, 869				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	47, 233, 763	2, 275, 869				10. 00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	<u>2552-10</u>
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2019	Worksheet A-7	
						Date/Time Pre 6/29/2020 8:4	
			S	UMMARY OF CAPI	ΓAL		
	Cost Center Description		Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	570, 106	(	1, 029, 475	71	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	(		ol ol	0	1. 01
1. 02	CAP REL COSTS-BLDG & FLXT - TLMOB	0	1	ol d	ol ol	0	1. 02

1.02	CAF KLL COSTS-BLDG & TIXT - TEMOD	U	1	l ol	υĮ	υĮ	1. UZ
3.00	Total (sum of lines 1-2)	570, 106	0	1, 029, 475	71	0	3.00
		SUMMARY 0	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 - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 599, 652				1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0				1. 01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0				1. 02
3.00	Total (sum of lines 1-2)	0	1, 599, 652				3.00
						·	

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	<u> </u>	Period: From 01/01/2019 Fo 12/31/2019	6/29/2020 8: 40	
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	1, 768, 130		.,			1. 00
1. 01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	30, 530, 430		30, 530, 430		0	1. 01
1.02	CAP REL COSTS-BLDG & FLXT - TLMOB	14, 935, 204		14, 935, 204	0. 316198	0	1. 02
3.00	Total (sum of lines 1-2)	47, 233, 764		47, 233, 76			3. 00
		ALLOCAT	TION OF OTHER (	CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8.00	9, 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(	37, 802	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	) (	1, 605, 669	o	1. 01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	) (	542, 230	o	1. 02
3.00	Total (sum of lines 1-2)	0	0	) (	2, 185, 701	o	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		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE			1	_1		
1.00	CAP REL COSTS-BLDG & FIXT	0			0	37, 802	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1, 042, 828			0	2, 672, 736	1. 01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	ļ	-24, 238		517, 992	1. 02
3. 00	Total (sum of lines 1-2)	1, 042, 828	24, 239	-24, 238	3 0	3, 228, 530	3. 00

| Peri od: | Worksheet A-8 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1312

				Expense Classification on V	Worksheet A	6/29/2020 8: 40	o alli
				To/From Which the Amount is t			
				_			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00	1. 00
	COSTS-BLDG & FIXT (chapter 2)		0	CAL REE COSTS-BEDG & TTAT	1.00	ď	1.00
	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL	В	-653, 840	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1. 01	11	1. 01
1. 02	(chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1. 02	O	1. 02
2. 00	(chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00 I	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7. 00
8.00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -557, 840		0. 00	0 0	9. 00 10. 00
11.00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00 I	(chapter 23) Related organization	A-8-1	4, 275, 402			0	12. 00
	transactions (chapter 10) Laundry and linen service		0		0.00	o	13. 00
14. 00	Cafeteria-employees and guests Rental of quarters to employee	1	-49, 839 0	CAFETERI A	11. 00 0. 00	0	14. 00
l	and others Sale of medical and surgical		0		0. 00	0	
li li	supplies to other than patients						
ļ.	Sale of drugs to other than patients		0		0.00	0	
	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00 I	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)		0		0. 00	0	20. 00
21. 00	Vending machines Income from imposition of interest, finance or penalty		0	l l	0.00	0	21. 00
	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
-	Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00 I	limitation (chapter 14) Utilization review – physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00 I	(chapter 21) Depreciation - CAP REL	А	26, 225	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
26. 01 I	COSTS-BLDG & FLXT Depreciation - CAP REL COSTS BLDC & FLXT HOSPITAL	А	104, 068	CAP REL COSTS-BLDG & FIXT -	1. 01	9	26. 01
26. 02 I	COSTS-BLDG & FIXT - HOSPITAL Depreciation - CAP REL	А	293, 636	HOSPITAL CAP REL COSTS-BLDG & FIXT -	1. 02	9	26. 02
27. 00 I	COSTS-BLDG & FIXT - TLMOB Depreciation - CAP REL COSTS MARIE FOULD		0	TLMOB *** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	O	28. 00 29. 00

				T	o 12/31/2019	Date/Time Prep 6/29/2020 8:40	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of						
	limitation (chapter 14)		_				
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
04 00	instructions)	4.0.0	•	CDEFOUL DATUOLOGY	40.00		04 00
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for	A	9 400	CAP REL COSTS-BLDG & FIXT -	1. 01	9	32. 00
32.00	Depreciation and Interest	A	-0, 009	HOSPITAL	1.01	9	32.00
33. 00	EMPLOYEE BENEFITS	A	_1 530 471	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
33. 01	LOSS ON ABANDONMENT	Ä		CAP REL COSTS-BLDG & FIXT -	1. 01	0	33. 00
33.01	LOSS ON ADAMOUNIMENT	^	77, 320	HOSPITAL	1.01	7	33.01
33. 02	MARKETI NG	A	-2 244	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	MEDICALD HAF FEES	A	·	ADMINISTRATIVE & GENERAL	5. 00	ő	33. 03
33. 04	MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	5. 00	Ő	33. 04
33. 05	MI SCELLANEOUS I NCOME	В		DI ETARY	10. 00	o o	33. 05
33. 06	MI SCELLANEOUS I NCOME	В		CAFETERI A	11. 00	0	33. 06
33. 07	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00	o	33. 07
33. 08	MI SCELLANEOUS I NCOME	В		CENTRAL SERVICES & SUPPLY	14. 00	o	33. 08
33. 09	MI SCELLANEOUS I NCOME	В		PHARMACY	15. 00		33. 09
33. 10	MI SCELLANEOUS I NCOME	В	-252	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 10
33. 11	WIC PROGRAM COSTS	A	-213, 039	DI ETARY	10.00	0	33. 11
33. 12	WIC PROGRAM BENEFIT COSTS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 12
33. 13	ACCRUED PTO - GENERAL	A	-60, 170	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	CONTRI BUTI ON EXPENSE	A	-13, 000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	TELEPHONE EXPENSE	Α	-5, 216	ADULTS & PEDIATRICS	30.00	0	33. 15
33. 16	TELEPHONE EXPENSE	A		OPERATING ROOM	50.00	0	33. 16
50.00	TOTAL (sum of lines 1 thru 49)		-159, 973				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

  B. Amount Received if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1312 Period: From O'

Peri od: Worksheet A-8-1 From 01/01/2019

OFFICE	FFICE COSTS			To 12/31/2019		epared:
					6/29/2020 8: 4	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1. 00			HOME OFFICE ALLOCATION	1, 696, 668	1, 029, 475	1. 00
2.00			HOME OFFICE ALLOCATION	1, 844, 695	0	2. 00
3.00	II	l .	HOME OFFICE ALLOCATION	4, 829, 519	4, 281, 046	
3. 01			POOLED CAPITAL - H.O.	237, 084	0	3. 01
3. 02			HOME OFFICE ALLOCATION	0	31, 271	3. 02
4.00	II		RELATED PARTY	1, 151, 670	773, 298	
4. 01		OPERATION OF PLANT - HOSPITA		89, 772	52, 992	
4.02		l .	RELATED PARTY	84, 152	0	4. 02
4.03			RELATED PARTY	58, 234	0	4. 03
4.04		l -	RELATED PARTY	424, 038	216, 286	
4.05	30.00	ADULTS & PEDIATRICS	RELATED PARTY	202, 610	84, 011	4. 05
4.06			RELATED PARTY	260, 263	253, 048	4. 06
4.07	76. 00	CARDI OPULMONARY	RELATED PARTY	136, 455	36, 561	4. 07
4.08	91.00	EMERGENCY	RELATED PARTY	137, 939	119, 709	4. 08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	152	152	4. 09
4. 10	5. 00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	10, 569	10, 569	4. 10
4. 11	7. 01	OPERATION OF PLANT - HOSPITA	SHARED EMPLOYEES	39, 283	39, 283	4. 11
4. 12	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	333, 249	333, 249	4. 12
4. 13	50.00	OPERATING ROOM	SHARED EMPLOYEES	224, 591	224, 591	4. 13
4.14	60.00	LABORATORY	SHARED EMPLOYEES	1, 220, 567	1, 220, 567	4. 14
4. 15	66. 00	PHYSI CAL THERAPY	SHARED EMPLOYEES	28, 821	28, 821	4. 15
4. 16	192.00	PHYSICIANS' PRIVATE OFFICES	SHARED EMPLOYEES	28, 625	28, 625	4. 16
5.00	TOTALS (sum of lines 1-4).			13, 038, 956	8, 763, 554	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas no	been posted to worksheet A,	corullins r and/or 2, the alliour	it allowable sn	oura de marcatea en corumn 4	or this part.			
				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1. 00	2. 00	3. 00	4. 00	5. 00			
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00	В	IU HEALTH	100.00	0.00	6. 00
7.00	В	IUH ARNETT	1. 00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

- (1) 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.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider}.$
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

					To 12/31/2019	Date/Time Pre 6/29/2020 8:4	epared: 10 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			ENTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED O	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO						
1.00	667, 193						1. 00
2.00	1, 844, 695						2. 00
3.00	548, 473						3. 00
3. 01	237, 084						3. 01
3.02	-31, 271						3. 02
4.00	378, 372						4. 00
4.01	36, 780						4. 01
4.02	84, 152						4. 02
4.03	58, 234						4. 03
4.04	207, 752	0					4. 04
4.05	118, 599						4. 05
4.06	7, 215						4. 06
4.07	99, 894						4. 07
4.08	18, 230	0					4. 08
4.09	0	0					4. 09
4. 10	0	0					4. 10
4. 11	0	0					4. 11
4. 12	0	0					4. 12
4. 13	0	0					4. 13
4.14	0	0					4. 14
4. 15	0	0					4. 15
4. 16	0	0					4. 16
5.00	4, 275, 402						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.

1103 110	been posted to norkaneet A,	cordining 1 and or 2, the amount arrowable should be mareated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ei ilibui	Termbur Sement under title XVIII.								
6.00		6.00							
7. 00 8. 00		7.00							
8.00		8.00							
9.00		9.00							
10. 00		10.00							
100.00		100.00							

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						0 12/31/2019	6/29/2020 8:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	333, 249	333, 249	0	0	0	1. 00
2.00	50.00	OPERATING ROOM	224, 591		0	0	0	2. 00
3.00	91. 00	EMERGENCY	1, 158, 969		1, 158, 969	0	0	3. 00
4.00	0.00		0		0	0	0	4. 00
5.00	0.00		0		0	0	0	5. 00
6.00	0.00		0		0	0	l 0	6. 00
7. 00	0. 00		0		0	0	0	1
8. 00	0. 00		0	i o	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	1
10. 00	0. 00		0	ĺ	0	0	1 0	10. 00
200.00	0.00		1, 716, 809	557, 840	1, 158, 969		0	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	MKSt. A LITTO "	I denti fi er			Memberships &	Component	of Malpractice	
		T deliter i i e		Li mi t	Continuing	Share of col.	Insurance	
				2	Educati on	12	11.04.41.00	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0			0		1. 00
2. 00		OPERATING ROOM	0	l c	0	0	0	1
3.00		EMERGENCY	0	l c	0	0	0	1
4. 00	0.00	1	0	i o	0	0	0	1
5. 00	0.00		0	i o	0	0	0	1
6. 00	0.00		0		0	0	0	1
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	
9. 00	0. 00		0		0	0	1 0	9. 00
10. 00	0.00			ĺ	0	0	0	
200.00	0.00			ĺ	0	0	0	1
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	MKSt. A LITTO "	I denti fi er	Component	Limit	Di sal I owance	naj astilient		
		T deliter i i e	Share of col.	21 (	Di Sai i Gwarice			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	1	
1. 00	30.00	ADULTS & PEDIATRICS	0	C	0	333, 249		1. 00
2.00	50. 00	OPERATING ROOM	0		0	224, 591		2. 00
3.00	91. 00	EMERGENCY	0		0	0		3. 00
4.00	0.00		0	0	0	0		4.00
5.00	0. 00		0	0	0	0		5. 00
6. 00	0.00		0	i o	0	0		6. 00
7. 00	0.00		0	0	0	0		7. 00
8. 00	0.00		1 0	l o	0	l n		8. 00
9. 00	0.00		0	l o	0	l n		9. 00
10. 00	0.00		1 0	1	0	١		10.00
200.00	3.00			Ö	Ö	557, 840		200.00
200.00	1	l	1	1	.1	337,040	I	200.00

| Period: | Worksheet B | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1312

				T	0 12/31/2019	Date/Time Prep 6/29/2020 8:40	
			CAP	TAL RELATED CO	STS	6/29/2020 8: 4	U alli
	Cost Center Description	Net Expenses	BLDG & FIXT	BLDG & FIXT -		EMPLOYEE	
		for Cost Allocation		HOSPI TAL	TLMOB	BENEFITS DEPARTMENT	
		(from Wkst A				DEI ARTIMENT	
		col . 7)					
	CENEDAL CEDIU CE COCT CENTEDO	0	1.00	1. 01	1. 02	4. 00	
1. 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT	37, 802	37, 802				1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	2, 672, 736	37, 602				1. 00
1. 02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB	517, 992	0		517, 992		1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 862, 151	0	0	0	1, 862, 151	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 822, 454	3, 476	109, 371	88, 359	95, 359	5. 00
7.00	00700 OPERATION OF PLANT	395, 994	0	0	0	81, 046	1
7. 01	00701 OPERATION OF PLANT - HOSPITAL	1, 726, 130	5, 226		0	0	7. 01
7. 02 8. 00	00702 OPERATION OF PLANT - TLMOB 00800 LAUNDRY & LINEN SERVICE	330, 942 68, 164	2, 842 168		98, 981 0	0	7. 02 8. 00
9. 00	00900 HOUSEKEEPI NG	385, 463	561		1, 583	71, 247	•
10.00	01000 DI ETARY	390, 745	1, 285		44, 735	87, 094	•
11. 00	01100 CAFETERI A	90, 364	612		21, 298	23, 590	
13.00	01300 NURSING ADMINISTRATION	1, 027, 130	544	32, 119	9, 344	200, 929	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	643, 023	1, 487	173, 376	0	0	14. 00
15. 00	01500 PHARMACY	869, 645	635		0	84, 065	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 671, 553	4, 106	478, 621	ol	308, 523	30. 00
30.00	ANCI LLARY SERVI CE COST CENTERS	1,071,333	4, 100	470,021	J O	300, 323	30.00
50.00	05000 OPERATI NG ROOM	794, 228	2, 690	313, 611	0	105, 230	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	433, 829	1, 019	118, 760	0	72, 049	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	106, 399	209		0	18, 553	1
56. 00	05600 RADI OI SOTOPE	134, 286	144		0	28, 734	1
57. 00	05700 CT SCAN	395, 112	197		0	82, 865	1
58. 00 60. 00	05800   MAGNETIC RESONANCE   MAGING (MRI)   06000   LABORATORY	144, 073 1, 259, 706	278 925		0	29, 272 0	•
66. 00	06600 PHYSI CAL THERAPY	420, 488	896		0	88, 335	•
67. 00	06700 OCCUPATI ONAL THERAPY	129, 523	71		o	27, 011	67. 00
68. 00	06800 SPEECH PATHOLOGY	74, 221	33		0	15, 701	68. 00
69. 00	06900 ELECTROCARDI OLOGY	123, 170	213	24, 821	0	25, 417	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 870	0		0	0	•
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 056	0	1	0	0	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY DRUGS	389, 094 2, 306, 631	0			0	73. 00 73. 01
76. 00	03160 CARDI OPULMONARY	667, 119	421		j	107, 185	•
76. 97	07697 CARDI AC REHABI LI TATI ON	180, 067	510		17, 772	4, 984	•
	OUTPATIENT SERVICE COST CENTERS				, ,		
90.00	09000 CLI NI C	164, 356	487	56, 800	0	26, 991	90. 00
91. 00	09100 EMERGENCY	2, 524, 080	1, 992	232, 222	0	259, 795	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01	O9201   OBSERVATI ON BEDS (DISTINCT PART)     OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92. 01
101 00	10100 HOME HEALTH AGENCY	0	0	0	O	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>	0	1101.00
118.00		29, 790, 596	31, 027	2, 672, 736	282, 072	1, 843, 975	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19100 RESEARCH	0 0 450	0	1	0		191. 00
	19200   PHYSICIANS' PRIVATE OFFICES   19202   MOB	86, 458 -1	1, 189		41, 403	18, 176	192. 00 192. 02
	19202 MOB 19203 ARNETT SURGERY OFFICE	-1	4, 412 1, 174		153, 628 40, 889		192. 02
	19201 OCCUPATIONAL MEDICINE		1, 174	1	40, 009 N		192. 03
	19300 NONPALD WORKERS		o	ا	l		193. 00
200.00					]	- 1	200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	29, 877, 053	37, 802	2, 672, 736	517, 992	1, 862, 151	202. 00

				1	0 12/31/2019	6/29/2020 8: 4	
	Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	
	·		& GENERAL	PLANT	PLANT -	PLANT - TLMOB	
					HOSPI TAL		
	DENERAL DERIVINE COOT DENTERO	4A	5. 00	7.00	7. 01	7. 02	
4 00	GENERAL SERVICE COST CENTERS		I				4 00
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	7 440 040	7 440 040				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 119, 019		1			5. 00
7.00	00700 OPERATION OF PLANT	477, 040		l	0.4/7.0//		7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL	2, 340, 497		l	3, 167, 966		7. 01
7. 02	00702 OPERATION OF PLANT - TLMOB	432, 765		1		619, 999	7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	87, 947		l			
9.00	00900 HOUSEKEEPI NG	518, 955		1			
10.00	01000 DI ETARY	523, 859		1			10.00
11. 00	01100 CAFETERI A	135, 864	42, 500			39, 936	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 270, 066		1		17, 521	13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	817, 886		1			14.00
15. 00	01500 PHARMACY	1, 028, 390		1			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	16. 00
30. 00	03000 ADULTS & PEDIATRICS	2, 462, 803	770, 397	74, 904	775, 886	0	30. 00
30.00	ANCI LLARY SERVI CE COST CENTERS	2, 402, 003	170, 377	74, 704	773,000		30.00
50. 00	05000 OPERATING ROOM	1, 215, 759	380, 305	49, 080	508, 391	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	625, 657	195, 714	1	· ·	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	149, 564		1		0	55. 00
56. 00	05600 RADI OI SOTOPE	179, 990		1		0	56. 00
57. 00	05700 CT SCAN	501, 136			,	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	206, 021	64, 446	1		0	58. 00
60.00	06000 LABORATORY	1, 368, 422		l			60.00
66. 00	06600 PHYSI CAL THERAPY	614, 163		l		l o	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	164, 925			· ·		67. 00
68. 00	06800 SPEECH PATHOLOGY	93, 859			6, 329		68. 00
69. 00	06900 ELECTROCARDI OLOGY	173, 621	54, 311	1		0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 870		l	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 056		1	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	389, 094		1	0	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	2, 306, 631		1	0	ĺ	73. 01
76. 00	03160 CARDI OPULMONARY	823, 810		1	79, 570	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	203, 333		l	0		1
	OUTPATIENT SERVICE COST CENTERS	·					
90.00	09000 CLI NI C	248, 634	77, 776	8, 889	92, 078	0	90.00
91.00	09100 EMERGENCY	3, 018, 089	944, 107	36, 343	376, 452	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	00 500 705	7 040 070	500 (50		177 (00	
118. 00		29, 529, 725	7, 010, 370	502, 658	3, 167, 966	177, 629	1118.00
100.00	NONREI MBURSABLE COST CENTERS		1 0	1 0	0	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00 191. 00
	19100 RESEARCH	147 224	44 054	21 (02	0		
	19200 PHYSI CLANS' PRI VATE OFFI CES	147, 226		l	0		192. 00
	19202 MOB 19203 ARNETT SURGERY OFFICE	158, 039			0	288, 067	
	1 1	42, 063	13, 158	21, 423	0	76, 670	
	19201 OCCUPATIONAL MEDICINE   19300 NONPAID WORKERS	0					192. 04 193. 00
200.00	1 1	0		ı o		1	200. 00
200.00		0	_	_	^	_	200.00
201.00		29, 877, 053	7, 119, 019	626, 264	3, 167, 966		
202.00	1. OTAL (Sam TITIOS TTO CITIONGIT 201)	27,077,000	1, 117, 017	020, 204	3, 107, 700	017, 777	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:40 am

						6/29/2020 8: 4	0 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE				ADMI NI STRATI ON	
		8.00	9. 00	10.00	11.00	13. 00	
GE	NERAL SERVICE COST CENTERS						
1.00 00	0100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00	0101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1.02 00	0102 CAP REL COSTS-BLDG & FIXT - TLMOB						1. 02
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMINISTRATIVE & GENERAL						5. 00
	0700 OPERATION OF PLANT						7. 00
	0701 OPERATION OF PLANT - HOSPITAL						7. 01
	0702 OPERATION OF PLANT - TLMOB						7. 02
	0800 LAUNDRY & LINEN SERVICE	150, 326					8. 00
	0900 HOUSEKEEPI NG	130, 320					9. 00
		1					•
	000 DI ETARY	0	,		0.41 40.4		10.00
	100 CAFETERI A	0	12, 025		241, 484	l	11.00
	300 NURSI NG ADMI NI STRATI ON	0	4, 123		22, 271	1, 773, 263	13. 00
	400 CENTRAL SERVICES & SUPPLY	0	4, 123		0	0	14. 00
	500 PHARMACY	0	21, 988		9, 515	0	15. 00
	600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	150, 326	179, 686	820, 472	51, 852	954, 510	30. 00
	CILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0			15, 973	177, 403	50.00
54.00 05	6400 RADI OLOGY-DI AGNOSTI C	0	32, 295	0	11, 331	0	54.00
55. 00   05	5500 RADI OLOGY-THERAPEUTI C	0	6, 528	0	2, 206	0	55. 00
56.00 05	6600 RADI 0I SOTOPE	0	4, 466	0	3, 585	0	56. 00
57.00 05	5700 CT SCAN	0	6, 184	0	12, 112	0	57.00
58. 00 05	800 MAGNETIC RESONANCE IMAGING (MRI)	0	8, 933	0	4, 528	0	58. 00
60.00 06	0000 LABORATORY	0	30, 234	0	21, 213	0	60.00
66.00 06	6600 PHYSI CAL THERAPY	0	25, 080	0	12, 434	0	66. 00
67. 00 06	700 OCCUPATIONAL THERAPY	0		0	2, 758		67. 00
68. 00 06	800 SPEECH PATHOLOGY	0	1, 031	0	1, 586	l	68. 00
	900 ELECTROCARDI OLOGY	0	0	0	3, 953	0	69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	300 DRUGS CHARGED TO PATIENTS	0	1	0	0	l ő	73. 00
	7301 ONCOLOGY DRUGS	0	١	o o	0	Ö	73. 01
	3160 CARDI OPULMONARY	0	1		17, 237	l ő	76. 00
	7697 CARDI AC REHABI LI TATI ON	0		0	781	0	76. 97
	TPATIENT SERVICE COST CENTERS		10,031	U U	701		10. 71
	2000 CLINIC	0	22, 675	0	5, 010	56, 749	90.00
	2100 EMERGENCY	0			39, 439		91.00
		0	103, 070	U	39, 439	364, 601	91.00
	0200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	_	
	2201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	U	0	92. 01
	HER REIMBURSABLE COST CENTERS		1				101 00
	0100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	PECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	150, 326	628, 384	820, 472	237, 784	1, 773, 263	118. 00
	NREI MBURSABLE COST CENTERS		T	T		Г	
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	2100 RESEARCH	0		0	0		191. 00
	2200 PHYSICIANS' PRIVATE OFFICES	0			3, 700		192. 00
192. 02 19	2202 MOB	0	134, 678	0	0	0	192. 02
	2203 ARNETT SURGERY OFFICE	0	0	0	0	•	192. 03
192. 04 19	2201 OCCUPATIONAL MEDICINE	0	0	0	0		192. 04
193. 00 19	2300 NONPALD WORKERS	0	0	0	0	0	193. 00
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)	150, 326	791, 922	820, 472	241, 484		
'		1	,	'			•

| Norksheet B | Worksheet B | Part | | Bat/2019 | Date/Time Prepared: | 6/29/2020 8:40 am | Otal | Intern & | Residents Cost Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH WHITE HOSPITAL Provider CCN: 15-1312 Peri od: From 01/01/2019 To 12/31/2019 Cost Center Description CENTRAL PHARMACY MEDI CAL Subtotal

		SERVICES &		RECORDS &		Residents Cost	
		SUPPLY		LI BRARY		& Post Stepdown	
						Adjustments	
		14. 00	15. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS			<u>.</u>			
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
1.01	OO101 CAP REL COSTS-BLDG & FLXT - HOSPITAL						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL						7. 01
7. 02	00702 OPERATION OF PLANT - TLMOB						7. 02
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	1 20/ 045					13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	1, 386, 045	1 50/ 077				14. 00
15. 00	01500 PHARMACY	23, 168	1, 536, 377				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0			16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	197, 954	3, 884	0	6, 442, 674	0	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	177, 754	3, 004	U <sub>I</sub>	0, 442, 074	0	30.00
50. 00	05000 OPERATI NG ROOM	318, 278	2, 691	0	2, 765, 797	0	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 170	876	Ö	1, 086, 150	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	214	19	0	248, 695	0	55. 00
56. 00	05600 RADI OI SOTOPE	17, 140	118	Ö	291, 512	0	56.00
57. 00	05700 CT SCAN	133, 421	83	0	850, 515	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	21, 110	6	0	362, 633	0	58.00
60.00	06000 LABORATORY	0	o	0	2, 039, 536	0	60.00
66. 00	06600 PHYSI CAL THERAPY	8, 894	o	0	1, 038, 347	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	256	0	0	236, 381	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	O	0	132, 776	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	8, 882	3	0	284, 892	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	175, 257	o	0	205, 281	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 124	0	0	30, 013	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	219, 491	0	730, 299	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	1, 301, 193	0	4, 329, 368	0	73. 01
76.00	03160 CARDI OPULMONARY	96, 982	3	0	1, 312, 872	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	476	0	0	321, 480	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	12, 514	2, 368	0	526, 693	0	
91. 00	09100 EMERGENCY	340, 919	5, 642	0	5, 448, 662	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_	_	_	_	0	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
101 00	OTHER REIMBURSABLE COST CENTERS	ما	ما		ما	0	101 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1, 382, 759	1, 536, 377	0	28, 684, 576	0	118. 00
110.00	NONREI MBURSABLE COST CENTERS	1, 302, 734	1, 550, 577	U <sub>I</sub>	20, 004, 570	0	] 110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	0	0	190. 00
	19100 RESEARCH	o	o	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 286	o	0	328, 451		192. 00
	19202 MOB	0, 230	ol	n	710, 712		192. 02
	19203 ARNETT SURGERY OFFICE		ol	n	153, 314		192. 03
	19201 OCCUPATI ONAL MEDI CI NE	0	ol	Ö	0		192. 04
	19300 NONPALD WORKERS	ol	ol	o	ol		193. 00
200.00				1	o		200. 00
201.00	, ,	О	o	0	o		201. 00
202.00		1, 386, 045	1, 536, 377	0	29, 877, 053		202. 00
	•	•	· ·	,			

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

Provider CCN: 15-1312 

		6/29/2020 8:4	
Cost Center Description	Total	0/27/2020 0.	
, , , , , , , , , , , , , , , , , , ,	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 CAP REL COSTS-BLDG & FLXT			1.00
1.01   00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL			1. 01
1.02 O0102 CAP REL COSTS-BLDG & FIXT - TLMOB			1. 02
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL			5. 00
7. 00 00700 OPERATION OF PLANT			7. 00
7. 01   00701 OPERATION OF PLANT - HOSPITAL			7. 01
7. 02   00702   OPERATION OF PLANT - TLMOB			7. 02
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
			1
15. 00 01500 PHARMACY			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY			16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	( 440 (74		20.00
30. 00   03000   ADULTS & PEDI ATRI CS	6, 442, 674		30.00
ANCILLARY SERVICE COST CENTERS	0 7/5 707		
50. 00   05000   OPERATI NG ROOM	2, 765, 797		50.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	1, 086, 150		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	248, 695		55. 00
56. 00   05600   RADI OI SOTOPE	291, 512		56. 00
57. 00   05700   CT   SCAN	850, 515		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	362, 633		58. 00
60. 00  06000   LABORATORY	2, 039, 536		60.00
66. 00   06600   PHYSI CAL THERAPY	1, 038, 347		66. 00
67. 00   06700 OCCUPATI ONAL THERAPY	236, 381		67. 00
68.00   06800   SPEECH PATHOLOGY	132, 776		68. 00
69. 00   06900   ELECTROCARDI OLOGY	284, 892		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	205, 281		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	30, 013		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	730, 299		73.00
73. 01   07301   0NCOLOGY DRUGS	4, 329, 368		73. 01
76. 00 03160 CARDI OPULMONARY	1, 312, 872		76. 00
76. 97 07697 CARDIAC REHABILITATION	321, 480		76. 97
OUTPATIENT SERVICE COST CENTERS			
90. 00 09000 CLINIC	526, 693		90. 00
91. 00 09100 EMERGENCY	5, 448, 662		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	O		92. 01
OTHER REIMBURSABLE COST CENTERS	<u>.                                      </u>		
101. 00 10100 HOME HEALTH AGENCY	0		101. 00
SPECIAL PURPOSE COST CENTERS	<u>'</u>		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	28, 684, 576		118. 00
NONREI MBURSABLE COST CENTERS			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
191. 00 19100 RESEARCH	o		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	328, 451		192.00
192. 02 19202 MOB	710, 712		192. 02
192.03 19203  ARNETT SURGERY OFFICE	153, 314		192. 02
192. 04 19201 OCCUPATI ONAL MEDI CI NE	155, 514		192. 03
193. 00 19300 NONPALD WORKERS	0		193. 00
200.00 Cross Foot Adjustments	0		200.00
201.00   Negative Cost Centers	0		200.00
202.00 Regative cost centers 202.00 TOTAL (sum lines 118 through 201)	29, 877, 053		201.00
202.00   TOTAL (Suil TITIES TTO LIII OUGH 201)	27,011,003		1202.00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1312

				T	o 12/31/2019	Date/Time Pre 6/29/2020 8:4	pared:
			CAPITAL RELATED COSTS		0/29/2020 8.4	o alli	
	Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT -		Subtotal	
		Assigned New		HOSPI TAL	TLMOB		
		Capi tal Rel ated Costs					
		0	1. 00	1. 01	1. 02	2A	
	GENERAL SERVICE COST CENTERS		1.00	1.01	1.02	2/1	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	237, 084	3, 476	109, 371	88, 359	438, 290	
7.00	00700 OPERATION OF PLANT	0	0	0	0	0	7.00
7. 01	00701 OPERATION OF PLANT - HOSPITAL	0	5, 226		0	614, 367	7. 01
7. 02 8. 00	00702 OPERATION OF PLANT - TLMOB	0	2, 842		98, 981	101, 823	7. 02
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	168 561	19, 615 60, 101	1, 583	19, 783 62, 245	8. 00 9. 00
10.00	01000 DI ETARY	0	1, 285		44, 735	46, 020	
11. 00	01100 CAFETERI A	0	612		21, 298	21, 910	
13. 00	01300 NURSING ADMINISTRATION	0	544		9, 344	42, 007	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 487		0	174, 863	
15. 00	01500 PHARMACY	0	635		0	74, 680	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	0	4, 106	478, 621	0	482, 727	30. 00
	ANCILLARY SERVICE COST CENTERS	1	0.400			01/ 001	
50. 00 54. 00	05000 OPERATING ROOM	0	2, 690		0	316, 301	50.00
55.00	05400   RADI OLOGY-DI AGNOSTI C   05500   RADI OLOGY-THERAPEUTI C	0	1, 019 209		0	119, 779 24, 612	54. 00 55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0	144		0	16, 970	
57. 00	05700 CT SCAN	0	197		0	23, 159	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	l o	278		0	32, 676	
60.00	06000 LABORATORY	0	925		o	108, 716	60. 00
66.00	06600 PHYSI CAL THERAPY	0	896		0	105, 340	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	71	8, 320	0	8, 391	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	33		0	3, 937	
69. 00	06900 ELECTROCARDI OLOGY	0	213		0	25, 034	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY DRUGS	0	0		0	0	73. 00
73. 01 76. 00	03160 CARDI OPULMONARY	0	0 421		0	0 49, 506	73. 01 76. 00
76. 97	07697 CARDI AC REHABILI TATI ON	0	510		17, 772	18, 282	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	310		17,772	10, 202	70.77
90.00	09000 CLI NI C	0	487	56, 800	0	57, 287	90. 00
91.00	09100 EMERGENCY	0	1, 992	232, 222	0	234, 214	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS			T			
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	237, 084	31, 027	2, 672, 736	282, 072	3, 222, 919	110 00
110.00	NONREI MBURSABLE COST CENTERS	237,004	31,027	2,072,730	202, 072	3, 222, 919	116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0		o		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 189	0	41, 403	42, 592	192. 00
192.02	2 19202 MOB	0	4, 412	0	153, 628	158, 040	192. 02
	19203 ARNETT SURGERY OFFICE	0	1, 174	0	40, 889	42, 063	
	19201 OCCUPATIONAL MEDICINE	0	0	0	0	0	192. 04
	19300 NONPALD WORKERS	0	0	0	이	0	193. 00
200.00			^	_			200. 00
201. 00 202. 00		227 004	27 000	2 472 724	517, 992	0 3, 465, 614	201. 00
202. U	TIOTAL (Suil TITIES TIS LITTOUGH 201)	237, 084	37, 802	2, 672, 736	517, 992	3, 403, 014	2U2. UU

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1312

				To	o 12/31/2019	Date/Time Prep 6/29/2020 8:40	
	Cost Center Description	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	J diii
	p	BENEFITS	& GENERAL	PLANT	PLANT -	PLANT - TLMOB	
		DEPARTMENT			HOSPI TAL		
		4. 00	5. 00	7. 00	7. 01	7. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0					4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	0	438, 290				5. 00
7. 00	00700 OPERATION OF PLANT	0	9, 187				7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL	0	45, 076		660, 840		7. 01
7. 02	00702 OPERATION OF PLANT - TLMOB	0	8, 335	1	0	110, 919	7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 694		6, 633		8. 00
9. 00	00900 HOUSEKEEPI NG	0	9, 995	1	20, 324	531	9. 00
10.00	01000 DI ETARY	0	10, 089	1	0	15, 007	10.00
11. 00	01100 CAFETERI A	0	2, 617	i i	0	.,	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	24, 460	1	10, 861	3, 135	13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	15, 752	1	58, 629		14.00
15. 00	01500 PHARMACY	0	19, 806	1	25, 039		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	47 401	1 000	1/1 0/0		20.00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	0	47, 431	1, 099	161, 849	0	30. 00
50. 00	05000 OPERATING ROOM	0	23, 414	720	106, 051	0	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	12, 050	1	40, 160		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	2, 880		8, 252	Ö	55. 00
56. 00	05600 RADI OI SOTOPE	0	3, 466	1	5, 690	Ö	56. 00
57. 00	05700 CT SCAN	0	9, 651	1	7, 765		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	3, 968		10, 956	0	58. 00
60.00	06000 LABORATORY	0	26, 354		36, 450	-	60.00
66. 00	06600 PHYSI CAL THERAPY	0	11, 828	1	35, 319		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 176		2, 814		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1, 808	1	1, 320		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	3, 344	1	8, 394	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	440		0, 0, 1	Ö	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	174	1	0	Ö	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	7, 494	1	0	Ö	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	44, 423	1	0	0	73. 01
76. 00	03160 CARDI OPULMONARY	0	15, 866	1	16, 598	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	3, 916	1	0	l I	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	4, 788	130	19, 208	0	90.00
91.00	09100 EMERGENCY	0	58, 119	533	78, 528	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
101. 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS			1			
118. 00		0	431, 601	7, 374	660, 840	31, 780	118. 00
	NONREI MBURSABLE COST CENTERS	0					100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1	0		190. 00
	19100 RESEARCH  19200 PHYSICIANS'PRIVATE OFFICES	0	0 2, 835	1	0	13, 889	191. 00
		0			0		
	19202 MOB  19203 ARNETT SURGERY OFFICE	0	3, 044 810		0	51, 534 13, 716	
	19201 OCCUPATI ONAL MEDICINE	0	810		0		192. 03 192. 04
	19300 NONPALD WORKERS	0		0	0		192. 04 193. 00
200.00		U	١	ا ا	U		200. 00
200.00		^		o	^		200. 00 201. 00
201.00		0	438, 290		660, 840		
202.00	TOTAL (Sum Times To thi bugh 201)	1	1 430, 290	7, 10/	000, 040	110,719	202.00

Provider CCN: 15-1312

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:40 am

						6/29/2020 8: 4	O am
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE				ADMI NI STRATI ON	
		8. 00	9. 00	10.00	11. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL						7. 01
7.02	00702 OPERATION OF PLANT - TLMOB						7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE	28, 155					8. 00
9.00	00900 HOUSEKEEPI NG	0	93, 245				9.00
10. 00	01000 DI ETARY	0	2, 994	74, 454			10.00
11. 00	01100 CAFETERI A	0	1, 416	, , ,	33, 252		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	485	o o	3, 067	84, 161	13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	485	o o	0,007	0 1, 101	14. 00
15. 00	01500 PHARMACY	0	2, 589	o o	1, 310	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	2,007	0	1, 510	0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		10.00
30. 00	03000 ADULTS & PEDI ATRI CS	28, 155	21, 157	74, 454	7, 139	45, 302	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	20, 133	21, 137	74,454	7, 137	45, 502	30.00
50. 00	05000 OPERATING ROOM	0	11, 529	0	2, 199	8, 420	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1	0	1, 560	0, 420	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	769	0	304	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	526	0	494	0	56. 00
57. 00	05700 CT SCAN		728	0	1, 668	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1, 052	0	623	0	58. 00
60. 00	06000 LABORATORY		3, 560	0	2, 921	0	60.00
66. 00	06600 PHYSI CAL THERAPY	0	2, 953	0	1, 712	0	66.00
67. 00	06700 OCCUPATIONAL THERAPY	0	2, 953	0	380	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	121	0	218	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	121	0	544	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	044	0	71. 00
71.00	1	0	0	0	o O	0	71.00
73. 00	07200 DRUCS CHARGED TO PATIENTS	0	0	0	o O	0	73.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o O	0	•
	07301 ONCOLOGY DRUGS	-	2 510	0	2 274	-	73. 01
76. 00	03160 CARDI OPULMONARY	0	3, 519	0	2, 374	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 254	0	108	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		2 (70		(00	2 (02	00.00
90.00	09000 CLI NI C	0			690	2, 693	1
91.00	09100 EMERGENCY	0	12, 136	0	5, 431	27, 746	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0	0	0	0	92. 01
404.00	OTHER REIMBURSABLE COST CENTERS				ام		404 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
440.00	SPECIAL PURPOSE COST CENTERS	00.455	70.000		00 7.0	0.444	
118. 00		28, 155	73, 989	74, 454	32, 742	84, 161	118.00
	NONREI MBURSABLE COST CENTERS	T		Г			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1		0		190. 00
	19100 RESEARCH	0		0	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	510		192. 00
	19202 MOB	0	15, 858	0	0		192. 02
	19203 ARNETT SURGERY OFFICE	0	0	0	0		192. 03
	19201 OCCUPATI ONAL MEDI CI NE	0	_	0	0		192. 04
	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	28, 155	93, 245	74, 454	33, 252	84, 161	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1312 Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/29/2020 8:40 am Intern & Cost Center Description CENTRAL PHARMACY MEDI CAL Subtotal SERVICES & RECORDS & Residents Cost **SUPPLY** LI BRARY & Post Stendown Adjustments 14.00 15.00 16.00 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 1.02 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 7.01 7.02 00702 OPERATION OF PLANT - TLMOB 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 250, 127 14.00 01500 PHARMACY 15.00 4, 181 127, 775 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 O 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 35, 723 323 0 905, 359 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 57 437 O 526, 295 n 50 00 224 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1,655 73 179, 353 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 36, 914 0 55.00 55.00 39 0 56.00 05600 RADI 0I SOTOPE 3,093 10 30, 288 0 56.00 0 57 00 05700 CT SCAN 24.077 67.108 57 00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 3,810 53, 160 0 58.00 06000 LABORATORY 0 0 178, 248 60.00 60.00 0 06600 PHYSI CAL THERAPY 0 0 158, 997 66.00 1, 605 0 66, 00 06700 OCCUPATIONAL THERAPY 0 15, 069 0 67.00 46 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 7, 413 0 68.00 06900 ELECTROCARDI OLOGY 38, 976 69 00 1,603 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 627 0 0 32, 067 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 3.271 r 3.445 0 72 00 07300 DRUGS CHARGED TO PATIENTS 18, 254 25, 748 0 73.00 73.00 07301 ONCOLOGY DRUGS 0 73. 01 108, 215 152, 638 0 73.01 0 03160 CARDI OPULMONARY 17,501 76.00 105.477 0 76.00 07697 CARDIAC REHABILITATION 76.97 29, 745 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 258 197 0 89, 921 0 90.00 0 91.00 91.00 09100 EMERGENCY Λ 61,522 469 478, 698 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 92.01 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 249, 534 127, 775 0 3, 114, 919 0 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 192, 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 593 0 64. 135 192. 02 19202 MOB 0 0 192. 02 0 0 229, 657 192. 03 19203 ARNETT SURGERY OFFICE 0 0 0 56, 903 0 192. 03 192. 04 19201 OCCUPATIONAL MEDICINE 0 192. 04 0 0 0 0 193. 00 19300 NONPALD WORKERS 0 C 0 0 0 193.00 0 200. 00 200.00 Cross Foot Adjustments 0

250, 127

127, 775

0 201. 00

0 202.00

3, 465, 614

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet B | From 01/01/2019 | Part I I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1312

			6/29/2020 8:4	
	Cost Center Description	Total	0/2//2020 0.	To am
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL			1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB			1. 02
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
7. 00	00700 OPERATION OF PLANT			7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL			7. 01
7. 02	00702 OPERATION OF PLANT - TLMOB			7. 02
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
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
	1 1			1
16. 00	01600 MEDI CAL RECORDS & LI BRARY			16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	005 350		30.00
30. 00	03000 ADULTS & PEDI ATRI CS	905, 359		30. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	F2/ 20F		
50.00	05000 OPERATING ROOM	526, 295		50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	179, 353		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	36, 914		55. 00
56. 00	05600 RADI OI SOTOPE	30, 288		56. 00
57. 00	05700 CT SCAN	67, 108		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	53, 160		58. 00
60.00	06000 LABORATORY	178, 248		60.00
66. 00	06600 PHYSI CAL THERAPY	158, 997		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	15, 069		67. 00
68. 00	06800 SPEECH PATHOLOGY	7, 413		68. 00
69. 00	06900 ELECTROCARDI OLOGY	38, 976		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32, 067		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 445		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	25, 748		73. 00
73. 01	07301 ONCOLOGY DRUGS	152, 638		73. 01
76. 00	03160 CARDI OPULMONARY	105, 477		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	29, 745		76. 97
	OUTPATIENT SERVICE COST CENTERS			
90. 00	09000 CLI NI C	89, 921		90. 00
91. 00	09100 EMERGENCY	478, 698		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0		92. 01
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY	0		101. 00
	SPECIAL PURPOSE COST CENTERS			
118.00		3, 114, 919		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19100 RESEARCH	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	64, 135		192. 00
	19202 MOB	229, 657		192. 02
	19203 ARNETT SURGERY OFFICE	56, 903		192. 03
192. 04	19201 OCCUPATIONAL MEDICINE	O		192. 04
193.00	19300 NONPALD WORKERS	O		193. 00
200.00	Cross Foot Adjustments	o		200. 00
201.00	Negative Cost Centers	o		201. 00
202.00	TOTAL (sum lines 118 through 201)	3, 465, 614		202. 00

		CI AI SYSTEMS	IU HEALIH WHI		ON 45 4040 D		u or Form CWS-2	
COST A	LLUCA	TION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2019	Worksheet B-1	
					To			pared:
							6/29/2020 8: 4	0 am
			CAPI	TAL RELATED CO	0STS			
		0 1 0 1 0 1 1	DI DO A FLVT	DI DO A FLYT	DIDO A FLYT	EMBL OVEE		
		Cost Center Description			BLDG & FIXT - TLMOB	EMPLOYEE	Reconciliation	
			(SQUARE FEET)	HOSPI TAL		BENEFITS DEPARTMENT		
				(SQUARE FEET)	(SQUARE FEET)	(GROSS		
						SALARI ES)		
			1.00	1. 01	1. 02	4. 00	5A	
	GENER	AL SERVICE COST CENTERS	1.20					
1.00		CAP REL COSTS-BLDG & FIXT	94, 809					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	57, 501				1. 01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	37, 308			1. 02
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	o	8, 129, 274		4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	8, 717	2, 353	6, 364	416, 292	-7, 119, 019	5. 00
7.00		OPERATION OF PLANT	0	0	0	353, 809		7. 00
7. 01		OPERATION OF PLANT - HOSPITAL	13, 105	1		0	0	
7. 02		OPERATION OF PLANT - TLMOB	7, 129		1 ., .=.	0	0	
8.00		LAUNDRY & LINEN SERVICE	422	l e		0	0	8. 00
9. 00		HOUSEKEEPI NG	1, 407	1		311, 032		9. 00
		DIETARY	3, 222			380, 210		10.00
		CAFETERI A	1, 534	ł	,	102, 981		11.00
		NURSI NG ADMINI STRATI ON	1, 364	ł		877, 162		13.00
		CENTRAL SERVICES & SUPPLY	3, 730	1		0 2// 000	0	14. 00
		PHARMACY MEDICAL DECORDS & LIBRARY	1, 593	1		366, 989		
16.00		MEDICAL RECORDS & LIBRARY  ENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	16. 00
20.00		ADULTS & PEDIATRICS	10, 297	10, 297	'l 0	1, 346, 846	0	30.00
30.00		LARY SERVICE COST CENTERS	10, 297	10, 297	1 0	1, 340, 640	U	30.00
50 00		OPERATING ROOM	6, 747	6, 747	'l ol	459, 387	0	50.00
		RADI OLOGY-DI AGNOSTI C	2, 555			314, 533		1
		RADI OLOGY-THERAPEUTI C	525			80, 994		55.00
		RADI OI SOTOPE	362	l .		125, 439		
		CT SCAN	494	l .		361, 752		
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	697	697		127, 789		58.00
		LABORATORY	2, 319	l .		0	1	60.00
66. 00		PHYSI CAL THERAPY	2, 247	l		385, 631	•	66. 00
		OCCUPATI ONAL THERAPY	179	1		117, 917		67.00
		SPEECH PATHOLOGY	84	l		68, 545		68. 00
		ELECTROCARDI OLOGY	534	534	l o	110, 960		69. 00
	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l c	o	0	0	71. 00
		IMPL. DEV. CHARGED TO PATIENTS	0	l c	o	0	0	72. 00
		DRUGS CHARGED TO PATIENTS	0	0	o	0	0	73. 00
73. 01	07301	ONCOLOGY DRUGS	0	0	o	0	0	73. 01
76.00	03160	CARDI OPULMONARY	1, 056	1, 056	0	467, 921	0	76. 00
76. 97	07697	CARDIAC REHABILITATION	1, 280	0	1, 280	21, 760	0	76. 97
		TIENT SERVICE COST CENTERS						
		CLI NI C	1, 222			117, 832		
	1	EMERGENCY	4, 996	4, 996	0	1, 134, 144	0	91. 00
		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01		OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
		REIMBURSABLE COST CENTERS		Г				
101. 00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
110 00		AL PURPOSE COST CENTERS	77.03	F7 F0:	00.011	0.040.005	7 440 610	110 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	77, 817	57, 501	20, 316	8, 049, 925	-7, 119, 019	1118.00
100.00		MBURSABLE COST CENTERS		_	\			100 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	0			0		190. 00 191. 00
		PHYSICIANS' PRIVATE OFFICES	2, 982	1	2, 982	79, 349		191.00
192.00				l e		79, 349		192. 00
		ARNETT SURGERY OFFICE	11, 065 2, 945		11, 065	0		192. 02
		OCCUPATIONAL MEDICINE	2, 945		2, 945	0		192. 03
		NONPAID WORKERS	0			0		192. 04
200.00		Cross Foot Adjustments			)	0	0	200.00
201.00	1	Negative Cost Centers						201.00
202.00	1	Cost to be allocated (per Wkst. B,	37, 802	2, 672, 736	517, 992	1, 862, 151		202.00
202.00		Part I)	07,002	2,072,700	) 017,772	1,002,101		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0. 398717	46. 481557	13. 884207	0. 229067		203. 00
204.00		Cost to be allocated (per Wkst. B,				0		204.00
		Part II)						
205.00		Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00
		11)						
206. 00		NAHE adjustment amount to be allocated						206. 00
		(per Wkst. B-2)						
207. 00		NAHE unit cost multiplier (Wkst. D,						207. 00
	I	Parts III and IV)		l			I	I

Provider CCN: 15-1312

			T	o 12/31/2019	Date/Time Pre 6/29/2020 8: 4	
Cost Center Description	ADMI NI STRATI VE		OPERATION OF	OPERATION OF	LAUNDRY &	
	& GENERAL	PLANT	PLANT -		LINEN SERVICE	
	(ACCUM. COST)	(SQUARE FEET)	HOSPITAL (SQUARE FEET)	(SQUARE FEET)	(PATIENT DAYS)	
	5. 00	7. 00	7. 01	7. 02	8. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01 O0101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1.02   OO102 CAP REL COSTS-BLDG & FIXT - TLMOB 4.00   OO400 EMPLOYEE BENEFITS DEPARTMENT						1. 02 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	22, 758, 034					5. 00
7.00 00700 OPERATION OF PLANT	477, 040	86, 092				7. 00
7.01 00701 OPERATION OF PLANT - HOSPITAL	2, 340, 497	13, 105				7. 01
7. 02   00702   OPERATION OF PLANT - TLMOB	432, 765	l		23, 815	0.040	7. 02
8.00   00800   LAUNDRY & LINEN SERVICE 9.00   00900   HOUSEKEEPING	87, 947 518, 955	422 1, 407		0 114	2, 240 0	8. 00 9. 00
10. 00   01000 DI ETARY	523, 859	l		3, 222	0	10. 00
11. 00 01100 CAFETERI A	135, 864	1, 534	•	1, 534	0	11. 00
13.00 01300 NURSING ADMINISTRATION	1, 270, 066	1, 364	691	673	0	13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY	817, 886				0	14. 00
15. 00 01500 PHARMACY	1, 028, 390 0	1		0	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0		0	U	U	16. 00
30. 00 03000 ADULTS & PEDIATRICS	2, 462, 803	10, 297	10, 297	0	2, 240	30. 00
ANCILLARY SERVICE COST CENTERS					·	
50.00   05000   OPERATING ROOM	1, 215, 759			0	0	50.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	625, 657	2, 555		0	0	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	149, 564 179, 990	525 362		0	0	55. 00 56. 00
57. 00   05700 CT   SCAN	501, 136		494	0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	206, 021	697	697	0	0	58. 00
60. 00   06000   LABORATORY	1, 368, 422	2, 319	2, 319	0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	614, 163	l		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	164, 925	179	•	0	0	67. 00
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	93, 859 173, 621	84 534	•	0	0	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 870	ł	0.00	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	9, 056	Ö	Ö	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	389, 094	0	0	0	0	73. 00
73. 01   07301   0NCOLOGY DRUGS	2, 306, 631	0	0	0	0	73. 01
76. 00   03160   CARDI OPULMONARY 76. 97   07697   CARDI AC   REHABI LI TATI ON	823, 810	l			0	76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	203, 333	1, 200	0	1, 280	0	70. 97
90. 00 09000 CLINIC	248, 634	1, 222	1, 222	0	0	90. 00
91. 00   09100   EMERGENCY	3, 018, 089		4, 996	0	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	_	_	_	_	_	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS				J	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	22, 410, 706	69, 100	42, 043	6, 823	2, 240	118. 00
NONREI MBURSABLE COST CENTERS	_	_	_	_	_	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00 191. 00
191. 00 19100  RESEARCH 192. 00 19200  PHYSI CLANS'   PRI VATE OFFI CES	147, 226	2, 982	0	2, 982		191.00
192. 02 19202 MOB	158, 039	l		11, 065		192. 02
192. 03 19203 ARNETT SURGERY OFFICE	42, 063			2, 945		192. 03
192. 04 19201 OCCUPATI ONAL MEDICINE	0	0	0	0		192. 04
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00   Cross Foot Adjustments 201.00   Negative Cost Centers						200. 00 201. 00
202.00   Cost to be allocated (per Wkst. B,	7, 119, 019	626, 264	3, 167, 966	619, 999	150, 326	
Part I)		525, 201	]	3.7,777	.55, 520	
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 312813	l .			67. 109821	
204.00 Cost to be allocated (per Wkst. B,	438, 290	9, 187	660, 840	110, 919	28, 155	204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	0. 019259	0. 106711	15. 718193	4. 657527	12. 569196	205 00
205.00 Only Cost murtiplier (wkst. B, Part	0.019259	0. 100/11	15. / 10193	4.00/02/	12. 309 190	200.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
praits iii ana iv)	I	I	I	ı		I

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1312 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 8:40 am Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL (PATIENT DAYS) (TIME SPENT) (FTE'S) ADMI NI STRATI ON SERVICES & **SUPPLY** (DI RECT (COSTED NURSING HOURS) REQUIS.) 9.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 1.02 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7 00 00701 OPERATION OF PLANT - HOSPITAL 7.01 7.01 7.02 00702 OPERATION OF PLANT - TLMOB 7.02 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 2,305 9.00 10.00 01000 DI ETARY 74 2, 240 10.00 11.00 01100 CAFETERI A 35 10, 507 11.00 01300 NURSING ADMINISTRATION 76, 087 13 00 12 969 13 00 C 14.00 01400 CENTRAL SERVICES & SUPPLY 12 C C 692, 552 14.00 01500 PHARMACY 15.00 64 414 0 11, 576 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 523 2, 240 2, 256 40, 956 98, 910 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM n 159 031 50 00 285 695 7.612 54.00 05400 RADI OLOGY-DI AGNOSTI C 94 0 493 4,582 54.00 05500 RADI OLOGY-THERAPEUTI C 19 96 0 107 55.00 56, 00 05600 RADI 0I SOTOPE 13 0 156 0 8, 564 56, 00 05700 CT SCAN 18 0 57 00 57 00 Ω 527 66, 665 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 26 197 10, 548 58.00 06000 LABORATORY 88 0 60.00 923 0 60.00 0 06600 PHYSI CAL THERAPY 66.00 73 541 4, 444 66,00 06700 OCCUPATIONAL THERAPY 67.00 6 120 128 67.00 3 06800 SPEECH PATHOLOGY 0 0 0 68.00 68.00 69 0 06900 ELECTROCARDI OLOGY 69 00 172 4, 438 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 87, 569 0 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 C 0 9, 056 72 00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 0 73. 01 07301 ONCOLOGY DRUGS 0 0 0 73.01 03160 CARDI OPULMONARY 76.00 87 750 48, 458 0 76, 00 07697 CARDIAC REHABILITATION 76. 97 34 238 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 218 2, 435 6, 253 90.00 66 91.00 09100 EMERGENCY 300 C 91.00 1,716 25, 084 170, 343 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 92.01 92.01 0 OTHER REIMBURSABLE COST CENTERS 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 1, 829 2, 240 10, 346 76, 087 690, 910 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 0 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1, 642 192, 00 84 0 161 0 192.02 192. 02 19202 MOB 392 0 C 192. 03 19203 ARNETT SURGERY OFFICE 0 0 0 0 0 192.03 192. 04 19201 OCCUPATIONAL MEDICINE 0 0 0 0 192. 04 193. 00 19300 NONPALD WORKERS 0 O 0 0 193.00 r 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 Cost to be allocated (per Wkst. B, 1, 386, 045 202. 00 202.00 791, 922 820, 472 241, 484 1, 773, 263 Part I) 343, 567028 22, 983154 2. 001359 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 366, 282143 23 305729 204.00 Cost to be allocated (per Wkst. B, 93, 245 33, 252 250, 127 204. 00 74, 454 84, 161 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 40. 453362 33. 238393 3.164747 1. 106115 0. 361167 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)

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH WHITE HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1312 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 8:40 am Cost Center Description **PHARMACY** MEDI CAL RECORDS & (COSTED REQUIS.) LI BRARY (GROSS CHARGES) 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 1.02 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 7.01 7.02 00702 OPERATION OF PLANT - TLMOB 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 2, 723, 544 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 886 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 4 770 n 50 00 |05400| RADI OLOGY-DI AGNOSTI C 54.00 1,553 0 54.00 05500 RADI OLOGY-THERAPEUTI C 33 0 55.00 56.00 05600 RADI 0I SOTOPE 210 0 56.00 05700 CT SCAN 0 57 00 57.00 147 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 11 0 58.00 06000 LABORATORY 0 0 60.00 60.00 0 06600 PHYSI CAL THERAPY 0 66.00 66, 00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 0 5 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 69 00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 389, 094 0 73.00 73.00 07301 ONCOLOGY DRUGS 73. 01 2, 306, 631 0 73.01 03160 CARDI OPULMONARY 76.00 76.00 0 07697 CARDIAC REHABILITATION 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 197 0 90.00 91.00 09100 EMERGENCY Λ 91.00 10,001 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 2, 723, 544 0 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 191. 00 19100 RESEARCH 191. 00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 0 192. 02 19202 MOB 0 192.02 192. 03 19203 ARNETT SURGERY OFFICE 0 0 192.03 192. 04 19201 OCCUPATIONAL MEDICINE 0 0 192.04 193. 00 19300 NONPALD WORKERS 0 193. 00 Ω 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 202.00 1,536,377 Part I) 0.564109 203 00 Unit cost multiplier (Wkst. B, Part I) 203. 00 0.000000 204.00 Cost to be allocated (per Wkst. B, 127, 775 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.046915 0.000000 205.00 11) 206.00 NAHE adjustment amount to be allocated 206. 00

207. 00

207.00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/29/2020 8:4	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 442, 674		6, 442, 674	0	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 765, 797		2, 765, 797		0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 086, 150		1, 086, 150		0	54.00
	05500 RADI OLOGY-THERAPEUTI C	248, 695		248, 695		0	55. 00
	05600 RADI 0I S0T0PE	291, 512		291, 512	2 0	0	56. 00
	05700 CT SCAN	850, 515		850, 515		0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	362, 633		362, 633	0	0	58. 00
	06000 LABORATORY	2, 039, 536		2, 039, 536	0	0	60.00
	06600 PHYSI CAL THERAPY	1, 038, 347	0	1, 038, 347	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	236, 381	0	236, 381	0	0	67. 00
	06800 SPEECH PATHOLOGY	132, 776	0	132, 776	0	0	68. 00
	06900 ELECTROCARDI OLOGY	284, 892		284, 892	2 0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	205, 281		205, 281	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	30, 013		30, 013	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	730, 299		730, 299	0	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	4, 329, 368		4, 329, 368	0	0	73. 01
76.00	03160 CARDI OPULMONARY	1, 312, 872		1, 312, 872	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	321, 480		321, 480	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	526, 693		526, 693	0	0	90. 00
91.00	09100 EMERGENCY	5, 448, 662		5, 448, 662	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 500, 303		1, 500, 303	3	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0		(	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		(		0	101. 00
200.00	Subtotal (see instructions)	30, 184, 879	0	30, 184, 879	0	0	200. 00
201.00	Less Observation Beds	1, 500, 303		1, 500, 303	3	0	201. 00
202.00	Total (see instructions)	28, 684, 576	0	28, 684, 576	0	0	202. 00

Health Financial Systems	IU HEALTH WHIT	E HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	CN: 15-1312	2 Peri od: From 01/01/2019 Part I To 12/31/2019 Date/Time P 6/29/2020 8		
		Ti tl e	xVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	

				'	0 12/31/2019	6/29/2020 8: 40	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	4, 493, 934		4, 493, 934			30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	12, 341	7, 183, 604			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	71, 977	5, 474, 609			0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	25, 465	926, 395	951, 860		0.000000	
56.00	05600 RADI 0I SOTOPE	84, 968	2, 319, 348			0.000000	1
57. 00	05700  CT SCAN	193, 832	4, 489, 425			0.000000	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	78, 639	1, 437, 173			0.000000	
60.00	06000 LABORATORY	806, 725	5, 406, 799			0.000000	
66.00	06600 PHYSI CAL THERAPY	402, 110	1, 576, 380	1, 978, 490	0. 524818	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	179, 798	172, 687	352, 485	0. 670613	0.000000	
68.00	06800 SPEECH PATHOLOGY	24, 743	157, 257	182, 000	0. 729538	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 524, 421	1, 524, 421	0. 186885	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 214	601, 487	609, 701	0. 336691	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	96, 380	96, 380	0. 311403	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 372, 063	2, 899, 030	4, 271, 093	0. 170986	0.000000	
73. 01	07301 ONCOLOGY DRUGS	0	11, 908, 888	11, 908, 888	0. 363541	0.000000	73. 01
76.00	03160 CARDI OPULMONARY	781, 317	3, 184, 750	3, 966, 067	0. 331026	0.000000	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	73	383, 778	383, 851	0. 837512	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	2, 289, 168	2, 289, 168	0. 230081	0.000000	90. 00
91.00	09100 EMERGENCY	538, 363	25, 179, 683	25, 718, 046	0. 211861	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 150	4, 930, 117	4, 954, 267	0. 302830	0.000000	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	C	0. 000000	0.000000	92. 01
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	C			101. 00
200.00	Subtotal (see instructions)	9, 098, 712	82, 141, 379	91, 240, 091			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	9, 098, 712	82, 141, 379	91, 240, 091			202. 00

Health Financial Systems	IU HEALTH WHITE HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1312	From 01/01/2019	Worksheet C Part I Date/Time Prepared:

Cost Center Description				To 12/31/2019	Date/Time Prepared:   6/29/2020 8:40 am
Ratio   11.00			Title XVIII	Hospi tal	
INPATI ENT ROUTINE SERVICE COST CENTERS   30. 00   03000  ADULTS & PEDI ATRICS   30. 00   05000  PEDI TING ROOM   50. 00   05000  PEDI TING ROOM   50. 00   05000  PEDI TING ROOM   55. 00   05000  PEDI TING ROOM   55. 00   05500  RADI OLOGY-THERAPEUTIC   0. 000000   55. 00   05500  MARIETIC RESONANCE IMAGING (MRI)   0. 000000   55. 00   05500  MARIETIC RESONANCE IMAGING (MRI)   0. 000000   56. 00   06000  DELECTROLA THERAPY   0. 000000   06. 00   06000  DELECTROLA THERAPY   0. 000000   06. 00   06700  OCCUPATI ONAL THERAPY   0. 000000   06. 00   06700  OCCUPATI ONAL THERAPY   0. 000000   06. 00   06700  OCCUPATI ONAL THERAPY   0. 000000   06. 00   06700  DELECTROCARDI OLOGY   0. 000000   0. 000000   07. 00   0	Cost Center Description	PPS Inpatient		<u> </u>	
INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   30.00   ADULTS & PEDI ATRI CS   50.00   30.00   ADULTS & PEDI ATRI CS   50.00   30.00		Ratio			
30. 00		11. 00			
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   DPERATI NG ROOM   0.000000   54. 00   54. 00   05400   RADI OLLOGY-DIAGNOSTIC   0.000000   55. 00   05500   RADI OLLOGY-DIAGNOSTIC   0.000000   55. 00   05500   RADI OLOGY-THERAPEUTI C   0.000000   55. 00   05500   MAGNETI C RESONANCE I MAGI NG (MRI )   0.000000   58. 00   06000   LABORATORY   0.000000   66. 00   06600   LABORATORY   0.000000   66. 00   06600   PHYSI CAL THERAPY   0.000000   06. 00   06600   PHYSI CAL THERAPY   0.000000   67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   67. 00   06800   SPECCH PATHOLOGY   0.000000   06800   SPECCH PATHOLOGY   0.000000   071. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   07507   CARDI OLOGY DRUGS   0.000000   73. 00   07507   CARDI AC REHABI LITATI ON   0.000000   76. 97   0.00000   07507   CARDI AC REHABI LITATI ON   0.000000   0.000000   0.00000   0.000000   0.000000   0.0000000   0.000000   0.00000000					30.00
54.00   05400   RADI OLOGY-DI AGNOSTI C   0.000000   0.5500   RADI OLOGY-THERAPEUTI C   0.000000   0.5500   RADI OLOGY-THERAPEUTI C   0.000000   0.5600   RADI OLOGY-THERAPEUTI C   0.000000   0.5600   RADI OLOGY-THERAPEUTI C   0.000000   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5800   MAGNETI C RESONANCE   IMAGI NG (MRI )   0.0000000   0.0000000   0.00000000					
55. 00       05500 RADI OLOGY-THERAPEUTI C       0.000000       55. 00         56. 00       05600 RADI OLOGY-THERAPEUTI C       0.000000       56. 00         57. 00       05700 CT SCAN       0.000000       57. 00         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000       58. 00         60. 00       06000 LABORATORY       0.000000       60. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 SPECCH PATHOLOGY       0.000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       68. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71. 00         72. 00       07200 I IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72. 00         73. 01       07300 DRUGS CHARGED TO PATI ENTS       0.000000       73. 01         76. 00       07400 J IMPL. DEV. CHARGED TO PATI ENTS       0.000000       73. 01         76. 07       0797 CARDI AC REHABI LITATI ON       0.000000       73. 01         76. 07       076. 07       076 CARDI OPULMONARY       0.000000       76. 07         70. 00	50.00   05000   OPERATING ROOM	0. 000000			50.00
56. 00   05600   RADI OI SOTOPE   0.000000   57. 00   57. 00   570. 00   570. 00   570. 00   570. 00   570. 00   570. 00   570. 00   570. 00   570. 00   58. 00   580. 00   58	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
57. 00	55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
58. 00       05800 MAGNETIC RESONANCE I MAGI NG (MRI)       0.000000       58. 00         60. 00       06000 LABORATORY       0.000000       60. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 SPEECH PATHOLOGY       0.000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       69. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.000000       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATIENTS       0.000000       72. 00         73. 01       073010 ONCOLOGY DRUGS       0.000000       73. 01         73. 01       07301 ONCOLOGY DRUGS       0.000000       73. 01         76. 00       03160 CARDI OPULMONARY       0.000000       73. 01         76. 97       07697 CARDI AC REHABI LITATI ON       0.000000       90. 00         91. 00       09000 CLI NI C       0.000000       91. 00         92. 01       09200 DRSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       91. 00         92. 01       09201 DBSERVATI ON BEDS (DI STI NCT PART)       0.000000       92. 01         0THER REI MBURSABLE COST CENTERS	56. 00   05600   RADI OI SOTOPE	0. 000000			56.00
60. 00	57. 00   05700   CT   SCAN	0. 000000			57. 00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 68. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 01 07301 ONCOLOGY DRUGS 0. 000000 73. 01 07301 ONCOLOGY DRUGS 0. 000000 73. 01 07301 ONCOLOGY DRUGS 0. 000000 0 76. 00 03160 CARDI OPULMONARY 0. 000000 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 0 00000 0 00000 CLI NI C 0. 000000 0 00000 0 00000 0 00000 0 00000 0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
67. 00	60. 00   06000   LABORATORY	0. 000000			60.00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00   06900   ELECTROCARDI OLOGY   0.000000   69. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07301 OVOCLOGY DRUGS 0. 000000 73. 01 07301 OVOCLOGY DRUGS 0. 000000 73. 01 07301 OVOCLOGY DRUGS 0. 000000 73. 01 073. 01 07301 OVOCLOGY DRUGS 0. 000000 756. 00 07407 CARDI AC REHABILITATION 0. 000000 76. 97 000000 CLINIC 0. 000000 9000 CLINIC 0. 000000 91. 00 09100 EMERGENCY 0. 0000000 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0. 000000 92. 01 000000 DTHER REIMBURSABLE COST CENTERS 92. 01 07101 ON 10100 HOME HEALTH AGENCY 92. 01 000000 UNITED TO THE REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 92. 01 000000 UNITED TO THE REIMBURSABLE COST CENTERS 101. 00 10100 UNITED TO U	69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   73. 01   07301   0NCOLOGY DRUGS   0.000000   73. 01   07301   0NCOLOGY DRUGS   0.000000   73. 01   076. 00   03160   CARDI AC REHABI LI TATI ON   0.000000   76. 00   000000   0000000   0000000   000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
73. 01	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 97   07697   CARDI AC REHABILITATION   0.000000   76. 97   0UTPATI ENT   SERVICE   COST   CENTERS   90. 00   09000   CLINIC   0.000000   91. 00   09100   EMERGENCY   0.000000   91. 00   92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)   0.000000   92. 00   09201   OBSERVATION   BEDS (DISTINCT PART)   0.000000   92. 01   OTHER   REI MBURSABLE   COST   CENTERS   101. 00   10100   HOME   HEALTH   AGENCY   101. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less   Observation   Beds   201. 00	73. 01   07301   0NCOLOGY DRUGS	0. 000000			73. 01
OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   0.000000   91.00   09100   EMERGENCY   0.000000   91.00   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.000000   92.00   09201   OBSERVATION BEDS (DISTINCT PART)   0.000000   92.01   OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME HEALTH AGENCY   101.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	76. 00 03160 CARDI OPULMONARY	0. 000000			76. 00
90. 00   990. 00   990. 00   991. 00   991. 00   991. 00   991. 00   992. 00   992. 00   992. 01	76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
91.00   09100   EMERGENCY   0.000000   91.00   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.000000   92.00   09201   OBSERVATION BEDS (DISTINCT PART)   0.000000   92.01   OTHER REIMBURSABLE COST CENTERS   101.00   OTHER REIMBURSABLE COST CENTERS   101.00   OUNDER CONTROL   101.00   OUNDER CO	OUTPATIENT SERVICE COST CENTERS				
92. 00   09200   095ERVATI ON BEDS (NON-DISTINCT PART)   0.0000000   92. 01   071   071   072   073   074	90. 00 09000 CLINIC	0. 000000			90.00
92. 01   09201   0BSERVATI ON BEDS (DISTINCT PART)   0.0000000   92. 01	91. 00 09100 EMERGENCY	0. 000000			91.00
OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME HEALTH AGENCY   101.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
101. 00	92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00	OTHER REIMBURSABLE COST CENTERS				
201.00 Less Observation Beds 201.00	101.00 10100 HOME HEALTH AGENCY				101. 00
	200.00 Subtotal (see instructions)				200. 00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				201. 00
	202.00 Total (see instructions)				202. 00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/29/2020 8:4	pared: O am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3.00	4. 00	5. 00	

				CAIA	поэрт саг	0031	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDI ATRI CS	6, 442, 674		6, 442, 674	0	6, 442, 674	30. 00
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	2, 765, 797		2, 765, 797	0	2, 765, 797	50. 00
54. 00   0540	00 RADI OLOGY-DI AGNOSTI C	1, 086, 150		1, 086, 150	0	1, 086, 150	54.00
55. 00 0550	00 RADI OLOGY-THERAPEUTI C	248, 695		248, 695	0	248, 695	55. 00
56. 00 0560	00 RADI 0I SOTOPE	291, 512		291, 512	0	291, 512	56. 00
57. 00 0570	DO CT SCAN	850, 515		850, 515	0	850, 515	57. 00
58.00 0580	OO MAGNETIC RESONANCE IMAGING (MRI)	362, 633		362, 633	0	362, 633	58. 00
60.00 0600	00 LABORATORY	2, 039, 536		2, 039, 536	0	2, 039, 536	60.00
66.00 0660	00 PHYSI CAL THERAPY	1, 038, 347	0	1, 038, 347	0	1, 038, 347	66. 00
67. 00 0670	OO OCCUPATIONAL THERAPY	236, 381	0	236, 381	0	236, 381	67. 00
68. 00 0680	OO SPEECH PATHOLOGY	132, 776	0	132, 776	0	132, 776	68. 00
69.00 0690	00 ELECTROCARDI OLOGY	284, 892		284, 892	0	284, 892	69. 00
71. 00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	205, 281		205, 281	0	205, 281	71. 00
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	30, 013		30, 013	0	30, 013	72. 00
73. 00 0730	OO DRUGS CHARGED TO PATIENTS	730, 299		730, 299	0	730, 299	73. 00
73. 01 0730	01 ONCOLOGY DRUGS	4, 329, 368		4, 329, 368	0	4, 329, 368	73. 01
76. 00 0316	60 CARDI OPULMONARY	1, 312, 872		1, 312, 872	0	1, 312, 872	76. 00
76. 97 0769	97 CARDIAC REHABILITATION	321, 480		321, 480	0	321, 480	76. 97
OUTF	PATIENT SERVICE COST CENTERS						1
90.00 0900	OO CLI NI C	526, 693		526, 693	0	526, 693	90. 00
91. 00 0910	OO EMERGENCY	5, 448, 662		5, 448, 662	0	5, 448, 662	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	1, 500, 303		1, 500, 303		1, 500, 303	92.00
92. 01 0920	O1 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92. 01
ОТНЕ	ER REIMBURSABLE COST CENTERS	•					
101.00 1010	OO HOME HEALTH AGENCY	0		0		0	101. 00
200.00	Subtotal (see instructions)	30, 184, 879	0	30, 184, 879	0	30, 184, 879	200.00
201.00	Less Observation Beds	1, 500, 303		1, 500, 303		1, 500, 303	201.00
202.00	Total (see instructions)	28, 684, 576	0	28, 684, 576	0	28, 684, 576	202. 00

Health Financial Systems	IU HEALTH WHITE HOSPITAL				In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-13	F	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prep 6/29/2020 8:40	
		Ti tl	e XIX		Hospi tal	Cost	
		Charges					
Cost Contor Doscription	Innationt	Outpationt	Total (	col 6	Cost or Other	TEEDA	

					0 12/31/2019	6/29/2020 8: 4	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 493, 934		4, 493, 934			30. 00
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	12, 341	7, 183, 604			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	71, 977	5, 474, 609			0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	25, 465	926, 395	· ·		0. 000000	
	05600 RADI OI SOTOPE	84, 968	2, 319, 348			0. 000000	
	05700 CT SCAN	193, 832	4, 489, 425			0. 000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	78, 639	1, 437, 173			0. 000000	
	06000 LABORATORY	806, 725	5, 406, 799			0. 000000	
	06600 PHYSI CAL THERAPY	402, 110	1, 576, 380			0. 000000	
	06700 OCCUPATI ONAL THERAPY	179, 798	172, 687	· ·		0. 000000	
	06800 SPEECH PATHOLOGY	24, 743	157, 257			0. 000000	
	06900 ELECTROCARDI OLOGY	0	1, 524, 421	1, 524, 421		0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 214	601, 487	· ·		0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	96, 380			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	1, 372, 063	2, 899, 030			0. 000000	
	07301 ONCOLOGY DRUGS	0	11, 908, 888			0. 000000	
	03160 CARDI OPULMONARY	781, 317	3, 184, 750			0. 000000	
	07697 CARDIAC REHABILITATION	73	383, 778	383, 851	0. 837512	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	2, 289, 168			0. 000000	
	09100 EMERGENCY	538, 363	25, 179, 683			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 150	4, 930, 117			0. 000000	
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0. 000000	0. 000000	92. 01
	OTHER REIMBURSABLE COST CENTERS						1
	10100 HOME HEALTH AGENCY	0	0	-			101. 00
200.00	,	9, 098, 712	82, 141, 379	91, 240, 091			200. 00
201.00							201. 00
202. 00	Total (see instructions)	9, 098, 712	82, 141, 379	91, 240, 091	]		202. 00

Health Financial Systems	IU HEALTH WHITE I	HOSPI TAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-1312	From 01/01/2019	Worksheet C Part I Date/Time Prepared: 6/29/2020 8:40 am

			10 12/31/2019	6/29/2020 8:40 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000			56. 00
57. 00  05700 CT SCAN	0. 000000			57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
60. 00   06000   LABORATORY	0. 000000			60.00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 000000			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73. 01   07301   0NCOLOGY DRUGS	0. 000000			73. 01
76. 00 03160 CARDI OPULMONARY	0. 000000			76. 00
76. 97 O7697 CARDI AC REHABILITATION	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00  09000  CLI NI C	0. 000000			90. 00
91. 00   09100   EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Heal th	Fi nan	cial Systems	IU HEALTH WHI	TE H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMEN	T OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	F	Provider C		Peri od:	Worksheet D	
							From 01/01/2019		
							To 12/31/2019		
					Title	XVIII	Hospi tal	6/29/2020 8: 4 Cost	u aiii
		Cost Center Description	Capi tal	Tota		Ratio of Cos		Capital Costs	
		oost contor bescription	Related Cost				Program	(column 3 x	
			(from Wkst. B,			(col . 1 ÷ col		column 4)	
			Part II, col.		8)	2)	. onal goo	001 0	
			26)		-,				
			1.00		2.00	3.00	4. 00	5. 00	
	ANCI LI	ARY SERVICE COST CENTERS		•					
50.00	05000	OPERATING ROOM	526, 295	5	7, 195, 945	0. 07313	12, 341	903	50. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	179, 353	3	5, 546, 586	0. 03233	29, 642	959	54.00
55.00	05500	RADI OLOGY-THERAPEUTI C	36, 914	ļ l	951, 860	0. 03878	13, 541	525	55. 00
56.00	05600	RADI OI SOTOPE	30, 288	3	2, 404, 316	0. 01259	56, 542	712	56. 00
57.00	05700	CT SCAN	67, 108	3	4, 683, 257	0. 01432	29 54, 628	783	57. 00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53, 160	)	1, 515, 812	0. 03507	70 50, 892	1, 785	58. 00
60.00	06000	LABORATORY	178, 248	3	6, 213, 524	0. 02868	390, 490	11, 202	60.00
66.00	06600	PHYSI CAL THERAPY	158, 997	'	1, 978, 490	0. 08036	135, 430	10, 884	66. 00
67.00	06700	OCCUPATIONAL THERAPY	15, 069		352, 485	0. 04275	54, 919	2, 348	67. 00
68. 00	06800	SPEECH PATHOLOGY	7, 413	3	182, 000	0. 04073	15, 347	625	68. 00
69.00	06900	ELECTROCARDI OLOGY	38, 976		1, 524, 421	0. 02556	0 8	0	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32, 067	'	609, 701	0. 05259	95 4, 444	234	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3, 445	5	96, 380	0. 03574	14 0	0	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	25, 748	3	4, 271, 093	0. 00602	676, 914	4, 080	73. 00
73. 01	07301	ONCOLOGY DRUGS	152, 638	3	11, 908, 888	0. 01281	7 0	0	73. 01
76.00	03160	CARDI OPULMONARY	105, 477	'	3, 966, 067	0. 02659	95 448, 204	11, 920	76. 00
76. 97	07697	CARDI AC REHABI LI TATI ON	29, 745	5	383, 851	0. 07749	0	0	76. 97
	OUTPA	FIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	89, 921		2, 289, 168	0. 03928	31 0	0	90. 00
91.00	09100	EMERGENCY	478, 698	3 :	25, 718, 046	0. 01861	3 24, 334	453	91. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	210, 830	)	4, 954, 267	0. 04255	55 2, 475	105	92. 00
92. 01	09201	OBSERVATION BEDS (DISTINCT PART)	0	)	0	0.00000	00	0	92. 01
200.00		Total (lines 50 through 199)	2, 420, 390	) :	36, 746, 15 <mark>7</mark>	1	1, 970, 143	47, 518	200. 00

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1312	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2019	Part IV

				]	To 12/31/2019	Date/Time Pre 6/29/2020 8:4	pared: O am
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description				Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(	0	0	50.00
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	05600 RADI 0I SOTOPE	0	0	(	0	0	56. 00
57.00	05700  CT SCAN	0	0	(	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0	0	58. 00
60.00	06000 LABORATORY	0	0	(	0	0	60.00
66.00	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	0	(	0	0	73. 01
76.00	03160 CARDI OPULMONARY	0	0	(	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	0	0	(	0	0	90. 00
91.00	09100 EMERGENCY	0	0	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(		0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(	0	0	92. 01
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00

Health Financial Systems	IU HEALTH WHITE HOSPITAL				In Lieu of Form CMS-2552		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS	S Provider C	CN: 15-1312	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/29/2020 8:40		
		Title	e XVIII	Hospi tal	Cost		
Cost Center Description	All Other Medical	Total Cost	Total Outpatient		Ratio of Cost		

					0 12/31/2019	6/29/2020 8:40	
			Ti tl e	XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	LARY SERVICE COST CENTERS	_	_	1 -	1		
	OPERATING ROOM	0	0		7, 195, 945	0. 000000	
	RADI OLOGY-DI AGNOSTI C	0	0		5, 546, 586	0. 000000	54. 00
	RADI OLOGY-THERAPEUTI C	0	0		951, 860	0. 000000	
	RADI OI SOTOPE	0	0		2, 404, 316		
	CT SCAN	0	0		4, 683, 257		
1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	1, 515, 812	0. 000000	
	LABORATORY	0	0	C	6, 213, 524		
	PHYSI CAL THERAPY	0	0	C	1, 978, 490	0. 000000	
	OCCUPATIONAL THERAPY	0	0	C	352, 485	0. 000000	67. 00
	SPEECH PATHOLOGY	0	0	C	182, 000	0. 000000	
	ELECTROCARDI OLOGY	0	0	C	1, 524, 421	0. 000000	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	609, 701	0. 000000	
	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	96, 380	0. 000000	
	DRUGS CHARGED TO PATIENTS	0	0	C	4, 271, 093		
	ONCOLOGY DRUGS	0	0	C	11, 908, 888		
	CARDI OPULMONARY	0	0	C	3, 966, 067	0. 000000	
	CARDIAC REHABILITATION	0	0	C	383, 851	0. 000000	76. 97
	ATIENT SERVICE COST CENTERS	_	_	1 -	1		
	CLINIC	0	0		2, 289, 168		
	EMERGENCY	0	0	1	25, 718, 046	0. 000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	4, 954, 267	0. 000000	
	OBSERVATION BEDS (DISTINCT PART)	0	0	(	0	0. 000000	
200.00	Total (lines 50 through 199)	0	0	( C	86, 746, 157		200. 00

Health Financial Systems	IU HEALTH WHITE	In Lieu of Form CMS-2552-10				
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI	ILLARY SERVICE OTHER PASS	Provi der CO		Peri od: From 01/01/2019	Worksheet D	
THROUGH COSTS				To 12/31/2019		
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7.		1 400		1 40)	

			Title	XVIII	Hospi tal Cost		
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	1	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 000000	12, 341		0	0	50. 00
	O RADI OLOGY-DI AGNOSTI C	0. 000000	29, 642		0	0	54. 00
	O RADI OLOGY-THERAPEUTI C	0. 000000	13, 541		0	0	55. 00
	PADI OI SOTOPE	0. 000000	56, 542		0	0	56. 00
57.00 0570	D CT SCAN	0. 000000	54, 628		0	0	57. 00
	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	50, 892		0	0	58. 00
60.00 06000	DLABORATORY	0. 000000	390, 490		0	0	60. 00
66. 00 0660	PHYSI CAL THERAPY	0. 000000	135, 430		0	0	66. 00
67. 00 0670	OCCUPATIONAL THERAPY	0. 000000	54, 919		0	0	67. 00
68. 00 0680	SPEECH PATHOLOGY	0. 000000	15, 347		0	0	68. 00
69. 00 0690	D ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 444		0	0	71. 00
72.00 0720	DIMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 0730	DRUGS CHARGED TO PATIENTS	0. 000000	676, 914		0	0	73. 00
73. 01 0730	1 ONCOLOGY DRUGS	0. 000000	0		0	0	73. 01
76. 00 03160	CARDI OPULMONARY	0. 000000	448, 204		0	0	76. 00
76. 97 0769	7 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
OUTPA	ATIENT SERVICE COST CENTERS						
90.00 09000	CLI NI C	0. 000000	0		0	0	90. 00
91.00 0910	D EMERGENCY	0. 000000	24, 334		0	0	91.00
92.00 0920	OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 475		0	0	92.00
92. 01 0920	1 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0	0	92. 01
200. 00	Total (lines 50 through 199)		1, 970, 143		0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1312 Peri od: Worksheet D From 01/01/2019 Part V 12/31/2019 Date/Time Prepared: 6/29/2020 8:40 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 384355 2, 459, 352 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 195823 1, 444, 231 0 0 0 0 0 0 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 0 261273 0 383, 506 55 00 0 56.00 05600 RADI 0I S0T0PE 0.121245 0 963, 978 0 56.00 57. 00 05700 CT SCAN 0. 181608 1, 708, 031 0 57.00 575, 734 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0. 239233 0 0 58.00 06000 LABORATORY 0 60.00 0.328241 2, 133, 389 0 60.00 66.00 06600 PHYSI CAL THERAPY 0. 524818 633, 812 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.670613 64,040 0 67.00 06800 SPEECH PATHOLOGY 0. 729538 68.00 30, 501 68 00 0 69.00 06900 ELECTROCARDI OLOGY 0.186885 496, 101 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 336691 252, 048 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.311403 0 26, 866 o 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 1, 327 0.170986 737, 320 Ω 73.00 73. 01 07301 ONCOLOGY DRUGS 0.363541 0 5, 824, 621 0 73.01 03160 CARDI OPULMONARY 0. 331026 1, 354, 898 0 0 76.00 76.00 07697 CARDIAC REHABILITATION 0.837512 168, 041 0 76. 97 76. 97 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 230081 1, 405, 171 0 90.00 09100 EMERGENCY 0. 211861 0 6, 661, 866 0 91.00 91.00 2, 210 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 302830 92.00 92.00 0 2, 063, 985 0 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92.01 Ω Ω 200.00 Subtotal (see instructions) 0 29, 387, 491 0 200.00 3,537 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

0

29, 387, 491

3, 537

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	IU HEALTH WHITE	HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1312	Peri od: From 01/01/2019	Worksheet D Part V

12/31/2019 Date/Time Prepared: To 6/29/2020 8:40 am Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 945, 264 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 282, 814 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 100, 200 0 55.00 0 56.00 05600 RADI 0I S0T0PE 116,878 56.00 57. 00 05700 CT SCAN 310, 192 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 137, 735 58.00 0 06000 LABORATORY 700, 266 60.00 60.00 66.00 06600 PHYSI CAL THERAPY 332, 636 0 66.00 06700 OCCUPATIONAL THERAPY 42, 946 0 67.00 67.00 06800 SPEECH PATHOLOGY 22, 252 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 92, 714 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 84, 862 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 8, 366 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 227 126, 071 73.00 73.01 07301 ONCOLOGY DRUGS 2, 117, 489 0 73.01 76.00 03160 CARDI OPULMONARY 448, 506 0 76.00 07697 CARDIAC REHABILITATION 140, 736 0 76. 97 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 323, 303 90.00 91.00 09100 EMERGENCY 1, 411, 390 91.00 468 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 625, 037 0 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 200.00 Subtotal (see instructions) 8, 369, 657 695 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges 695 202.00 202.00 Net Charges (line 200 - line 201) 8, 369, 657

			Componer	nt CCN: 15-Z312	То	12/31/2019	Date/Time Pre 6/29/2020 8:4	
			Ti	tle XVIII	Swi	ng Beds - SNF		
				Charges		<i>J</i>	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbur			Cost	PPS Services	
	·	Ratio From	Services (s	ee Reimburse	t	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces		Services Not		
		Part I, col. 9		Subject To	)	Subject To		
				Ded. & Coin	s. [	Ded. & Coins.		
				(see inst.	)	(see inst.)		
		1.00	2.00	3. 00		4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0. 384355		0	0	0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 195823		0	0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 261273		0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 121245		0	0	0	0	56. 00
57.00	05700 CT SCAN	0. 181608		0	0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 239233		0	0	0	0	58. 00
60.00	06000 LABORATORY	0. 328241		0	0	0	0	60.00
66.00	06600 PHYSI CAL THERAPY	0. 524818		0	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 670613		0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 729538		0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 186885		0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 336691		o	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 311403		o	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 170986		o	0	0	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	0. 363541		o	0	0	0	73. 01
76.00	03160 CARDI OPULMONARY	0. 331026		o	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 837512		o	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS							1
90.00	09000 CLI NI C	0. 230081		0	0	0	0	90. 00
91.00	09100 EMERGENCY	0. 211861		0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 302830		0	0	0	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000		0	0	0	0	92. 01
200.00	Subtotal (see instructions)			0	0	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)			o	0	0	0	202. 00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-1312	Peri od: From 01/01/2019	Worksheet D Part V	
		Component	CCN: 15-Z312	To 12/31/2019	Date/Time Prep 6/29/2020 8:40	
		Title	e XVIII	Swing Beds - SNF	Cost	
	Cos	its				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				

			Title	XVIII Swi	ng Beds - SNF	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	CILLARY SERVICE COST CENTERS	_	_				
	OOO OPERATING ROOM	0	0				50.00
	400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
	600 RADI OI SOTOPE	0	0				56. 00
-	700 CT SCAN	0	0				57. 00
	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
4	DOO LABORATORY	0	0			•	60.00
	600 PHYSI CAL THERAPY	0	0			l l	66. 00
4	700 OCCUPATI ONAL THERAPY	0	0				67.00
	BOO SPEECH PATHOLOGY	0	0				68. 00
	900 ELECTROCARDI OLOGY	0	0				69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	BOO DRUGS CHARGED TO PATIENTS	0	0				73.00
	301 ONCOLOGY DRUGS	0	0				73. 01
4	160 CARDI OPULMONARY	0	0				76.00
	597 CARDI AC REHABI LI TATI ON	0	0				76. 97
	TPATIENT SERVICE COST CENTERS	ı					
	DOO CLI NI C	0	0				90.00
	100 EMERGENCY	0	0				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			•	92.00
	201 OBSERVATION BEDS (DISTINCT PART)	0	0				92. 01
200. 00	Subtotal (see instructions)	0	0				200.00
201. 00	Less PBP Clinic Lab. Services-Program	0				2	201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0			2	202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/29/2020 8:4	
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00		(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	0.004055	1				
50. 00 05000 OPERATING ROOM	0. 384355			0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 195823			0	0	0 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 261273			0	0	00.00
56. 00   05600   RADI OI SOTOPE	0. 121245	l .		0	0	
57. 00   05700   CT   SCAN	0. 181608	l .		0	0	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 239233			0	0	
60. 00   06000   LABORATORY	0. 328241			0	0	
66. 00   06600   PHYSI CAL THERAPY	0. 524818			0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 670613	l .		0	0	1 07.00
68. 00   06800   SPEECH PATHOLOGY	0. 729538	l .		0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 186885	0		0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 336691	0		0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 311403			0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 170986	0		0	0	
73. 01   07301   0NCOLOGY DRUGS	0. 363541	0		0	0	
76. 00   03160   CARDI OPULMONARY	0. 331026	l .		0	0	1 . 0. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 837512	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	0.000004					
90. 00   09000   CLI NI C	0. 230081			0	0	
91. 00 09100 EMERGENCY	0. 211861	l .		0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 302830	l .		0	0	
92.01   09201   OBSERVATION BEDS (DISTINCT PART) 200.00   Subtotal (see instructions)	0. 000000			0	0	
		0		0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		0		o	0	202. 00

Health Financial Systems IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1312	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/29/2020 8:40 am
	Title XIX	Hospi tal	Cost

				To 12/31/2019	Date/Time Prepared:   6/29/2020 8:40 am	:
		Ti t	le XIX	Hospi tal	Cost	_
	Co:	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	_			
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS	_	1				_
50. 00   05000   OPERATI NG ROOM	0		0		50. 0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	1	0		54. 0	
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	1	0		55. 0	
56. 00   05600   RADI 0I SOTOPE	0		0		56. 0	
57. 00   05700   CT   SCAN	0	1	0		57. 0	
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0		0		58. 0	
60. 00   06000   LABORATORY	0		0		60. 0	
66. 00   06600   PHYSI CAL THERAPY	0	1	0		66. 0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	1	0		67. 00	
68. 00 06800 SPEECH PATHOLOGY	0	1	0		68. 00	
69. 00 06900 ELECTROCARDI OLOGY	0		0		69. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		72. 0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0		73. 00	
73. 01   07301   0NCOLOGY DRUGS	0		0		73. 0	
76. 00 03160 CARDI OPULMONARY	0		0		76. 0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0		0		76. 9	)7
OUTPATIENT SERVICE COST CENTERS	T	T				
90. 00   09000   CLI NI C	0	-	0		90. 0	
91. 00   09100   EMERGENCY	0		0		91. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92. 0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	1	0		92. 0	
200.00 Subtotal (see instructions)	0		0		200. 0	
201.00 Less PBP Clinic Lab. Services-Program	0	1			201. 0	)()
Only Charges	_		_			_
202.00   Net Charges (line 200 - line 201)	0	1	0		202. 0	)()

Health Financial Systems	IU HEALTH WHITE HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1312	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/29/2020 8:40 am
	Title XVIII	Hospi tal	Cost

				6/29/2020 8: 4	0 am
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
	DART I ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	avaluding nawbarn)		2, 811	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed days)			2, 283	2.00
3. 00	Private room days (excluding swing-bed and observation bed day		ivata room davs	2, 203	3. 00
3.00	do not complete this line.	73). IT you have only pr	i vate i oom days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		1, 712	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	152	5. 00
	reporting period	3 , 3			
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	376	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	the Dreamen (evaluding	owing bod and	1 014	9. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	1, 014	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	152	10.00
10.00	through December 31 of the cost reporting period (see instruct		oom days)	102	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er		<i>,</i>		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including privat	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
44.00	after December 31 of the cost reporting period (if calendar ye			0	44.00
14. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
15. 00 16. 00	Nursery days (title V or XIX only)			0	16. 00
16.00	SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 o	f the cost		17. 00
17.00	reporting period	23 thi bugh becember 31 0	the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	118. 90	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21 00	reporting period			( 442 (74	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing ported (line	6, 442, 674 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost report	ing perrou (inne	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23. 00
	x line 18)		9	_	
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	44, 706	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
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	(1) 04 1 11 0()		444, 086	
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		5, 998, 588	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation had ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cir	ai ges)	0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34. 00
35.00					35. 00
36. 00				0	36. 00
37. 00	6.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line			5, 998, 588	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTNENTC			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			2 (27 52	20.00
38.00	Adjusted general inpatient routine service cost per diem (see	•		2, 627. 50	38. 00 39. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		2, 664, 285 0	40.00
	Total Program general inpatient routine service cost (line 39	,		2, 664, 285	
00	1.112 13. dai. 30.10. dapat. 5t Toutino 301 vi 00 005t (11110 07		ı	2, 00 1, 200	

Heal th Financial Systems	IU HEALTH WHIT		ON 45		u of Form CMS-2	
COMPUTATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1312	Peri od: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 6/29/2020 8:4	
		Ti tl e	XVIII	Hospi tal	Cost	o aiii
Cost Center Description	Total Inpatient Costl	Total	Average Per		Program Cost (col. 3 x col.	
	impatrent costi	ilpati ent bays	col. 2)	<del>-</del>	4)	
42.00 NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	12.00
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Un	i ts					42.00
43. 00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
					1. 00	
48.00 Program inpatient ancillary service cost 49.00 Total Program inpatient costs (sum of lin			unc)		561, 824 3, 226, 109	
PASS THROUGH COST ADJUSTMENTS	les 41 till ough 40) (s	see mstructro	1115)		3, 220, 109	49.00
50.00 Pass through costs applicable to Program	inpatient routine s	services (from	Wkst. D, sur	n of Parts I and	0	50.00
III )   51.00   Pass through costs applicable to Program	inpatient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.00
and IV)		•			_	F2 22
52.00   Total Program excludable cost (sum of lir 53.00   Total Program inpatient operating cost ex		ated, non-phy	sician anestl	netist, and	0	
medical education costs (line 49 minus li	ne 52)					
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0	]   54. 00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient ope	rating cost and tag	rget amount (L	ine 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period	endi ng 1996, ι	pdated and co	ompounded by the	0. 00	59.00
60.00 Lesser of lines 53/54 or 55 from prior ye					0. 00	
61.00 If line 53/54 is less than the lower of I which operating costs (line 53) are less					0	61.00
amount (line 56), otherwise enter zero (s		3 (TITIES 54 X	00), 01 1% 0	the target		
<ul><li>62.00   Relief payment (see instructions)</li><li>63.00   Allowable Inpatient cost plus incentive p</li></ul>	avment (see instru	ctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00   Medicare swing-bed SNF inpatient routine instructions) (title XVIII only)	costs through Decer	mber 31 of the	cost reporti	ng period (See	399, 380	64.00
65.00 Medicare swing-bed SNF inpatient routine	costs after Decembe	er 31 of the c	ost reporting	g period (See	0	65.00
instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient ro	utine costs (line /	54 nlus line A	5)(title XVII	Lonly) For	399, 380	66.00
CAH (see instructions)	attile costs (Tille t	or prus rine c	o) (trite xvr	1 on y). 101	377, 300	
67.00 Title V or XIX swing-bed NF inpatient rou (line 12 x line 19)	tine costs through	December 31 c	of the cost re	eporting period	0	67.00
68.00 Title V or XIX swing-bed NF inpatient rou	tine costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatie	ent routine costs (	ine 67 ± line	68)		0	69.00
PART III - SKILLED NURSING FACILITY, OTHE						07.00
70.00   Skilled nursing facility/other nursing fa 71.00   Adjusted general inpatient routine service	•			)		70.00
72.00 Program routine service cost (line 9 x li	ne 71)		•			72.00
73.00 Medically necessary private room cost app 74.00 Total Program general inpatient routine s						73. 00 74. 00
75. 00 Capital -related cost allocated to inpatie	•	,		Part II, column		75. 00
26, line 45)	Line 2)					7/ 00
76.00   Per diem capital-related costs (line 75 ÷ 77.00   Program capital-related costs (line 9 x l						76. 00 77. 00
78.00 Inpatient routine service cost (line 74 m	,	:	1->			78.00
79.00 Aggregate charges to beneficiaries for ex 80.00 Total Program routine service costs for c			· .	nus line 79)		79. 00 80. 00
81.00 Inpatient routine service cost per diem I	imitation			ŕ		81.00
82.00   Inpatient routine service cost limitation 83.00   Reasonable inpatient routine service cost	· ·					82. 00 83. 00
84.00 Program inpatient ancillary services (see	instructions)	,				84.00
85.00 Utilization review - physician compensati 86.00 Total Program inpatient operating costs (	•					85. 00 86. 00
PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST	_ug 00)				1
87.00 Total observation bed days (see instructi 88.00 Adjusted general inpatient routine cost p		line 2)			571 2, 627. 50	
55. 55 majustou generar riipatrent routrile Cost p	or arom (TITIC 2/ =	1110 2/			2,021.30	89.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 6/29/2020 8:4	pared: O am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	905, 359	6, 442, 674	0. 14052	5 1, 500, 303	210, 830	90.00
91.00 Nursing School cost	0	6, 442, 674	0.00000	0 1, 500, 303	0	91.00
92.00 Allied health cost	0	6, 442, 674	0.00000	0 1, 500, 303	0	92.00
93.00 All other Medical Education	0	6, 442, 674	0.00000	0 1, 500, 303	0	93.00

Health Financial Systems	IU HEALTH WHITE HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1312	Peri od: From 01/01/2019	Worksheet D-1
			Date/Time Prepared: 6/29/2020 8:40 am
	Title XIX	Hospi tal	Cost

NAME   - ALL PROVIDER CONVINENTS   1.09				12,01,201,	6/29/2020 8: 4	0 am
			Title XIX	Hospi tal	Cost	
Next   I. ALL PROVIDER COMPONENTS   Next		Cost Center Description				
MEATLEST DAYS					1. 00	
Impatient days (including private room days and seing-bed days, excluding newborn)   2,881   1,00						
Inpatient days (Including private room days, excluding saing-bed and newborn days)   2,283   2,00   Private room days (secluding saing-bed and observation bed days)   17 you have only private room days (and on the complete this it inc.   1,00						
Private room days (excluding swing-bed and observation bed days)   1 ry you have only private room days   0   3.00					-	•
do not complete this line.  10 OSC   Control						1
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newborn days) (see Instructions)   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   0	0 00		the Program (excluding	swing-had and	12	0 00
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after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00   10.01   10			3 (	,		
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35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 998, 588 and part in a service line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1
36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 998, 588 27.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 36.00 37.00				tions)		1
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 998, 588 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37. 00  5, 998, 588  5, 998, 588  37. 00  5, 998, 588  37. 00  1, 998, 588  2, 627. 50  38. 00  39. 00  40. 00		, , , , , , , , , , , , , , , , , , , ,	ne 31)			•
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2, 627.50 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,		66 (1.1		•
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,627.50 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00		and private room cost di	fferential (line	5, 998, 588	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,627.50 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00Adjusted general inpatient routine service cost per diem (see instructions)2,627.5038.0039.00Program general inpatient routine service cost (line 9 x line 38)31,53039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 31,530 39.00 40.00	20 00				2 427 50	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	,			1
		, , , , , , , , , , , , , , , , , , , ,	•			1
1 30   10 tal. 1. 10g. a.m. general impatrion: 10 at the 30 for 60 at (1116 37 for 1116 40)		, , , , , , , , , , , , , , , , , , , ,	,			1
	<del>-</del> 1. 00	Trotal Trogram general impatrent routine service cost (Tine 37			31, 330	1 -1.00

	Financial Systems IU F ATION OF INPATIENT OPERATING COST	HEALTH WHITE		CN. 1E 1212		u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	UN: 15-1312	Peri od: From 01/01/2019	Worksheet D-1	
					To 12/31/2019	Date/Time Pre	
			Titl	e XIX	Hospi tal	6/29/2020 8: 40 Cost	u alli
	Cost Center Description	Total	Total	Average Per		Program Cost	
	Inpat	ient Cost r	npatient Days		÷	(col. 3 x col.	
		1.00	2. 00	col. 2) 3.00	4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42. 00
12.00	Intensive Care Type Inpatient Hospital Units						12.00
43.00	INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00 46. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			•			47. 00
17.00	Cost Center Description						17.00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D					14, 922	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 the PASS THROUGH COST ADJUSTMENTS	rough 48)(Se	ee instructio	ons)		46, 452	49. 00
50. 00	Pass through costs applicable to Program inpatien	t routine se	ervices (from	n Wkst. D. sui	n of Parts I and	0	50.00
						_	
51. 00	Pass through costs applicable to Program inpatien	t ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51.00
E2 00	and IV)	d E1)				0	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and Total Program inpatient operating cost excluding of the cos	,	ated non-nhy	sician anest	natist and	0	52. 00 53. 00
33.00	medical education costs (line 49 minus line 52)	capital rela	ateu, non-pny	isi ci aii aliesti	leti st, and	O	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program di scharges					0	54. 00
55. 00	Target amount (Line E4 v Line E5)					0. 00 0	55. 00 56. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operating of	nst and tar	net amount (1	ine 56 minus	line 53)	0	57.00
58. 00	Bonus payment (see instructions)	ost and tary	get amount (i	THE 30 III HGS	11116 33)	0	58.00
59.00						0.00	59. 00
	market basket						
60. 00 61. 00							60. 00 61. 00
01.00	which operating costs (line 53) are less than exp					0	01.00
	amount (line 56), otherwise enter zero (see instru		(		9-1		
62.00	Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (: PROGRAM INPATIENT ROUTINE SWING BED COST	see instruc	tions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs the	rough Decemb	ber 31 of the	cost report	na period (See	0	64. 00
	instructions)(title XVIII only)				(		
65. 00	Medicare swing-bed SNF inpatient routine costs af	ter Decembe	r 31 of the c	ost reporting	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine co	sts (lino 6	4 plus lipo 6	5) (+i+lo VVI	Lonly) For	0	66. 00
00.00	CAH (see instructions)	313 (11116 0	4 prus rine o	o)(title XVI	1 0111 9). 101	O	00.00
67. 00	1	ts through [	December 31 o	of the cost re	eporting period	0	67. 00
(0.00	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routine cost (line 13 x line 20)	ts arter Dec	cember 31 or	tne cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routing	ne costs (li	ine 67 + line	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING						
70. 00	Skilled nursing facility/other nursing facility/l			•	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service cost per Program routine service cost (line 9 x line 71)	er diem (lin	ne 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applicable	to Program	(line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine service co		•				74. 00
75. 00	Capital-related cost allocated to inpatient routing	ne service (	costs (from W	lorksheet B, I	Part II, column		75. 00
7/ 00	26, line 45)						7/ 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line	e 77)					78. 00
79. 00	Aggregate charges to beneficiaries for excess cos		ovi der record	ls)			79. 00
80.00	Total Program routine service costs for comparison		st limitation	ı (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitation						81. 00 82. 00
82.00	Inpatient routine service cost limitation (line 9 Reasonable inpatient routine service costs (see in		)				82.00
84. 00	Program inpatient ancillary services (see instruc						84. 00
85. 00	Utilization review - physician compensation (see						85.00
86. 00	Total Program inpatient operating costs (sum of I)		ough 85)				86. 00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	905, 359	6, 442, 674	0. 14052	5 1, 500, 303	210, 830	90.00
91.00 Nursing School cost	0	6, 442, 674	0.00000	1, 500, 303	0	91.00
92.00 Allied health cost	0	6, 442, 674	0.00000	1, 500, 303	0	92.00
93.00 All other Medical Education	0	6, 442, 674	0.00000	1, 500, 303	0	93.00

Health Financial Systems	IU HEALTH WHITE HOSPITAL	_	eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1312	Peri od:	Worksheet D-3	
		From 01/01/2019 To 12/31/2019		nared:
		10 12/31/2017	6/29/2020 8: 4	
	Title XVIII	Hospi tal	Cost	
Cost Center Description	Ratio of C		I npati ent	
	To Charge	es Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		2, 213, 683		30. 00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 384		4, 743	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 195			
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 261		3, 538	
56. 00   05600   RADI OI SOTOPE	0. 121			
57. 00  05700 CT SCAN	0. 181			
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 239			
60. 00   06000   LABORATORY	0. 328			
66. 00  06600 PHYSI CAL THERAPY	0. 524			
67. 00 06700 OCCUPATI ONAL THERAPY	0. 670			
68. 00   06800   SPEECH PATHOLOGY	0. 729		11, 196	
69. 00   06900   ELECTROCARDI OLOGY	0. 186		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 336			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 311	403	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 170	986 676, 914	115, 743	
73. 01   07301   ONCOLOGY DRUGS	0. 363	3541 0	0	73. 01
76. 00   03160   CARDI OPULMONARY	0. 331	026 448, 204	148, 367	76. 00
76. 97 07697 CARDI AC REHABI LITATION	0. 837	7512 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 230	0081 0	0	90. 00
91. 00   09100   EMERGENCY	0. 211			91. 00
02 00 00200 OBSERVATION BEDS (NON DISTINCT DART)	0.202	0000 0 475	1 750	00 00

5, 155 91. 00 750 92. 00 0 92. 01

201. 00 202. 00

561, 824 200. 00

1, 970, 143

0. 302830 0.000000

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	IU HEALTH WHITE HOSPITAL		In lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN	: 15-1312	Peri od:	Worksheet D-3	
THE PROPERTY OF THE STATE OF TH			From 01/01/2019		
	Component CC	N: 15-Z312	To 12/31/2019	Date/Time Prep 6/29/2020 8:40	
	Title)	(//	Swing Beds - SNF		U alli
Cost Center Description		atio of Cost		Inpati ent	
		To Charges		Program Costs	
		3		(col. 1 x col.	
				2)	
		1. 00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 38435	5 0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 19582	2, 266	444	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C		0. 26127	3 4, 151	1, 085	55. 00
56. 00   05600   RADI 0I SOTOPE		0. 12124	5 0	0	56.00
57.00   05700   CT SCAN		0. 18160	8 744	135	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 23923	3 0	0	58. 00
60. 00   06000   LABORATORY		0. 32824	1 18, 347	6, 022	60.00
66. 00 06600 PHYSI CAL THERAPY		0. 52481	8 53, 730	28, 198	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 67061	3 25, 711	17, 242	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 72953	8 3, 789	2, 764	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 18688	5 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 33669	78	26	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 31140	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 17098	6 29, 259	5, 003	73.00
73. 01   07301   0NCOLOGY DRUGS		0. 36354	1 0	0	73. 01
76.00 03160 CARDI OPULMONARY		0. 33102	15, 091	4, 996	76.00
76. 97 07697 CARDIAC REHABILITATION		0. 83751	2 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 23008	1 0	0	90.00
91. 00   09100   EMERGENCY		0. 21186	1 0	0	91.00
02 00 00200 ODCEDVATION DEDC (NON DISTINCT DADT)		0 20202	ما م		00 00

0. 211861 0. 302830

0.000000

0

153, 166

153, 166

92.00 0

92. 01 0

201. 00 202. 00

65, 915 200. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	IU HEALTH WHITE HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN:	F	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prep 6/29/2020 8:40	pared:
	Title X	TY	Hospi tal	Cost	J alli
Cost Center Description		tio of Cost		Inpatient	
cost center bescription		o Charges	Program	Program Costs	
	''	o charges		(col. 1 x col.	
			onal ges	2)	
		1. 00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			25, 993		30. 00
ANCILLARY SERVICE COST CENTERS	1				
50. 00 05000 OPERATING ROOM		0. 384355	5 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 195823	1, 974	387	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 261273		o	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 121245	5 0	o	56. 00
57. 00 05700 CT SCAN		0. 181608	1, 643	298	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 239233		o	58. 00
60. 00   06000   LABORATORY		0. 328241	1 8, 033	2, 637	60.00
66. 00 06600 PHYSI CAL THERAPY		0. 524818	976	512	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 670613	3 455	305	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 729538	8 0	o	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 186885	5 0	o	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 336691	1 0	ol	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 311403	3 0	o	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 170986	6 10, 146	1, 735	73.00
73. 01 07301 ONCOLOGY DRUGS		0. 363541	1 0	0	73. 01
76. 00 03160 CARDI OPULMONARY		0. 331026	6 2, 605	862	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 837512	2 0	o	76. 97
OUTPATIENT SERVICE COST CENTERS	•				
90. 00 09000 CLI NI C		0. 230081	1 0	0	90. 00
91. 00 09100 EMERGENCY		0. 21186	1 18, 807	3, 984	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 302830	13, 875	4, 202	92.00
02 01 00201 OBSEDVATION BEDS (DISTINCT DART)		0 000000		ام	02 01

91.00 O9100 EMERGENCY
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
92.01 O9201 OBSERVATION BEDS (DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 Net charges (line 200 minus line 201)

58, 514

0.000000

0 14, 922 200. 00 201. 00 202. 00

92. 00 92. 01

		6/29/2020 8: 4	o am
	Title XVIII Hospital	Cost	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	8, 370, 352	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3. 00
4.00	Outlier payment (see instructions)	0	4. 00
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5. 00 6. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00
8. 00	Transitional corridor payment (see instructions)	0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9. 00
10.00	Organ acqui si ti ons	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8, 370, 352	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12. 00	Ancillary service charges	0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	0	14. 00
15. 00	Customary charges  Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18. 00	Total customary charges (see instructions)	0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19. 00
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
21. 00	instructions)     Lesser of cost or charges (see instructions)	8, 454, 056	21. 00
22. 00	Interns and residents (see instructions)	0, 434, 030	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	•	
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	74, 254	25.00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5, 374, 089	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	3, 005, 713	27. 00
20.00	instructions)		20.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28. 00 29. 00
30. 00	Subtotal (sum of lines 27 through 29)	3, 005, 713	30.00
31. 00	Primary payer payments	1, 365	
32.00	Subtotal (line 30 minus line 31)	3, 004, 348	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34. 00	Allowable bad debts (see instructions)	1, 003, 196	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)	652, 077	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	647, 447 3, 656, 425	
38. 00	MSP-LCC reconciliation amount from PS&R	0,030,423	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40. 00	Subtotal (see instructions)	3, 656, 425	40.00
40. 01	Sequestration adjustment (see instructions)	73, 129	40. 01
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs   Interim payments	3, 875, 805	40. 03 41. 00
41. 01	Interim payments	3, 073, 003	41. 01
42. 00	Tentative settlement (for contractors use only)	0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 01
43.00	Balance due provider/program (see instructions)	-292, 509	43.00
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	494, 231	44. 00
	§115. 2		
00.00	TO BE COMPLETED BY CONTRACTOR		00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0	90. 00 91. 00
92. 00	The rate used to calculate the Time Value of Money	0.00	92.00
93. 00	Time Value of Money (see instructions)	0.00	93. 00
	Total (sum of lines 91 and 93)		94. 00

Health Financial Systems IU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:40 am Provider CCN: 15-1312

					6/29/2020 8: 40	<u>am</u>
			XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		2, 425, 65		3, 875, 805	1.00
2.00	Interim payments payable on individual bills, either		(	O	0	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	07/23/2019	116, 10	1	0	3. 01
3. 02	ADSOSTWENTS TO TROVIDER	0772372017			0	3. 02
3. 03					0	3. 03
3. 04					o o	3. 04
3. 05					0	3. 05
	Provider to Program			-1		
3.50	ADJUSTMENTS TO PROGRAM		(	D	0	3. 50
3.51			(	)	0	3. 51
3.52			(	O	0	3. 52
3.53			(	O	0	3. 53
3.54			(	O	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		116, 10	)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 541, 75	2	3, 875, 805	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(	D	0	5. 01
5.02			(	o l	0	5. 02
5.03			(	O	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		(	O	0	5. 50
5. 51				O	0	5. 51
5. 52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(	O	0	5. 99
	5. 50-5. 98)					,
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		363, 310		0	6. 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM				292, 509	6. 01
7. 00	Total Medicare program liability (see instructions)		2, 905, 06:		3, 583, 296	7. 00
7.00	Total medicale program frability (see Histructions)		2, 705, 00.	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	'	•		•	. '	

Health Financial Systems IU ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED 

		Component	JUN. 13-Z312	0 12/31/2019	6/29/2020 8: 40	
		Title	XVIII Sv	ving Beds - SNF		
			t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	I	1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		390, 188		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		0		0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	07/23/2019	46, 900		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3. 04 3. 05			0		0	3. 04 3. 05
3.05	Provider to Program				U	3. 03
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	THE OF THE PROPERTY OF THE OFFICE OFFICE OF THE OFFICE OF THE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFFICE OFF		Ö		ő	3. 51
3. 52			Ō		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		46, 900		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		437, 088		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
F 50	Provi der to Program		_			F F6
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51 5. 52			0		0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
5. //	5. 50-5. 98)					5. //
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		22, 563		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		459, 651		0	7. 00
				Contractor	NPR Date	
		,	2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		)	1. 00	2. 00	8. 00
5.00	Indino of contractor	I		l	ı	0.00

Heal th	Financial Systems IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL					epared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	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
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 seguestration	(see instructions)			10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	(222 2322 2227 0330)			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
					22.00

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

30. 00 31. 00 32. 00

		Component CCN: 15-Z312	To 12/31/2019		
		Title XVIII	Swing Beds - SNF	6/29/2020 8: 4 Cost	U alli
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		403, 374	0	1.00
2. 00 3. 00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of Wkst D	44 674	0	2. 00 3. 00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin		66, 574	U	3.00
	instructions)	g bed pass till dagil, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4. 00
F 00	instructions)		450		F 00
5. 00 6. 00	Program days	structions)	152	0	5. 00 6. 00
7. 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional met		0	U	7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	riod offi y	469, 948	0	8.00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		469, 948	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11. 00
40.00	professional services)				40.00
12. 00 13. 00	Subtotal (line 10 minus line 11)	(avaluda sai nauransa	469, 948	0	12. 00 13. 00
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	(exclude collisulance	1, 023	U	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (see instructions)		468, 925	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ation) payment	0		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		165	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		107	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
19. 00	Total (see instructions)		469, 032	0	19. 00
19. 01	Sequestration adjustment (see instructions)		9, 381	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs		427 000	0	19. 03
20. 00 20. 01	Interim payments Interim payments-PARHM		437, 088	U	20. 00 20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	nd 21)	22, 563	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	27, 625	0	23. 00
	<pre>chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstr</pre>	ation) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	. od dilder tile 2.et			200.00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201. 00
202.00	66 (title XVIII hospital))  Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst D 2 col 2 lin			202. 00
202.00	200 (title XVIII swing-bed SNF))	I WKSt. D-3, COI. 3, IIII	E		202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	rati on	
	peri od)				
	Medicare swing-bed SNF target amount	mag line 204)			205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				206. 00
207 00	Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	•	1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement	00 plus line 210) (			215 00
∠15. UU	Total adjustment to Medicare swing-bed SNF PPS payment (line 2 instructions)	or prus rine 210) (See			215. 00
	princer doctroits)		ı		I

Health Financial Systems	IU HEALTH WHITE HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1312	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 8:40 am

				6/29/2020 8: 40	o am
		Title XVIII	Hospi tal	Cost	
			· •		
				1, 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		
1.00	Inpatient services	77 77 02 02.0	TET III DOTTOE III ETT	3, 226, 109	1. 00
2. 00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0,220,107	2. 00
3. 00	Organ acquisition	0113)		0	3. 00
4. 00	Subtotal (sum of lines 1 through 3)			3, 226, 109	4. 00
5. 00	Primary payer payments			0, 220, 107	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 258, 370	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 230, 370	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	, ,			0	9. 00
10.00	Organ acquisition charges, net of revenue Total reasonable charges			0	10.00
10.00	Customary charges			U	10.00
11 00	, ,	normant for complete on	a abanga basi s	0	11 00
11. 00 12. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	11. 00 12. 00
12.00	'	1 3	n a charge basis	U	12.00
12 00	had such payment been made in accordance with 42 CFR 413.13(e)	)		0. 000000	13. 00
13. 00 14. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	14. 00
15. 00	Total customary charges (see instructions)	ly if lime 14 eyeeede li	no () (ooo	0	15. 00
15.00	Excess of customary charges over reasonable cost (complete on instructions)	ry ir irne 14 exceeds ir	ne o) (see	U	15.00
16. 00	Excess of reasonable cost over customary charges (complete on	Ly if line 4 eyecods lin	0 14) (600	o	16. 00
10.00	instructions)	Ty IT TIME 0 exceeds ITM	e 14) (See	U	10.00
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	r de trons)		0	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-	4 line 40)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	4, 11116 47)		3, 258, 370	19. 00
20. 00	Deductibles (exclude professional component)			312, 308	
21. 00	Excess reasonable cost (from line 16)			312, 300	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 946, 062	22. 00
23. 00	Coi nsurance			341	23. 00
24. 00	Subtotal (line 22 minus line 23)			2, 945, 721	
25. 00	Allowable bad debts (exclude bad debts for professional service	cae) (saa instructions)		28, 659	
26. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistructions)		18, 628	26. 00
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		4, 010	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	ructions)		2, 964, 349	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2, 704, 347	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	c)		0	29.50
29. 50		5)		0	29. 30
	Demonstration payment adjustment amount before sequestration				
30.00	Subtotal (see instructions)			2, 964, 349	
30. 01	Sequestration adjustment (see instructions)			59, 287	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM			0 544 750	30. 03
31.00	Interim payments			2, 541, 752	
31. 01	Interim payments-PARHM				31. 01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)	0 04 1 00)		0,000	32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0)		1 00 61	363, 310	33. 00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		,		33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub. 15-2,	cnapter 1,	191, 495	34. 00
	§115. 2				l

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

Provider CCN: 15-1312

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Time Prepared:

onl y)			1	0 12/31/2019	6/29/2020 8: 4	
		General Fund		Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1. 00	
1.00	Cash on hand in banks	26, 318, 590	1	0	0	
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	1, 737, 685	_	0	0	3. 00 4. 00
5.00	Other recei vable	1,737,003	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	232, 295	1	0	0	7. 00
8.00	Prepaid expenses	252, 273		0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	0	_	0	0	
11. 00	Total current assets (sum of lines 1-10)	28, 540, 843	_	· ·	0	•
11.00	FIXED ASSETS	20,010,010		<u> </u>		11.00
12.00	Land	972, 779	0	0	0	12. 00
13. 00	Land improvements	122, 178	1	0	0	13. 00
14.00	Accumulated depreciation	-96, 584	1	0	0	14. 00
15. 00 16. 00	Buildings Accumulated depreciation	30, 277, 094 -6, 659, 791		0	0	15. 00 16. 00
17. 00	Leasehold improvements	-0,037,771	0	0	0	•
18. 00	Accumulated depreciation	O	Ō	0	0	
19. 00	Fi xed equipment	0	0	0	0	19. 00
20. 00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00 23. 00	Accumulated depreciation Major movable equipment	10, 524, 008	0	0	0	22. 00 23. 00
24. 00	Accumulated depreciation	-6, 548, 559	1	o	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	•
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00 29. 00	Accumulated depreciation		0	0	0	28. 00 29. 00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	28, 591, 125		0	0	30.00
50. 00	OTHER ASSETS	20,071,120		<u> </u>		00.00
31.00	Investments	158, 803	0	0	0	31. 00
32. 00	Deposits on Leases	0	0	0	0	
33.00	Due from owners/officers	20.175	0	0	0	•
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	30, 175 188, 978	1	0	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	57, 320, 946	1	o	0	36.00
	CURRENT LIABILITIES					
37. 00	Accounts payable	1, 868, 419	1	0	0	37. 00
38. 00	Salaries, wages, and fees payable	860, 766	1	0	0	38. 00
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	44, 640 650, 000	1	0	0	
41. 00	Deferred income	030,000	1	0	0	
42. 00	Accel erated payments	O	_			42. 00
43.00	Due to other funds	4, 921, 253		0	0	
44.00	Other current liabilities	10, 750			0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	8, 355, 828	0	0	0	45. 00
46. 00	Mortgage payable		0	O	0	46. 00
47. 00	Notes payable	19, 665, 000	l .	ő	0	
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	39, 388	1	0	0	•
50.00	Total long term liabilities (sum of lines 46 thru 49)	19, 704, 388	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)  CAPITAL ACCOUNTS	28, 060, 216	0	0	0	51. 00
52. 00	General fund balance	29, 260, 730				52. 00
53. 00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			이	_	56. 00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
30.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	29, 260, 730		0	0	1
60.00	Total liabilities and fund balances (sum of lines 51 and	57, 320, 946	0	0	0	60. 00
	[59]	I	I			I

Provider CCN: 15-1312

					То	12/31/2019	Date/Time Prep 6/29/2020 8:40	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	y dill
		1.00	2.00	2.00		4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 28, 106, 675	3.00		4. 00	5. 00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1, 065, 406			U		2. 00
3.00	Total (sum of line 1 and line 2)		29, 172, 081			0		3. 00
4. 00	NET INTERCOMPANY TRANSACTIONS	88, 647	27, 172, 001		0	O	o	4. 00
5.00	ROUNDI NG	2			0		l ől	5. 00
6.00	NOOND1 NO	0			0		o o	6. 00
7. 00		0			0		0	7. 00
8. 00		o			0		l ol	8. 00
9. 00		o			Ō		o o	9. 00
10.00	Total additions (sum of line 4-9)		88, 649			0		10.00
11. 00	Subtotal (line 3 plus line 10)		29, 260, 730			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13.00		o			0		0	13.00
14.00		0			0		0	14.00
15.00		0			0		0	15.00
16.00		0			0		0	16.00
17. 00		0			0		0	17.00
18. 00	Total deductions (sum of lines 12-17)		0			0		18.00
19. 00	Fund balance at end of period per balance		29, 260, 730			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Endownert Fund	PLAIIL	Fullu				
		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	NET INTERCOMPANY TRANSACTIONS		0					4.00
5.00	ROUNDI NG		0					5.00
6.00			0					6. 00
7.00			0					7. 00
8. 00			0					8. 00
9.00	T		0					9.00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	o o	0		U			11. 00 12. 00
12.00	beductions (debit adjustments) (specify)		0					12.00
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)	0	Ĭ		0			18. 00
19. 00	Fund balance at end of period per balance	l			0			19. 00
	sheet (line 11 minus line 18)							

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1312

			To 12/31/2019	Date/Time Prep 6/29/2020 8:40	
	Cost Center Description	I npati ent	Outpati ent	Total	o diii
	<b>'</b>	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	4, 024, 0	13	4, 024, 013	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	469, 9	21	469, 921	5. 00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	4, 493, 9	34	4, 493, 934	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines		0	0	16. 00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4, 493, 9	34	4, 493, 934	17.00
18.00	Ancillary services	4, 042, 2	49, 742, 411	53, 784, 676	18. 00
19.00	Outpatient services	562, 5	13 32, 398, 968	32, 961, 481	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				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26, 00	HOSPI CE				26, 00
27. 00	PHYSI CI AN REVENUE		0 0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 9, 098, 7	12 82, 141, 379		28. 00
	G-3, line 1)			, , , , , ,	
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		30, 037, 026		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34.00			0		34.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38.00			0		38. 00
39.00			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)(trans	sfer	30, 037, 026		43.00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems	IU HEALTH WHITE		In Lie	u of Form CMS-	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1312 Period:		Worksheet G-3				
				From 01/01/2019 To 12/31/2019	Date/Time Pre	narodi
				10 12/31/2019	6/29/2020 8: 4	
					0,27,2020 0	- Cann
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, lin	e 28)		91, 240, 091	1. 00
2.00	Less contractual allowances and discounts on	patients' accoun	ts		61, 681, 382	2. 00
3.00	Net patient revenues (line 1 minus line 2)	•			29, 558, 709	3. 00
4.00	Less total operating expenses (from Wkst. G-2	2, Part II, line	43)		30, 037, 026	4. 00
5.00	Net income from service to patients (line 3 m	ninus line 4)			-478, 317	5. 00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6. 00
7.00	Income from investments				0	7. 00
8.00	00 Revenues from telephone and other miscellaneous communication services					8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				0	10. 00
11. 00	Rebates and refunds of expenses				0	11. 00
12.00	Parking Lot receipts				0	12. 00
13.00	Revenue from Laundry and Linen service				0	13. 00
14.00	Revenue from meals sold to employees and gues	sts			0	14. 00
15.00	Revenue from rental of living quarters				0	
16.00	Revenue from sale of medical and surgical sup	oplies to other t	han patients		0	16. 00
17. 00	Revenue from sale of drugs to other than pati				0	17. 00
18.00	Revenue from sale of medical records and abst	racts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, ar	nd canteen			0	20. 00
21.00	Rental of vending machines				0	21. 00
22. 00	Rental of hospital space				0	
23. 00	Governmental appropriations				0	23. 00
	MI SCELLANEOUS I NCOME				1, 543, 723	
05 00	T				4 540 700	1 05 00

0 27. 00

1, 065, 406 29. 00

25.00

26.00

28.00

1, 543, 723

1, 065, 406

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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)

27. 00 OTHER EXPENSES (SPECIFY)