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: 15-0173 Period: From 01/01/2019 To 12/31/2019 Date/Time Prepared: (40/2020 0.23 cm.)

				6/29/2020 8:33 am
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost rep	ort	Date: 6/29/202	20 Time: 8:33 ar
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report ent 4. [F] Medicare Utilization. Enter "F" $$		er resubmitted this co	ost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted 7. Contract(2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Recondant 7. Contract(8. [N] Ini (9. [N] Fin (9. [N] Fi	or No.		

PART II - CERTIFICATION

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 ARNETT HOSPITAL (15-0173) 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.

(Si gned) TODD WILLIAMS

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	-177, 836	38, 505	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
200.00	Total	0	-177, 836	38, 505	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.

reporting period? In column 2, enter "Y" for yes	or "N" for no						
	In-State	In-State	Out-of	Out-of	Medi cai	d Other	
	Medi cai d	Medi cai d	State	State	HMO day	's Medicaid	
	paid days	eligible	Medi cai d	Medi cai d		days	
		unpai d	pai d days	eligible			
		days		unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24.00 If this provider is an IPPS hospital, enter the	1, 991	502	2 3	61	7, 8	332 29	24.00
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 colu							
4, Medicaid HMO paid and eligible but unpaid days	i n						
column 5, and other Medicaid days in column 6.							

Health Financial Systems IU HEALTH ARNETT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0173 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:33 am In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26. 00 cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37 01 instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412 348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA Υ 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 N 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 Ν defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, 59.00 Pt. NAHE 413.85 Pass-Through Worksheet A Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 1 60.01 instructions)

61. 00	Did your hospital receive FTE slots under ACA	N			0.00	0.00	61. 00
	section 5503? Enter "Y" for yes or "N" for no in						
	column 1. (see instructions)						
61. 01	Enter the average number of unweighted primary care						61. 01
	FTEs from the hospital's 3 most recent cost reports						
	ending and submitted before March 23, 2010. (see						
	instructions)						
61. 02	Enter the current year total unweighted primary care						61. 02
	FTE count (excluding OB/GYN, general surgery FTEs,						
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
61. 03	Enter the base line FTE count for primary care						61. 03
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see						
	instructions)						
61. 04	Enter the number of unweighted primary care/or						61. 04
01.01	surgery allopathic and/or osteopathic FTEs in the						0 0 .
	current cost reporting period. (see instructions).						
61 05	Enter the difference between the baseline primary						61. 05
01.05	and/or general surgery FTEs and the current year's						01.03
	primary care and/or general surgery FTE counts (line						
(1.0/	61.04 minus line 61.03). (see instructions)						(1.0)
61.06	Enter the amount of ACA §5503 award that is being						61. 06
	used for cap relief and/or FTEs that are nonprimary						
	care or general surgery. (see instructions)	Die	oarom Nomo	Program Code	Unweighted IME	Upwai abtad	
		PI	ogram Name	Program code		9	
					FTE Count	Direct GME FTE	
						Count	
	00.11 575 1.11 14.05 1.0		1. 00	2. 00	3.00	4.00	(4.40
61. 10	Of the FTEs in line 61.05, specify each new program				0. 00	0.00	61. 10
	specialty, if any, and the number of FTE residents						
	for each new program. (see instructions) Enter in						
	column 1, the program name. Enter in column 2, the						
	program code. Enter in column 3, the IME FTE						
	unweighted count. Enter in column 4, the direct GME						
	FTE unweighted count.						
61. 20	Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61. 20
	program specialty, if any, and the number of FTE						
	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column						
	3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
						1. 00	
	ACA Provisions Affecting the Health Resources and Ser						
62.00	Enter the number of FTE residents that your hospital		d in this cost	reporting peri	od for which	0.00	62. 00
	your hospital received HRSA PCRE funding (see instruc						
62. 01	Enter the number of FTE residents that rotated from a	Teach	ing Health Cent	ter (THC) into	your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC prog			าร)			
	Teaching Hospitals that Claim Residents in Nonprovide						
63.00	Has your facility trained residents in nonprovider se	ttings	during this co	ost reporting p	eriod? Enter	Υ	63. 00
	"Y" for yes or "N" for no in column 1. If yes, comple	te lin	es 64 through 6	<u>67. (see instru</u>	ictions)		
				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 Base Year FTE Residents in No	nprovi	der Settings	This base year	is your cost r	eporti ng	
	period that begins on or after July 1, 2009 and befor						
64.00	, , , , , , , , , , , , , , , , , , , ,			0.00	0.00	0. 000000	64. 00
	in the base year period, the number of unweighted nor						
	resident FTEs attributable to rotations occurring in	all no	nprovi der				
	settings. Enter in column 2 the number of unweighted						
	resident FTEs that trained in your hospital. Enter in	col umi	n 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see	instru	ctions)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0173 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:33 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 ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 2.00 3. 00 1.00 4.00 5.00 67.00 Enter in column 1, the program FAMILY MEDICINE 0. 241742 67. 00 1350 1.61 5.05 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)

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0173	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S- Part I Date/Time Pr 6/29/2020 8:	repared:
					1.00	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			ng period? Enter	N N	80.00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (excluder §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
37. 00	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified	under sectio	า	N	87. 00
	1 100 Yes 31 N 101 No.			V 1. 00	XI X 2. 00	
20.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospita	L sarvicas? F	nter "V" for	N	Y	90.00
	yes or "N" for no in the applicable column.					
	Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appl	icable column		N	N	91.00
2. 00	Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applical		on)? (see		N	92.00
3. 00	Does this facility operate an ICF/IID facility for purposes ("Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00
4. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94. 00
	applicable column. If line 94 is "Y", enter the reduction percentage in the app Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
	If line 96 is "Y", enter the reduction percentage in the app Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" follow I for title V, and in column 2 for title XIX.	terns and res	dents post	0. 00 N	0. 00 Y	97. 00 98. 00
8. 01	Does title V or XIX follow Medicare (title XVIII) for the report of the policy of the XIX.				Y	98. 0 ⁻
8. 02	Does title V or XIX follow Medicare (title XVIII) for the calbed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes offor title V, and in column 2 for title XIX.			N	Υ	98. 02
8. 03	Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye: for title V, and in column 2 for title XIX.				N	98. 0
8. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N d	N	98. 04
8. 05	Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98. 0
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 00
05. 00	Rural Providers Does this hospital qualify as a CAH?			N		105. 00
	If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	nod of payme	4		106. 00
07. 00	Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do yapproved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instruction	1. (see ins you train I&R F and/or IRF	tructions) s in an			107. 00
08. 00	Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 4.	2 N		108. 00
		Physi cal 1.00	Occupation 2.00	Speech 3.00	Respi ratory 4.00	/

	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.		

Provider CC Provider CC		Peri od: From 01/01/2019 To 12/31/2019	w of Form CMS Worksheet S- Part I Date/Time Pr 6/29/2020 8:	2 repared:
		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, e 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.	eriod? Enter enter the column 2.	1.00 N	2.00	111. 0
	1. 00	2. 00	3. 00	
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	112.0
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			0115.0
"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. 0
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
18.01 List amounts of malpractice premiums and paid losses:	1. 00 816, 6	2.00	3.00	0118.0
		1.00	2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein.		N N	2.00	118. C
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 th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	for yes or e Outpatient		N	119. (120. (
21.00 Did this facility incur and report costs for high cost implantable devices	charged to	Y		121. 0
patients? Enter "Y" for yes or "N" for no.			5. 06	122. 0
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				
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	£	A.1	İ	125. C
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.	for no. If	N		
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 date (s) (mm/dd/yyyy)				126. 0
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 certifing in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certification.	ication date			
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 date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2.	ication date			126. (127. (128. (
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 in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart 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 column 1 and termination date, if applicable, in column 2.	ication date cation date cation date			127. (
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 certifin column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	ication date cation date cation date ation date in			127. (128. (129. (
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 certifin column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	ication date cation date cation date ation date in			127. (
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 heart 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 column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certification of the column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the certification column 1 and termination date, if applicable, in column 2.	ication date cation date cation date ation date in			127. (128. (129. (
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 heart 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 column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the certificate in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the certificate in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified intestinal transplant center, enter the certificate in column 1 and termination date, if applicable, in column 2.	ication date cation date cation date ation date if ification cation			127. (128. (129. (130. (
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 of this is a Medicare certified heart transplant center, enter the certification of this is a Medicare certified heart transplant center, enter the certification of 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 column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2.	cation date cation date cation date ation date in ification cation date			127. (128. (129. (130. (131. (

no, does the dialysis facility in		ition for this cost	reporting	9			
period? Enter "Y" for yes or "N"		soulously filed see	+		N		146. 00
146.00 Has the cost allocation methodolo					N		146.00
Enter "Y" for yes or "N" for no i		rub. 15-2, Chapter	40, 94020)			
yes, enter the approval date (mm/	ua/yyyy) in corumn 2.						
						1.00	+
147.00 Was there a change in the statist	ical basis? Entar "V"	for yes or "N" for	no			1.00	147. 00
						IN N	148. 00
148.00 Was there a change in the order o				6		IN N	
149.00 Was there a change to the simplif	rea cost finaing metho					IN TILL YEAR	149. 00
		Part A	Part		tle V	Title XIX	4
		1.00	2. 0	_	3. 00	4. 00	
Does this facility contain a prov							
or charges? Enter "Y" for yes or	"N" for no for each co	omponent for Part A	<u>and Part</u>	B. (See 42	CFR §413		
155. 00 Hospi tal		N	l N		N	N	155. 00
156.00 Subprovider - IPF		N	N		N	N	156. 00
157.00 Subprovider - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158.00
159. 00 SNF		N	l N		N	N	159.00
160.00 HOME HEALTH AGENCY		N	l N		N	l N	160.00
161. 00 CMHC			N		N	N	161. 00
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multic	ampus hospital that ha	as one or more camp	uses in di	ifferent CB	SAs?	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 OOLf line 165 is yes for each						0.0	166 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 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166. 00

		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"),	enter the		168. 00
reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	l"), enter the	9. 99	169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting			170. 00
period respectively (mm/dd/yyyy)			

period respectivery (mm/ad/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	Υ	2, 096	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

)SPLT	Financial Systems IU HEALTH ARNE TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0173	Peri od:	u of Form CMS- Worksheet S-2	
,0111	AL AND HOST THE HEALTH SAKE KETHOOKSEMENT GOEST ONWAT KE	Trovider e	ON. 13 0173	From 01/01/2019 To 12/31/2019	Part II	epared
				Y/N	Date 0.5	J aiii
	Canada Instruction, Enter V for all VEC responses. Enter N	for all NO sa	onences Ent	1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	TOT ALL NO FE	sponses. Enti	er all dates in	ine	
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c		instructions			ļ
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P	rogram? If	1.00 N	2. 00	3. 00	2.
	yes, enter in column 2 the date of termination and in colum					
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includin	a managamant	Υ			3.
00	contracts, with individuals or entities (e.g., chain home o	ffi ces, drug	'			٥.
	or medical supply companies) that are related to the provid	er or its				
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe relationships? (see instructions)	ı Sımırar				
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert	ified Public	Т	A		4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f	or Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date ava	ilable in				
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	rent from	N			5.
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider i	s N		6.
	the legal operator of the program?					_
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		l during the	Y N		7. 8.
00	cost reporting period? If yes, see instructions.	and/or renewed	a during the	IN		0.
00	Are costs claimed for Interns and Residents in an approved		cal education	Υ		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o		he current	N		10.
J. 00	cost reporting period? If yes, see instructions.	i renewed in t	.ne current	IN		10.
1. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11.
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes			ost roporting	Y	12.
5. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	orrey change c	iui i iig tiii s c	ust reporting	N	13.
1. 00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	yes, see in	structions.	N	14.
. 00	Bed Complement Did total beds available change from the prior cost reporti	ng poriod2 Lf	vos soo inc	tructions	Y	15.
<u>. 00</u>	Total beds available change from the pirol cost reporti		t A		t B	15.
		Y/N	Date	Y/N	Date	
	DC4D Data	1. 00	2.00	3. 00	4. 00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	N	I	N		16.
	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					
. 00	instructions) Was the cost report prepared using the PS&R Report for	Υ	04/01/2020	Υ	04/01/2020	17.
	totals and the provider's records for allocation? If	·	0 17 0 17 2020	·	0 17 0 17 2020	
	either column 1 or 3 is yes, enter the paid-through date		1			
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.
. 50	Report data for additional claims that have been billed	1 4	1	1.4		'0.
	but are not included on the PS&R Report used to file this		1			
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N		19.
, UU		11		IN		19.
	Report data for corrections of other PS&R Report					

Heal th	Financial Systems IU HEALTH ARNE	ETT HOSPITAL		In Lie	u of Form CM	S-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	Provider CCN: 15-0173 Pr		Worksheet S Part II Date/Time P 6/29/2020 8	repared:	
		Descr	i pti on	Y/N	Y/N		
	to a series of the series of t		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		
	I 5	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 I	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see				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	ed into during	this cost re	porting period?	N	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	'If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit	N	27. 00	
	Interest Expense						
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	N	28. 00				
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	N	29. 00				
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	N	30. 00				
31. 00	Has debt been recalled before scheduled maturity without is instructions.	N	31. 00				
	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care ser		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 no, see instructions.		ng to competi	tive bidding? If	N	33. 00	
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed physi ci ans?	Υ	34. 00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreemen	nts with the	provi der-based	N	35. 00	
	physicians during the cost reporting period? If yes, see in			Y/N	Date		
				1.00	2. 00		
	Home Office Costs						
36. 00	Were home office costs claimed on the cost report?			Υ		36. 00	
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		37. 00	
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	ice different	from that of	. N		38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			, Y		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	•	,	N		40. 00	
+0.00	instructions.	TIONIC OTTICE!	., yes, see	14		+0.00	
		1.	. 00	2.	00		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41. 00	
42. 00	. , , ,					42. 00	
43. 00		317-962-1093		RUTTER@I UHEALTI	H. ORG	43. 00	
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems	IU HEALTH ARN	NETT HOSPIT	AL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBU	RSEMENT QUESTIONNAIRE	Provi d	ler CCN: 15-017		eri od:	Worksheet S-2	!
					rom 01/01/2019 o 12/31/2019		
			3. 00				
Cost Report Preparer Contact Info	rmation	_					
41.00 Enter the first name, last name a	nd the title/position	DI RECTOR,	GOVT PROGRAMS	;			41.00
held by the cost report preparer	in columns 1, 2, and 3,						
respecti vel y.							
42.00 Enter the employer/company name o	f the cost report						42.00
preparer.							
43.00 Enter the telephone number and em	ail address of the cost						43.00
report preparer in columns 1 and	2, respecti vel y.						

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems IU HEAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0173

					Т	o 12/31/2019	Date/Time Pre 6/29/2020 8:3	
							I/P Days / 0/P	3 alli
							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		154	56, 210	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO I PF Subprovi der							3. 00
4.00	HMO I RF Subprovi der						_	4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			154	56, 210	0.00	0	7. 00
0.00	beds) (see instructions)	04.00		4.4	F 440	0.00		0.00
8.00	INTENSIVE CARE UNIT	31. 00		14	5, 110	0.00	0	8. 00
9.00	CORONARY CARE UNIT	22.00				0.00		9.00
10.00	BURN INTENSIVE CARE UNIT	33.00		0			0	
10. 01	BURN INTENSIVE CARE UNIT	33. 01		0	C	0.00	0	10. 01
11.00	SURGICAL INTENSIVE CARE UNIT	25.00		17	/ 205	0.00		11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00		17	6, 205	0.00	0	
13.00	NURSERY	43. 00		105	/7 505	0.00	0	13.00
14.00	Total (see instructions)			185	67, 525	0.00	0	14. 00
15.00	CAH visits						0	15.00
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF							16. 00 17. 00
18. 00	SUBPROVIDER - TRE							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							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	00.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	•
27. 00	Total (sum of lines 14-26)			185				27. 00
28. 00	Observation Bed Days						0	1
29.00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			7	2, 555			32. 00
32. 01	Total ancillary labor & delivery room				<u> </u>			32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared:
6/29/2020 8:33 am

						6/29/2020 8:3	3 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	17, 091	739	39, 081			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)	6, 341	7, 238				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0	1			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	47.004	0				6. 00
7. 00	Total Adults and Peds. (exclude observation	17, 091	739	39, 081			7. 00
0 00	beds) (see instructions)	1 050	771	2 012			8. 00
8. 00 9. 00	INTENSIVE CARE UNIT	1, 059	//1	2, 813			9.00
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0			10.00
10.00	BURN INTENSIVE CARE UNIT	0	0				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	U	Ü	1			11.00
12. 00	NEONATAL INTENSIVE CARE UNIT	0	299	3, 049			12. 00
13. 00	NURSERY		1, 342				13. 00
14. 00	Total (see instructions)	18, 150	3, 151			1, 869. 68	14. 00
15. 00	CAH visits	0	0, 101			1,007.00	15. 00
16. 00	SUBPROVIDER - I PF		· ·	Ĭ			16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			169			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				6. 64	1, 869. 68	
28. 00	Observation Bed Days		77	4, 869			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF		00	0			31.00
32. 00	Labor & delivery days (see instructions)	0	29	906			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days	0					33. 00
33. 00	_	0					33. 00
55. 01	Teron of to houti air days and air sonal ges	١		I	I	I	1 00.01

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0173

				To	12/31/2019	Date/Time Prep 6/29/2020 8:33	
		Full Time		Di sch	arges	072772020 0.00	J GIII
		Equi val ents			·		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	3, 919	292	11, 942	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)			1, 333	1, 496		2. 00
3.00	HMO IPF Subprovider			1, 333	1, 470		3. 00
4. 00	HMO IRF Subprovider				ol		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				آ		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	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
10. 01	BURN INTENSIVE CARE UNIT						10. 01
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT						12. 00
13.00	NURSERY	0.00		0.040	200	44 040	13.00
14. 00	Total (see instructions)	0. 00	C	3, 919	292	11, 942	
15. 00 16. 00	CAH visits SUBPROVIDER - IPF						15. 00 16. 00
17. 00	SUBPROVIDER - IPF						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						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 00
55. 01	Eron or to houtrar days and discharges	ı		1	ı	ı	55. 01

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared:

					''	0 12/31/2019	Date/lime Pre 6/29/2020 8:3	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4.00	col . 4 5.00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	184, 032, 557	-562, 166	183, 470, 391	3, 888, 927. 90	47. 18	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0		0.00	0. 00	
3. 00	A Non-physician anesthetist Part		177, 532	0	177, 532	1, 984. 00	89. 48	3. 00
4. 00	Physician-Part A -		2, 240, 957	0	2, 240, 957	13, 019. 42	172. 12	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		310, 585 17, 506, 015				117. 79 157. 33	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		560, 470	0	560, 470	10, 672. 00	52. 52	7. 01
8.00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 92, 344, 641	0 781, 931	0 93, 126, 572	0. 00 1, 366, 483. 48		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		3, 137, 852	0	3, 137, 852	33, 675. 70	93. 18	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		1, 946, 409	0	1, 946, 409	13, 013. 22	149. 57	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A		39, 750, 515 0 0	0 0 0	0	990, 530. 47 0. 00 0. 00	0. 00	1
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0. 00	16. 02
17. 00	Wage-related costs (core) (see instructions)		19, 501, 027	0	19, 501, 027			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		16, 826, 569 0	0	16, 826, 569 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part B		27, 070	0	27, 070			21. 00
22. 00	Physician Part A - Administrative		244, 733	0	244, 733			22. 00
22. 01 23. 00 24. 00 25. 00	Physician Part A - Teaching Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		40, 631 1, 988, 935 0 0	0 0 0 0	40, 631 1, 988, 935 0 0			22. 01 23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		16, 267, 015	0	16, 267, 015			25. 50
25. 51	(core) Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

					T	o 12/31/2019	Date/Time Prep 6/29/2020 8:3	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	, i	
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	1, 005, 720		1, 005, 720			
27. 00	Administrative & General	5. 00	8, 989, 720					
28. 00	Administrative & General under		332, 680	0	332, 680	3, 233. 85	102. 87	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	1, 806, 909	-81, 289	1, 725, 620			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32. 00	Housekeepi ng	9. 00	2, 523, 795	-14, 032	2, 509, 763			
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34. 00	Dietary	10. 00	885, 613	-379, 102	506, 511	35, 767. 67		34.00
35. 00	Di etary under contract (see		0	0	0	0. 00	0.00	35. 00
0/ 00	instructions)	44.00	•	07/ 440	07/ 440	0/ 440 00	44.04	07.00
36.00	Cafeteri a	11. 00	0	376, 418	376, 418	·		36. 00
37. 00	Maintenance of Personnel	12.00	0 0// 010	00 ((5	0 07/ 554	0.00		
38. 00	Nursing Administration	13. 00	3, 366, 219			·		
39. 00	Central Services and Supply	14. 00	309, 843		·	14, 432. 22		
40.00	Pharmacy	15. 00	3, 656, 435	-395, 618	3, 260, 817			
41. 00	Medical Records & Medical	16. 00	0	0	0	0. 00	0. 00	41. 00
40.00	Records Library	17.00	450 222	2.0(2	455 150	1/ /25 50	27.27	40.00
42. 00	Social Service	17. 00	458, 222		· ·	·		42. 00
43.00	Other General Service	18. 00	478, 528	-2, 242	476, 286	32, 928. 68	14. 46	43. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2019 | Part III | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0173

							6/29/2020 8: 3	3 am
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		165, 810, 635	-562, 166	165, 248, 469	3, 765, 600. 16	43. 88	1. 00
	instructions)							
2.00	Excluded area salaries (see		92, 344, 641	781, 931	93, 126, 572	1, 366, 483. 48	68. 15	2.00
	instructions)							
3.00	Subtotal salaries (line 1		73, 465, 994	-1, 344, 097	72, 121, 897	2, 399, 116. 68	30.06	3.00
	minus line 2)							
4.00	Subtotal other wages & related		44, 834, 776	0	44, 834, 776	1, 037, 219. 39	43. 23	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		36, 012, 775	0	36, 012, 775	0.00	49. 93	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		154, 313, 545	-1, 344, 097	152, 969, 448	3, 436, 336. 07	44. 52	6.00
7.00	Total overhead cost (see		23, 813, 684	-1, 336, 468	22, 477, 216	847, 058. 23	26. 54	7.00
	instructions)							

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0173	Peri od: Worksheet S-3
		From 01/01/2019 Part IV
		T- 10/01/0010 D-+-/T: D

	To 12/31/2019	Date/Time Prep 6/29/2020 8:33	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	9, 279, 698	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8. 00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	16, 599, 095	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10. 00	Dental, Hearing and Vision Plan	555, 874	
	Life Insurance (If employee is owner or beneficiary)	83, 712	
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	799, 723	
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	642, 747	
16. 00	·	0 12,717	16. 00
	Non cumulative portion)	١	10.00
	TAXES		
17. 00	FICA-Employers Portion Only	10, 506, 267	17. 00
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	161, 848	
20.00	OTHER	1017010	1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
200	instructions))	١	1
22.00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	38, 628, 964	24. 00
	Part B - Other than Core Related Cost	1 22, 222, 701	1
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
	1 · · · · · · · · · · · · · · · · · · ·	1	

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15	From 01/01/2019	Worksheet S-3 Part V Date/Time Prepared: 6/29/2020 8:33 am

			6/29/2020 8: 3:	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	809, 709	38, 628, 964	1.00
2.00	Hospi tal	809, 709	19, 501, 123	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18. 00	Other	0	19, 127, 841	18. 00

L	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	OSPITAL rovider CCI	N: 15-0173	Peri od:	Worksheet S-10	2552-1 0				
-				From 01/01/2019						
-				To 12/31/2019	Date/Time Prep 6/29/2020 8:3					
-					1. 00					
\cap	Uncompensated and indigent care cost computation									
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by lin	ne 202 column	1 8)	0. 195338	1.0				
	Medicaid (see instructions for each line)				22 012 017	1 , ,				
	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				22, 912, 917 N	2. C				
	If line 3 is yes, does line 2 include all DSH and/or supplementa	ıl pavments	from Medica	ai d?	.,,	4. (
	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid									
. 00	Medi cai d charges									
- 1	Medicaid cost (line 1 times line 6) 36,19									
	Difference between net revenue and costs for Medicaid program (I	ine 7 minu	ıs sum of lir	nes 2 and 5; if	13, 286, 650	8.0				
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	oach Lino	.)							
	Net revenue from stand-alone CHIP	each i i ile	:)		0	9.0				
	Stand-al one CHIP charges				0					
	Stand-alone CHIP cost (line 1 times line 10)				0	11. (
	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 min	nus line 9; i	f < zero then	0	12. 0				
	enter zero)									
	Other state or local government indigent care program (see instr Net revenue from state or local indigent care program (Not inclu				29, 506	1 12 (
	Charges for patients covered under state or local indigent care				346, 918					
	10)	program (N	iot Theradea	111 111103 0 01	340, 710	17. (
- 1	State or local indigent care program cost (line 1 times line 14)				67, 766	15. (
	Difference between net revenue and costs for state or local indi	gent care	program (lir	ne 15 minus line	38, 260	16. (
	13; if < zero then enter zero)		/1 1 : 1:		,					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state	e/Tocal Indig	jent care program	is (see					
	Private grants, donations, or endowment income restricted to fun				_	17.0				
- 1	Government grants, appropriations or transfers for support of ho			Cours of Lines	12 224 010	18.0				
	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	rnargent c	are programs	S (Suill OI IIIIeS	13, 324, 910	19.0				
			Uni nsured	Insured	Total (col. 1					
			pati ents	pati ents	+ col . 2)					
			1. 00	2. 00	3. 00					
	Uncompensated Care (see instructions for each line)	11+1	20 542 45	706, 152	30, 269, 810	20.0				
0.00	Charity care charges and uninsured discounts for the entire faci (see instructions)	iity	29, 563, 65	700, 132	30, 209, 610	20.0				
1. 00	Cost of patients approved for charity care and uninsured discoun	its (see	5, 774, 90	706, 152	6, 481, 058	21. 0				
	instructions)	`		·						
2. 00	Payments received from patients for amounts previously written o	off as	81, 19	94 0	81, 194	22.0				
	charity care		F (02 7	70/ 150	4 200 044	22.0				
	Cost of charity care (line 21 minus line 22)		5, 693, 7	12 706, 152	6, 399, 864	23.0				
					1. 00					
		days beyo	nd a Length	of stay limit	N	24. C				
3. 00	Does the amount on line 20 column 2, include charges for patient	imposed on patients covered by Medicaid or other indigent care program?								
4. 00	imposed on patients covered by Medicaid or other indigent care p		care program	n's length of	0	25. 0				
4. 00			care program	n's length of	0	25. (
4. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the	indigent	care program	n's length of	0 20, 064, 528					
4. 00 5. 00 6. 00 7. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex	e indigent ructions) (see instr	ructi ons)	n's length of	20, 064, 528 689, 142	26. 0 27. 0				
4. 00 5. 00 6. 00 7. 00 7. 01	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see	e indigent ructions) (see instr	ructi ons)	n's length of	20, 064, 528 689, 142 1, 060, 218	26. 0 27. 0 27. 0				
4. 00 5. 00 6. 00 7. 00 7. 01 8. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (se Non-Medicare bad debt expense (see instructions)	e indigent ructions) (see instr ee instruct	ructions) :ions)		20, 064, 528 689, 142 1, 060, 218 19, 004, 310	26. 0 27. 0 27. 0 28. 0				
23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 29. 00 20.	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see	e indigent ructions) (see instr ee instruct	ructions) :ions)		20, 064, 528 689, 142 1, 060, 218	26. 0 27. 0 27. 0 28. 0 29. 0				

	Financial Systems	IU HEALTH ARNETT		N 45 0470		u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Period: From 01/01/2019	Worksheet A	
					To 12/31/2019	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	6/29/2020 8: 3 Reclassi fi ed	3 am
	cost center bescription	Jai ai i es	Other	+ col . 2)	ons (See A-6)	Trial Balance	
					(555 11 5)	(col. 3 +-	
						col . 4)	
	OFNEDAL CEDIUSE COCT OFNEEDS	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		٥		0 4, 964, 452	4, 964, 452	1.00
1. 00	00101 CAP REL COSTS-BLDG & FLXT - NONHOSP		0		2, 085, 407	2, 085, 407	1. 00
1. 02	00102 CAP REL COSTS INTEREST EXPENSE		o		11, 336, 383	11, 336, 383	
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	(4, 412, 719	4, 412, 719	2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP		0	(2, 902, 271	2, 902, 271	2. 01
3.00	00300 OTHER CAP REL COSTS	1 005 700	015 07/	1 020 70	0 0	0	3.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING	1, 005, 720 3, 251, 253	815, 076 1, 791, 157	1, 820, 79 5, 042, 41		28, 561, 396 3, 953, 831	4. 00 5. 01
5.06	00590 OTHER ADMINISTRATIVE & GENERAL	5, 738, 467	36, 934, 165	42, 672, 63		92, 616, 704	
7.00	00700 OPERATION OF PLANT	1, 476, 160	14, 199, 517	15, 675, 67		10, 084, 429	7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL	330, 749	7, 517, 961	7, 848, 710		4, 711, 263	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		19, 181	19, 181	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 523, 795 885, 613	2, 331, 598 1, 740, 327	4, 855, 393 2, 625, 940		3, 865, 914 1, 636, 451	1
11. 00	01100 CAFETERI A	005, 015	1, 740, 327	2, 025, 940	612, 716	612, 716	
13. 00	01300 NURSI NG ADMI NI STRATI ON	3, 366, 219	1, 526, 997	4, 893, 21		3, 986, 507	
14.00	01400 CENTRAL SERVICES & SUPPLY	309, 843	1, 067, 180	1, 377, 02	3 11, 022, 172	12, 399, 195	
15. 00	01500 PHARMACY	3, 656, 435	6, 767, 573	10, 424, 00	-6, 505, 027	3, 918, 981	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	570.04	0 77.05(0	16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 PATIENT TRANSPORT SERVICES	458, 222 478, 528	115, 597 353, 863	573, 81 ⁹ 832, 39 ⁹		496, 463 725, 863	
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	470, 520	333, 603		560, 470	560, 470	1
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	358, 140	701, 791	1, 059, 93		1, 019, 432	1
23. 00	02300 PARAMED ED PRGM - PHARMACY	72, 902	30, 861	103, 76		195, 965	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	26, 956, 285	10, 204, 571	37, 160, 85		30, 367, 274	
31. 00 33. 00	03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	2, 443, 694	2, 412, 248	4, 855, 94	2 -1, 023, 966	3, 831, 976 0	31.00
33. 01	03301 BURN INTENSIVE CARE UNIT		0	·		0	33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	3, 214, 468	1, 079, 266	4, 293, 73	-573, 980	3, 719, 754	
43.00	04300 NURSERY	0	0	(706, 394	706, 394	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	4.507.007	44 047 000	40.750.40	40.047.004	F 407 000	F0 00
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	4, 536, 026 641, 810	14, 217, 098 218, 732	18, 753, 12, 860, 54;		5, 436, 803 691, 090	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 277, 535	1, 100, 967	3, 378, 50		2, 485, 767	
53. 00	05300 ANESTHESI OLOGY	9, 052, 589	5, 027, 441	14, 080, 030		13, 105, 947	
53. 01	05301 ASC ANESTHESI OLOGY	o	115, 176	115, 17	6 -110, 320	4, 856	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 617, 573	5, 859, 731	9, 477, 30	I	4, 127, 464	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	214, 903	0 1, 053, 288	1, 268, 19 ⁻	0 1 -955, 662	0 312, 529	
	05900 CARDI AC CATHETERI ZATI ON	1, 344, 842	4, 286, 377	5, 631, 21	1 ' 1	1, 826, 740	
	06000 LABORATORY	13, 333	10, 486, 204	10, 499, 53	1 1	10, 499, 537	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	O	685, 692	685, 693		686, 132	63. 00
65.00	06500 RESPI RATORY THERAPY	1, 767, 234	926, 381	2, 693, 61		1, 914, 549	
66. 00	06600 PHYSI CAL THERAPY	571, 084	164, 186	735, 270	1 ' 1	634, 646	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	370, 514 199, 294	105, 302 81, 535	475, 810 280, 820		411, 124 247, 482	1
69. 00	06900 ELECTROCARDI OLOGY	1, 308, 124	709, 837	2, 017, 96		1, 386, 329	
70. 00	07000 ELECTROENCEPHALOGRAPHY	81, 596	19, 293	100, 88		86, 640	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	(7, 590, 764	7, 590, 764	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(9, 294, 120	9, 294, 120	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	050 022	050 03:	38, 589, 315	38, 589, 315	
	07500 ASC (NON-DISTINCT PART)		858, 022 0	858, 02:	2 -18, 210 0 0	839, 812 0	1
75. 01	07501 ASC (NON-DISTINCT PART)	3, 309, 990	5, 527, 063	8, 837, 05		4, 492, 548	
76.00	03950 CARDI AC CATHERI ZATI ON	0	0		0	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	304, 443	262, 466	566, 90	9 -48, 570	518, 339	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		ما			0	00.00
90. 00 90. 01	09000 CLI NI C 04950 SLEEP CLI NI C	441, 529	209, 328	650, 85	0 7 -132, 470	0 518, 387	
90. 01	09002 ARNETT CANCER CARE CENTER	766, 179	25, 487, 616	26, 253, 79	1	1, 244, 232	
90. 04	09003 OUTPATIENT INFUSION CENTER	16, 739	9, 616	26, 35		23, 222	
91. 00	09100 EMERGENCY	4, 398, 988	4, 519, 551	8, 918, 53		6, 927, 294	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01 93. 00	O9201 OBSERVATION BEDS (DISTINCT PART) O4951 OTHER OUTPATIENT SERVICES	0	0	(0	
,3.00	SPECIAL PURPOSE COST CENTERS	ı V			<u>ا</u> ا	0	, ,3.00
118.00		91, 760, 818	171, 520, 650	263, 281, 46	84, 305, 591	347, 587, 059	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	31, 612	147, 915	179, 52		166, 539	
191.00	19100 RESEARCH	0	0	(0	0	191. 00

Health Financial Systems	IU HEALTH ARNET	T HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Period: From 01/01/2019	Worksheet A	
				Γο 12/31/2019	Date/Time Pre 6/29/2020 8:3	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	91, 634, 630	99, 507, 279	191, 141, 90	9 -86, 777, 941	104, 363, 968	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0	0	193. 00
193. 01 19301 RETAIL PHARMACY	605, 497	4, 651, 961	5, 257, 458	-233, 687	5, 023, 771	193. 01
193. 02 19302 WHI TE HOSPI TAL	O	0		1, 641, 777	1, 641, 777	193. 02
193. 03 19303 HOSPI CE	0	2, 572	2, 57:	2 0	2, 572	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	0	0		1, 077, 248	1, 077, 248	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0		0	0	194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	184, 032, 557	275, 830, 377	459, 862, 93	4 0	459, 862, 934	200. 00

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/29/2020 8:33 am

				6/29/2020 8: 33	3 am
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
	CENEDAL CEDULAE CAST CENTERS	6. 00	7. 00		
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1, 245, 039	4 200 401		1. 00
1. 00	00100 CAP REL COSTS-BLDG & FIXT - NONHOSP	1, 245, 039	6, 209, 491 2, 085, 407		1. 00
1. 01	00101 CAP REL COSTS INTEREST EXPENSE	-4, 765, 859			1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	7, 249, 944	11, 662, 663		2. 00
2.00	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP	7, 247, 744	2, 902, 271	1	2. 01
3.00	00300 OTHER CAP REL COSTS	0	2, 702, 271		3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	14, 275, 251	42, 836, 647		4. 00
5. 01	00570 ADMITTING	0	3, 953, 831		5. 01
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL	-16, 087, 333	76, 529, 371		5. 06
7.00	00700 OPERATION OF PLANT	-8, 421	10, 076, 008	1	7.00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL	-24, 477	4, 686, 786	1	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	19, 181		8.00
9.00	00900 HOUSEKEEPI NG	-302	3, 865, 612		9.00
10.00	01000 DI ETARY	-1, 837	1, 634, 614		10.00
11. 00	01100 CAFETERI A	-765, 925	-153, 209	1	11. 00
13. 00	01300 NURSING ADMINISTRATION	-11, 222	3, 975, 285	1	13. 00
14. 00	+ +	-38, 956			14. 00
15. 00		-77, 126			15. 00
16.00		0	0		16.00
17. 00		0	496, 463		17. 00
18.00		0	725, 863		18.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	560, 470 1, 018, 759		21. 00 22. 00
22. 00 23. 00		-673 -30, 000			23. 00
23.00	I NPATIENT ROUTINE SERVICE COST CENTERS	-30,000	100, 900		23.00
30. 00		-8, 206, 884	22, 160, 390		30. 00
31. 00	1 1	-289, 860			31. 00
33. 00	+ I	0	0, 012, 110		33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0	0		33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	-974, 751	2, 745, 003		35. 00
43.00		0	706, 394		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	5, 436, 803		50.00
51.00		0	691, 090		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-440	2, 485, 327		52.00
53.00	05300 ANESTHESI OLOGY	-10, 008, 651	3, 097, 296		53.00
53. 01	05301 ASC ANESTHESI OLOGY	0	4, 856		53. 01
54.00		-2, 600	4, 124, 864		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
56. 00	05600 RADI OI SOTOPE	0	312, 529		56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	1, 826, 740	·	59. 00
60.00	06000 LABORATORY	0	10, 499, 537	1	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	686, 132		63. 00
65. 00	06500 RESPI RATORY THERAPY	0	1, 914, 549	1	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	634, 646	·	66.00
68. 00	1 1	0	411, 124 247, 482		67. 00 68. 00
		0	1, 386, 329		69. 00
70. 00		0	86, 640		70. 00
71.00	+ I	0	7, 590, 764		71. 00
72. 00	+ I	0	9, 294, 120		72. 00
73. 00		0	38, 589, 315		73. 00
74. 00		0	839, 812		74.00
75.00		0	0		75.00
75. 01	07501 ASC (NON-DISTINCT PART)	-2, 132	4, 490, 416		75. 01
76.00	03950 CARDI AC CATHERI ZATI ON	0	0		76.00
76. 97		0	518, 339		76. 97
	OUTPATIENT SERVICE COST CENTERS				
90. 00		0	0		90. 00
90. 01	04950 SLEEP CLINIC	-1, 175	517, 212	·	90. 01
90. 03		0	1, 244, 232		90. 03
90. 04	I I	0	23, 222	1	90. 04
91.00	I I	-1, 086, 252	5, 841, 042		91.00
92. 00 92. 01		0	0		92. 00 92. 01
93. 00	04951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS	0	0		93. 00
118. 00		-19, 614, 642	327, 972, 417		118. 00
110.00	NONREI MBURSABLE COST CENTERS	17,014,042	321, 712, 417		. 10. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	166, 539		190. 00
	19100 RESEARCH	n	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	-1, 341, 961	103, 022, 007		192. 00
	19300 NONPALD WORKERS	0	0		193. 00
				<u>'</u>	

Health Financial Systems IU HEALTH ARNETT HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0173 Period: Worksheet A From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am

				0/29/2020 8:3	3 alli
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7.00		
193. 01 19301	RETAIL PHARMACY	0	5, 023, 771		193. 01
193. 02 19302	WHI TE HOSPI TAL	0	1, 641, 777		193. 02
193. 03 19303	HOSPI CE	0	2, 572		193. 03
193. 04 19304	FRANKFORT HOSPITAL	0	1, 077, 248		193. 04
194. 00 07950	MARKETING/PUBLIC RELATIONS	0	0		194. 00
200. 00	TOTAL (SUM OF LINES 118 through 199)	-20, 956, 603	438, 906, 331		200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0173

					6/29/2020 8: 3	3 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5 00		
	2. 00 A - NONBILLABLE SUPPLIES	3.00	4.00	5. 00		
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	11, 430, 114		1. 00
2.00	OPERATION OF PLANT -	7. 01	o	2, 955		2. 00
2.00	NONHOSPI TAL	7.01	ď	2, 755		2.00
3.00	SOCI AL SERVI CE	17. 00	О	39		3. 00
4.00	BLOOD STORING, PROCESSING &	63.00	О	440		4. 00
	TRANS.					
5.00		0.00	0	0		5. 00
6.00	1	0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0.00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	o	0		12. 00
13. 00		0.00	Ö	0		13. 00
14.00		0.00	O	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 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	0	0		20.00
22. 00		0.00	0	0		22. 00
23. 00		0.00	o	0		23. 00
24. 00		0.00	O	0		24. 00
25.00		0.00	О	0		25. 00
26.00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31. 00 32. 00		0. 00 0. 00	0	0		31. 00 32. 00
33. 00		0.00	o	0		33. 00
34. 00		0.00	o	0		34. 00
35.00		0.00	O	0		35. 00
	0		0	11, 433, 548		
	B - BILLABLE SUPPLIES					
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7, 590, 764		1. 00
2. 00	ADMITTING	5. 01	0	938		2. 00
3.00	ADMITTING	0.00	o	0		3. 00
4. 00		0.00	o	0		4. 00
5.00		0.00	О	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0. 00 0. 00	0	0		9.00
10. 00 11. 00		0.00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	ő	0		13. 00
14. 00		0.00	Ö	0		14. 00
15.00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18.00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
00	0 — — — — —	 	— — ŏ	7, 591, 702		00
	C - IMPLANTS		-1			
1.00	IMPL. DEV. CHARGED TO	72.00	0	9, 294, 120		1. 00
2.00	PATI ENTS	F 64		4 50		2 22
2.00	ADMITTING	5. 01 0. 00	0	1, 536		2.00
3. 00 4. 00		0.00	0	0		3. 00 4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	o	0		7. 00
8.00		0.00	o	0		8. 00
-				· · · · · · · · · · · · · · · · · · ·	.	

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0173 Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					lo 12/31/2019 Date/lim	ne Prepared: 20 8:33 am
		Increases				
	Cost Center	Li ne #	Sal ary 4.00	Other 5 00		
9. 00	2. 00	3.00	4.00	5. 00		9. 00
10. 00		0.00	Ö			10.00
	0 — — — — —			9, 295, 656		
	D - DRUGS	70.00		00 500 045		4 00
1. 00 2. 00	DRUGS CHARGED TO PATIENTS ADMITTING	73. 00 5. 01	0			1. 00 2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0			3. 00
4. 00	Service Services a Server	0.00	0	' '		4. 00
5.00		0.00	0			5. 00
6.00		0.00	0	l I		6. 00
7. 00 8. 00		0. 00 0. 00	0			7. 00 8. 00
9. 00		0.00	0			9. 00
10.00		0.00	0			10. 00
11. 00		0. 00	0			11. 00
12.00		0.00	0			12.00
13. 00 14. 00	•	0. 00 0. 00	0			13. 00 14. 00
15. 00		0.00	0			15. 00
16.00		0.00	0			16. 00
17. 00		0.00	0			17. 00
18.00		0.00	0			18.00
19. 00 20. 00		0. 00 0. 00	0			19. 00 20. 00
21. 00		0.00	Ö			21. 00
22. 00		0. 00	0			22. 00
23. 00		0.00	0			23. 00
24. 00			0			24. 00
	E - BENEFITS			30, 370, 701		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26, 740, 600		1. 00
2.00		0.00	0			2. 00
3.00		0. 00 0. 00	0			3.00
4. 00 5. 00		0.00	0			4. 00 5. 00
6. 00		0.00	0			6. 00
7. 00		0.00	0			7. 00
8.00		0.00	0			8. 00
9. 00 10. 00		0. 00 0. 00	0			9. 00 10. 00
11. 00		0.00	Ö	l l		11. 00
12.00		0. 00	0			12. 00
13.00		0.00	0			13.00
14. 00 15. 00		0. 00 0. 00	0			14. 00 15. 00
16. 00		0.00	Ö			16. 00
17.00		0. 00	0			17. 00
18. 00		0.00	0	0		18. 00
19. 00 20. 00		0. 00 0. 00	0			19. 00 20. 00
21. 00		0.00	0			21. 00
22.00		0.00	0			22. 00
23. 00		0.00	0			23. 00
24. 00 25. 00		0. 00 0. 00	0			24. 00 25. 00
26. 00		0.00	0			26. 00
27. 00		0.00	0			27. 00
28. 00		0.00	0			28. 00
29. 00		0.00	0			29. 00
30. 00 31. 00		0. 00 0. 00	0			30. 00 31. 00
32. 00		0.00	0			32.00
33.00		0.00	O	0		33. 00
34.00		0.00	0	0		34. 00
35. 00 36. 00		0. 00 0. 00	0			35. 00 36. 00
36. 00 37. 00		0.00	0			37.00
38. 00		0.00	0	0		38. 00
	0					
1. 00	F - CAFETERI A CAFETERI A	11. 00	274 /10	224 200		1. 00
1.00	0 — — — — — — — — — — — — — — — — — — —		37 <u>6, 4</u> 18 376, 418	23 <u>6, 2</u> 98 236, 298		1.00
	1*	ı I	5.5, 110	200, 2,0		ı

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0173

COST COSTS COSTS CLINE CLINE SALE CLINE CL						To 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am
1.00						
Department Dep						
1.00			3.00	4.00	5.00	
NOMESTIFFE INC. SERVICE 1.00 0.270 503 1.00	1.00		7.00	0	7, 261	1. 00
Deportery Instrument 1	2.00		7. 01	0	263, 342	2.00
1 - PROPERTY INSUMMEL: 1 - DO		NONHOSPI TAL	+			
Applied Costs Applied Costs Applied Costs Applied Costs Applied Costs Applied Applied Costs Applie		H _ DPODEDTY INSUDANCE		U _I	270, 603	
APP REL COSTS-LEDG & FIXT - 1.01 0 32,544 2,00	1. 00		1.00	0	208, 470	1.00
April Costs - MAN FOULP 2.00				0		
Description						
- LEASE EXPENSE 1.00	3. 00	CAP REL COSTS-MVBLE EQUIP				3.00
1.00		U _ LEASE EXPENSE		<u> </u>	253, 606	
CAP REL COSTS-BLDG & FLAT - 1.01 0 769,955 3.00 CAP REL COSTS-WORLE COUN P - 2.00 0 294,829 3.00 6.686 4.00 4	1.00		1.00	0	287, 870	1.00
CAP REL COSTS-AWBILE FOULP	2.00		1. 01	0	769, 955	2.00
A - 0.0		•			204 200	
NONINGSP			l l			
5 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00		2.01	٩	0, 000	4.00
7.00 9.00 1.00 1.00 1.00 1.00 1.00 1.00 1	5.00		0.00	0	0	5. 00
8.00				0	-	
9.00 0.00 0.00 0 0.00 0 0.00 0				0	-	
10.00		1	I .	-	-	
TOTALS				-	Ö	
1.00					1, 359, 340	
EXPENSE 0 0 11,336,383						
Note	1. 00		1. 02	0	11, 336, 383	1.00
NOUSEKEEPING SUPPLIES		U EXPENSE	+	 	11 336 383	
1.00		K - HOUSEKEEPING SUPPLIES		<u> </u>	11, 330, 303	
3.00	1.00		9. 00	0	58, 972	1.00
4.00						
5.00				1		
6. 00 7. 00 8. 00 9. 00 9. 00 10. 00 11. 00				-	-	
8. 00			I .			
9.00	7.00			0		7.00
10.00				-		
11.00				-	-	
12,00			I	-		
13, 00			I			
15.00				0		
16. 00				-		
17.00			· · · · · · · · · · · · · · · · · · ·			
18. 00 19				~		
20.00				o		
21.00	19.00		0.00	O		
22.00				0		
23.00				O O		
24.00				0		
26.00 0 0 0 58,972 1.00 L- LAUNDRY & LINEN SERVICE 8.00 0 19,181 2.00 3.00 4.00 0 0 0 0 0 0 3.00 4.00 0 0 0 0 0 0 3.00 6.00 0 0 0 0 0 0 5.00 6.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				o	-	
1.00				0	0	
L - LAUNDRY SUPPLIES 1.00	26. 00		0.00		0	26. 00
1. 00 LAUNDRY & LINEN SERVICE		U _ I AUNDRY SUDDITES		0	58, 972	
2. 00 3. 00 4. 00 5. 00 6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00		8. 00	0	19, 181	1.00
4. 00					4	
5. 00 6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	
6. 00				0	0	
1. 00 O TELEPHONE RECLASS O TELEPHONE RECLASS O O O O O O O O O				O O	0	
1.00 OTHER ADMINISTRATIVE & 5.06 O 24,995 1.00	0.00				19185	0.00
1. 00 OTHER ADMINISTRATIVE & 5. 06 O 24, 995 SENERAL 0. 00 0 0 22, 00 3. 00 4. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		O - TELEPHONE RECLASS			. , , , , , ,	
2.00 0.00 0 0 3.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0 6.00 0.00 0 0	1.00	OTHER ADMINISTRATIVE &	5. 06	0	24, 995	1.00
3.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0 6.00 0.00 0 0	2.00	GENERAL	0.00			
4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 0						
5. 00 0. 00 0 0 5. 00 6. 00 0. 00 0 0 6. 00				0		
			0.00	ő	-	
7.00 0.00 0 7.00						
	7. 00	<u> </u>	0.00	0	0	7.00

Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am

		Increases			
	Cost Center	Li ne #	Sal ary	Other	
8. 00	2. 00	3.00	4.00	5. 00 0	8. 00
9. 00		0.00	0	0	9. 00
10. 00		0.00	0	Ö	10.00
11. 00		0.00	0	0	11. 00
12.00		0.00	0	0	12. 00
	0		0	24, 995	
1. 00	P - DEPRECIATION EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	0	4, 475, 373	1.00
2.00	CAP REL COSTS-BLDG & FIXT -	1.00	0		2. 00
2.00	NONHOSP		3	1, 0.10, 200	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	4, 105, 318	3. 00
4.00	CAP REL COSTS-MVBLE EQUIP -	2. 01	0	2, 895, 585	4. 00
5. 00	NONHOSP	0.00	0	0	5. 00
6.00		0.00	0		6. 00
7. 00		0.00	0	Ō	7. 00
8.00		0.00	0	0	8. 00
9.00		0.00	0		9. 00
10.00		0.00	0		10.00
11. 00 12. 00		0. 00 0. 00	0	-	11. 00 12. 00
13. 00		0.00	0		13. 00
14.00		0.00	0		14. 00
15. 00		0.00	0		15. 00
16. 00		0.00	0		16. 00
17. 00		0.00	0		17. 00
18. 00 19. 00		0. 00 0. 00	0	-	18. 00 19. 00
20. 00		0.00	0	ő	20.00
21.00		0.00	0	0	21. 00
22. 00		0.00	0	0	22. 00
23. 00		0.00	0	0	23. 00
24. 00 25. 00		0. 00 0. 00	0	0	24. 00
23.00			$ \frac{0}{0}$		25. 00
	Q - FMLA RECLASS			10, 022, 000	
1.00	ADMI TTI NG	5. 01	0	17, 954	1. 00
2.00	OTHER ADMINISTRATIVE &	5. 06	0	18, 089	2. 00
2 00	GENERAL ON OF BLANT	7.00	0	050	2 00
3. 00 4. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0		3. 00 4. 00
5. 00	DI ETARY	10.00	0		5. 00
6.00	NURSING ADMINISTRATION	13.00	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14. 00	0	.,	7. 00
8.00	PHARMACY	15.00	0	,	8. 00
9. 00 10. 00	SOCIAL SERVICE PATIENT TRANSPORT SERVICES	17. 00 18. 00	0	-,	9. 00
11. 00	ADULTS & PEDIATRICS	30.00	0		11.00
12. 00	INTENSIVE CARE UNIT	31.00	0		12. 00
13.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	13, 399	13. 00
14. 00	OPERATING ROOM	50.00	0		14. 00
15.00	RECOVERY ROOM	51.00	0	12, 071	15. 00
16. 00 17. 00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	52. 00 53. 00	0	26, 799 12, 983	16. 00 17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 964	18. 00
19. 00	CARDIAC CATHETERIZATION	59. 00	0	18, 157	19. 00
20. 00	RESPIRATORY THERAPY	65.00	0	14, 782	20. 00
21. 00	PHYSI CAL THERAPY	66.00	0	1, 928	21.00
22. 00 23. 00	ELECTROCARDI OLOGY ASC (NON-DI STI NCT PART)	69. 00 75. 01	0	6, 383 8, 692	22. 00 23. 00
24. 00	SLEEP CLINIC	90. 01	0	1, 083	24. 00
25. 00	ARNETT CANCER CARE CENTER	90. 03	0	1, 854	25. 00
26. 00	EMERGENCY	91.00	0	34, 395	26. 00
27. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	146, 695	27. 00
	D NUDSEDV		0	562, 166	-
1. 00	R - NURSERY NURSERY	43.00	643, 484	62, 910	1.00
2.00	NOROZKI	0.00	043, 404	02, 910	2. 00
	0		643, 484]
	U - CORPORATE ADMIN EXPENSE				
1.00	OTHER ADMINISTRATIVE &	5. 06	0	63, 715, 538	1. 00
	GENERAL	$\vdash +$	— — _ō	63, 715, 538	
	11011120	1	O	05, 715, 556	I

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

Increases Cost Center Line # Salary Other 2.00 3.00 4.00 5.00	6/29/2020 8: 33 am
2.00 3.00 4.00 5.00	
V - GENERAL SURGERY LAF METRO - HOSPITAL	
1. 00 OPERATI NG ROOM 50. 00 92, 886 251, 174	1.00
2. 00 ASC (NON-DISTINCT PART) 75. 01 46, 443 125, 587	2. 00
TOTALS 139, 329 376, 761	
W - MEDICAL DIRECTOR FEES	
1.00 ADULTS & PEDIATRICS 30.00 0 14,875	1. 00
2. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 3, 050	2. 00
3. 00 ELECTROCARDI OLOGY 69. 00 0 43, 000	3. 00
0 - 60,925	
X - ARNETT TO WHITE ALLOCATION	
1. 00 WHITE HOSPITAL 193. 02 912, 229 729, 548	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	6. 00
7.00 0.00 0 0	7. 00
8.00 0.00 0	8. 00
9.00 0.00 0 0	9. 00
10.00 0 0 0	10.00
TOTALS 912, 229 729, 548	
Y - ARNETT TO FRANKFORT ALLOCATION	
1. 00 FRANKFORT HOSPITAL 193. 04 579, 076 498, 172	1.00
2.00 0.00 0	2. 00
3.00 0.00 0 0	3. 00
4.00 0.00 0 0	4. 00
5.00 0.00 0	5. 00
6.00 0.00 0	6. 00
7.00 0.00 0 0	7. 00
8.00 0.00 0	8. 00
9.00 0.00 0	9. 00
10. 00 0. 00 0 0 0	10.00
TOTALS 579, 076 498, 172	
Z - RESIDENCY STAFF	
1.00 I&R SERVICES-OTHER PRGM. 22.00 513,829 39,308	1.00
COSTS APPRVD	
TOTALS 513, 829 39, 308	
AB - INTERNS AND RESIDENTS	
1.00 I&R SERVICES-SALARY & 21.00 0 560,470	1.00
FRINGES APPRVD	
TOTALS 0 560, 470	
AC - PARAMEDICAL EDUCATION	
1.00 PARAMED ED PRGM - PHARMACY 23.00 99,937 0	1.00
2.00 0.00 0 0	2. 00
TOTALS 99, 937 0 500. 00 Grand Total: Increases 3, 264, 302 186, 840, 173	500. 00

Health Financial Systems RECLASSIFICATIONS

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 8: 33 am Provider CCN: 15-0173

						6/29/2020 8:3	33 am
		Decreases				ı	
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - NONBILLABLE SUPPLIES						
1. 00	ADMI TTI NG	5. 01	0	2, 703		l e	1. 00
2.00	OTHER ADMINISTRATIVE &	5. 06	0	1, 290	0		2. 00
	GENERAL						
3.00	OPERATION OF PLANT	7. 00	0	143, 188		l l	3. 00
4.00	HOUSEKEEPI NG	9. 00	0	205, 355		l e	4. 00
5. 00	DI ETARY	10. 00	0	2, 813		l .	5. 00
6.00	NURSING ADMINISTRATION	13. 00	0	423	0		6. 00
7.00	PHARMACY	15. 00	0	101, 644	0		7. 00
8.00	PATIENT TRANSPORT SERVICES	18. 00	0	6, 449	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	2, 021, 700	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	o	371, 273	0		10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	o	126, 313	0		11. 00
12.00	OPERATING ROOM	50.00	o	2, 698, 416	0		12. 00
13.00	RECOVERY ROOM	51.00	o	30, 487			13. 00
14.00	DELIVERY ROOM & LABOR ROOM	52. 00	o	293, 495			14. 00
15. 00	ANESTHESI OLOGY	53.00	o	281, 231			15. 00
16. 00	ASC ANESTHESIOLOGY	53. 01	0	95, 226			16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	710, 587		l l	17. 00
18. 00	RADI OI SOTOPE	56.00	0	11, 740			18. 00
19. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	384, 746		l l	19. 00
20. 00	RESPIRATORY THERAPY	65.00	0	322, 287			20. 00
21. 00	PHYSI CAL THERAPY	66.00	0	1, 347			21. 00
22. 00	OCCUPATI ONAL THERAPY	67. 00	0	153			22. 00
23. 00		68.00	0				23. 00
	SPEECH PATHOLOGY		0	1, 030		l l	1
24. 00	ELECTROCARDI OLOGY	69.00	0	13, 304			24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	935		l I	25. 00
26. 00	RENAL DI ALYSI S	74.00	0	10, 648			26. 00
27. 00	ASC (NON-DISTINCT PART)	75. 01	0	1, 215, 242			27. 00
28. 00	CARDIAC REHABILITATION	76. 97	0	4, 551	0		28. 00
29. 00	SLEEP CLINIC	90. 01	0	26, 986			29. 00
30. 00	ARNETT CANCER CARE CENTER	90. 03	0	121, 443		l .	30. 00
31. 00	OUTPATIENT INFUSION CENTER	90. 04	0	2, 077			31. 00
32.00	EMERGENCY	91. 00	0	866, 102	0		32. 00
33.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	59	0		33. 00
	CANTEEN						
34.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	1, 357, 101	0		34. 00
35.00	RETAIL PHARMACY	1 <u>93.</u> 01	0	<u>1, 204</u>			35. 00
	0		0	11, 433, 548]
	B - BILLABLE SUPPLIES						
1.00	OTHER ADMINISTRATIVE &	5. 06	0	127	0		1. 00
	GENERAL						
2.00	NURSING ADMINISTRATION	13. 00	0	734	0		2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	16, 361	0		3. 00
4.00	PHARMACY	15. 00	0	160	0		4. 00
5.00	ADULTS & PEDIATRICS	30.00	o	37, 767	0		5. 00
6.00	INTENSIVE CARE UNIT	31.00	o	62, 727	0		6. 00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	o	7, 029	0		7. 00
8.00	OPERATING ROOM	50.00	o	2, 949, 599	0		8. 00
9.00	RECOVERY ROOM	51.00	ol	44			9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	o	55, 365			10.00
11. 00	ANESTHESI OLOGY	53.00	o	65, 999			11.00
12. 00	ASC ANESTHESI OLOGY	53. 01	o	10, 938			12.00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	2, 073, 750		l I	13. 00
14. 00	CARDI AC CATHETERI ZATI ON	59.00	0	1, 047, 243		l l	14. 00
15. 00	RESPIRATORY THERAPY	65.00	o	38, 957		l .	15. 00
16. 00	ELECTROCARDI OLOGY	69.00	0	40		l l	16. 00
17. 00	RENAL DIALYSIS	74.00	0	759	-	l .	17. 00
18. 00	ASC (NON-DISTINCT PART)	75. 01	0	1, 012, 985		l e	18. 00
19. 00	ARNETT CANCER CARE CENTER	90. 03	0	11, 218		l e e e e e e e e e e e e e e e e e e e	19. 00
20. 00	OUTPATIENT INFUSION CENTER	90.03	0	55		l .	20.00
	1		0		-	l e e e e e e e e e e e e e e e e e e e	1
21. 00	EMERGENCY	91.00	U	31, 172			21. 00
22. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	168, 673			22. 00
	U IMPLANTS		0	7, 591, 702			-
4 66	C - IMPLANTS		-1				4
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	43, 417	0	l e	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	71		l e	2. 00
3.00	INTENSIVE CARE UNIT	31. 00	0	16, 109		l I	3. 00
4.00	OPERATING ROOM	50.00	0	5, 974, 697		l I	4. 00
5.00	ANESTHESI OLOGY	53. 00	0	900			5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	479, 147			6. 00
7.00	CARDIAC CATHETERIZATION	59. 00	0	1, 553, 244			7. 00
8.00	ASC (NON-DISTINCT PART)	75. 01	0	1, 222, 033		l	8. 00
9.00	EMERGENCY	91. 00	o	410	0		9. 00

RECLASSI FI CATIONS

Provider CCN: 15-0173

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

6/29/2020 8:33 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 5, 628 10.00 PHYSI CI ANS' PRIVATE OFFICES 192.00 0 10.00 9, 295, 656 D - DRUGS OTHER ADMINISTRATIVE & 1.00 5.06 0 18 0 1.00 **GENERAL** 2.00 OPERATION OF PLANT -7.01 0 292 0 2.00 NONHOSPI TAL 3.00 NURSING ADMINISTRATION 13.00 o 28 0 3 00 PHARMACY 4.00 0 5, 316, 386 0 15, 00 4.00 ADULTS & PEDIATRICS 0 5.00 30.00 0 150, 346 5.00 6.00 INTENSIVE CARE UNIT 31.00 0 21, 217 0 6.00 7.00 NEONATAL INTENSIVE CARE UNIT 35.00 o 13, 635 0 7.00 0 OPFRATING ROOM 50.00 0 98, 882 8.00 8.00 9.00 RECOVERY ROOM 51.00 0 280 0 9.00 10.00 DELIVERY ROOM & LABOR ROOM 52.00 o 1,835 10.00 0 ANESTHESI OLOGY 53.00 0 26, 957 11.00 11.00 0 ASC ANESTHESIOLOGY 0 12.00 53.01 4, 136 12.00 13.00 RADI OLOGY-DI AGNOSTI C 54.00 0 228, 283 0 13.00 o 0 14.00 RADI OI SOTOPE 56.00 650, 913 14.00 0 CARDIAC CATHETERIZATION 0 15 00 59 00 57 020 15 00 0| RESPIRATORY THERAPY 16.00 65.00 0 16, 350 16.00 17.00 ELECTROCARDI OLOGY 69.00 o 71, 335 0 17.00 18.00 RENAL DIALYSIS 74.00 0 6, 509 0 18.00 ASC (NON-DISTINCT PART) 0 96, 695 0 75 01 19 00 19 00 20.00 ARNETT CANCER CARE CENTER 90.03 0 24, 740, 293 0 20.00 21.00 OUTPATIENT INFUSION CENTER 90.04 0 313 0 21.00 22 00 EMERGENCY 91 00 0 61 885 0 22 00 PHYSICIANS' PRIVATE OFFICES 0 23.00 192.00 6, 895, 418 0 23.00 RETAIL PHARMACY 131, 955 24.00 24.00 193.01 0 ō 38, 590, 981 E - BENEFITS 1.00 ADMITTI NG 5.01 0 1,087,825 0 1.00 2.00 OTHER ADMINISTRATIVE & o 705, 694 0 5.06 2.00 GENERAL 3.00 OPERATION OF PLANT 7.00 0 271, 460 0 3.00 OPERATION OF PLANT -4.00 7.01 0 69, 299 0 4.00 NONHOSPI TAL 5.00 HOUSEKEEPI NG 9.00 o 843, 096 0 5.00 6.00 DI ETARY 10.00 0 273, 990 0 6.00 NURSING ADMINISTRATION 0 0 7 00 13 00 749.090 7 00 8.00 CENTRAL SERVICES & SUPPLY 14.00 0 79, 458 0 8.00 9.00 PHARMACY 15.00 o 505, 766 0 9.00 SOCIAL SERVICE 17.00 0 77, 395 0 10.00 10.00 PATIENT TRANSPORT SERVICES 99 968 0 0 11 00 18.00 11 00 12.00 I&R SERVICES-OTHER PRGM. 22.00 0 33, 166 0 12.00 COSTS APPRVD 13.00 PARAMED ED PRGM - PHARMACY 23.00 0 7, 735 0 13.00 ADULTS & PEDIATRICS 3, 602, 165 0 14.00 30.00 0 14.00 15.00 INTENSIVE CARE UNIT 31.00 0 448, 150 0 15.00 35.00 NEONATAL INTENSIVE CARE UNIT 0 406, 729 0 16.00 16.00 0 17.00 OPERATING ROOM 50.00 o 740, 098 17.00 18.00 RECOVERY ROOM 51.00 0 137, 572 0 18.00 0 19.00 DELIVERY ROOM & LABOR ROOM 52.00 0 499, 573 19.00 ANESTHESI OLOGY o 585, 177 0 20.00 53.00 20.00 0 0 RADI OLOGY-DI AGNOSTI C 591, 132 21.00 54.00 21.00 0 0 22.00 RADI OI SOTOPE 56.00 36, 538 22.00 23.00 CARDIAC CATHETERIZATION 59.00 0 232, 291 0 23.00 o 0 24.00 RESPIRATORY THERAPY 65.00 273, 363 24.00 0 25 00 PHYSICAL THERAPY 66 00 0 95 789 25 00 OCCUPATIONAL THERAPY 0 0 26.00 67.00 61, 831 26.00 27.00 SPEECH PATHOLOGY 68.00 o 31, 307 0 27.00 0 0 28.00 ELECTROCARDI OLOGY 69.00 237, 426 28.00 ELECTROENCEPHALOGRAPHY 0 0 29 00 70 00 13 314 29 00 0 30.00 ASC (NON-DISTINCT PART) 75.01 0 526, 891 30.00 0 31.00 CARDIAC REHABILITATION 76.97 0 44, 019 31.00 SLEEP CLINIC 0 0 32 00 90 01 91 574 32 00 0 ARNETT CANCER CARE CENTER 0 33.00 90.03 128, 092 33.00 OUTPATIENT INFUSION CENTER 90.04 0 688 0 34.00 34.00 EMERGENCY 91.00 0 858, 716 0 35.00 35.00 GIFT, FLOWER, COFFEE SHOP & 0 12, 929 0 36.00 190.00 36.00 CANTEEN PHYSICIANS' PRIVATE OFFICES 37 00 192 00 0 12, 181, 957 0 37 00 38.00 RETAIL PHARMACY 193.01 99, 337 38.00 26, 740, 600

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/29/2020 8: 33 am

						6/29/2020 8:	33 am
	Cook Cooker	Decreases	C-1	0+1	W+ A 7 D-E		
	Cost Center	Li ne # 7.00	Sal ary		<u>Vkst. A-7 Ref.</u> 10.00		
	6. 00 F - CAFETERI A	7.00	8. 00	9. 00	10.00		
1.00	DI ETARY	10.00	376, 418	236, 298	0		1.00
1.00	0		376, 418	236, 298	— — "		1.00
	G - PROPERTY TAX		3737 113	200,270			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7, 261	13		1.00
2.00	CAP REL COSTS-BLDG & FIXT -	1.01	o	263, 342	13		2. 00
	NONHOSP						
	0		0	270, 603			
	H - PROPERTY INSURANCE						
1. 00	OTHER ADMINISTRATIVE &	5. 06	0	253, 606	12		1. 00
0.00	GENERAL	0.00			10		0.00
2.00		0.00	0	0	12		2. 00
3. 00			0		12		3. 00
	I - LEASE EXPENSE		U	253, 606			-
1.00	OPERATION OF PLANT	7.00	0	290, 955	10		1.00
2.00	OPERATION OF PLANT -	7. 00	0	706, 159	10		2. 00
2.00	NONHOSPI TAL	7.01	٩	700, 134	10		2.00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	o	145, 177	10		3. 00
4. 00	ADULTS & PEDIATRICS	30.00	0	20, 094	10		4. 00
5. 00	INTENSIVE CARE UNIT	31.00	o	920	0		5. 00
6. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	ol	7, 560	o		6. 00
7.00	OPERATING ROOM	50.00	o	105, 383	O		7. 00
8.00	ANESTHESI OLOGY	53.00	o	9, 788	O		8.00
9.00	RESPIRATORY THERAPY	65.00	o	6, 570	o		9. 00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	66, 734	0		10.00
	TOTALS — — — — —			1, 359, 340			
	J - INTEREST EXPENSE RECLASS						
1.00	OTHER ADMINISTRATIVE &	5. 06	0	11, 336, 383	11		1. 00
	GENERAL						
	0		0	11, 336, 383			
	K - HOUSEKEEPING SUPPLIES						
1.00	ADMITTING	5. 01	0	623	0		1.00
2. 00	OTHER ADMINISTRATIVE &	5. 06	0	463	0		2. 00
2 00	GENERAL NUCLEAR ADMINISTRATION	12 00	o	222	0		3. 00
3. 00 4. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	919	0		4. 00
5.00	PHARMACY	15. 00	o	191	0		5. 00
6. 00	PATIENT TRANSPORT SERVICES	18. 00	o	49	0		6. 00
7. 00	ADULTS & PEDIATRICS	30.00	o	13, 529	0		7. 00
8. 00	INTENSIVE CARE UNIT	31.00	0	2, 031	0		8. 00
9. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	173	0		9. 00
10. 00	OPERATING ROOM	50.00	ő	4, 744	0		10. 00
11. 00	RECOVERY ROOM	51.00	o	1, 069	0		11. 00
12. 00	DELIVERY ROOM & LABOR ROOM	52. 00	ol	151	o		12. 00
13. 00	ANESTHESI OLOGY	53. 00	0	31	0		13. 00
14. 00	ASC ANESTHESIOLOGY	53. 01	o	20	O		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	5, 448	O		15. 00
16.00	RADI OI SOTOPE	56.00	o	72	O		16. 00
17.00	CARDIAC CATHETERIZATION	59.00	o	657	0		17. 00
18.00	RESPIRATORY THERAPY	65.00	o	27	O		18. 00
19.00	ELECTROCARDI OLOGY	69. 00	0	41	0		19. 00
20.00	RENAL DIALYSIS	74.00	o	159	O		20.00
21. 00	ASC (NON-DISTINCT PART)	75. 01	0	3, 651	0		21. 00
22. 00	SLEEP CLINIC	90. 01	0	187	0		22. 00
23. 00	ARNETT CANCER CARE CENTER	90. 03	0	2, 223	0		23. 00
24. 00	EMERGENCY	91.00	0	17, 783	0		24. 00
25. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	4, 464	0		25. 00
26. 00	RETAIL PHARMACY	1 <u>93.</u> 01	•	45	0		26. 00
	U LAUNDBY CUEST 150		0	58, 972			_
1 00	L - LAUNDRY SUPPLIES	F0 00		10 710	2		1 00
1.00	OPERATING ROOM	50.00	0	10, 742	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00 54. 00	0	502	0		2.00
3.00	RADI OLOGY-DI AGNOSTI C	54. 00 75. 01	-	373	-		3. 00
4.00	ASC (NON-DISTINCT PART)	75. 01	0	6, 056	0		4. 00 5. 00
5. 00 6. 00	ARNETT CANCER CARE CENTER PHYSICIANS' PRIVATE OFFICES	90. 03 192. 00		956 556	0		6. 00
0.00	O FRIVALE OFFICES	192.00		19, 185	— — — Ч		0.00
	O - TELEPHONE RECLASS		U	17, 100			1
1.00	OPERATION OF PLANT -	7. 01	ol	8, 334	0		1. 00
1.00	NONHOSPI TAL	7.01	٩	0, 334	٩		1.00
2.00	NURSING ADMINISTRATION	13. 00	0	2, 797	o		2. 00
3. 00	PHARMACY	15. 00	O	111	ō		3. 00
4.00	PATIENT TRANSPORT SERVICES	18. 00	O	62	O		4. 00
	•	- 1		l l	-1		·

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0173

Period: Worksheet A-6
From 01/01/2019
To 12/31/2019 Date/Time Prepared: 6/29/2020 8: 33 am

						6/29/2020 8	: 33 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
5.00	ADULTS & PEDIATRICS	30.00	0	222			5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	0				6. 00
7. 00	PHYSI CAL THERAPY	66. 00	0	3, 488			7. 00
8.00	OCCUPATI ONAL THERAPY	67. 00	0	2, 708			8. 00
9.00	SPEECH PATHOLOGY	68. 00	0	1, 010			9. 00
10.00	ASC (NON-DISTINCT PART)	75. 01	0	1, 301	0		10. 00
11. 00	EMERGENCY	91.00	0	389			11. 00
12. 00	PHYSICIANS' PRIVATE OFFICES_	192.00	0	<u>4, 1</u> 71	0		12. 00
	0		0	24, 995			
	P - DEPRECIATION EXPENSE	, , , , , , , , , , , , , , , , , , , ,					
1.00	OTHER ADMINISTRATIVE &	5. 06	0	203, 838	9		1. 00
	GENERAL						
2.00	OPERATION OF PLANT	7. 00	0	4, 781, 872			2. 00
3.00	OPERATION OF PLANT -	7. 01	0	2, 619, 660	9		3. 00
	NONHOSPI TAL	40.00					
4.00	DI ETARY	10.00	0	30, 904			4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00	0	97, 691	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	48, 020			6. 00
7.00	PHARMACY	15. 00	0	82, 301	0		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	103, 066			8. 00
9.00	INTENSIVE CARE UNIT	31.00	0	101, 539			9. 00
10.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	12, 541	0		10.00
11.00	OPERATING ROOM	50.00	0	875, 687	0		11.00
12. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	19, 307	0		12. 00
13. 00	ANESTHESI OLOGY	53.00	0	4, 000			13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 263, 768			14. 00
15. 00	RADI OI SOTOPE	56.00	0	256, 399			15. 00
16. 00	CARDIAC CATHETERIZATION	59. 00	0	529, 278			16. 00
17. 00	RESPIRATORY THERAPY	65.00	0	121, 512			17. 00
18. 00	ELECTROCARDI OLOGY	69. 00	0	220, 590			18. 00
19. 00	RENAL DIALYSIS	74. 00	0	135			19. 00
20.00	ASC (NON-DISTINCT PART)	75. 01	0	362, 865			20. 00
21. 00	SLEEP CLINIC	90. 01	0	13, 723			21. 00
22. 00	ARNETT CANCER CARE CENTER	90. 03	0	5, 338			22. 00
23. 00	EMERGENCY	91.00	0	29, 235			23. 00
24. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	1, 238, 091	0		24. 00
25. 00	RETAIL PHARMACY	<u> </u>	0	<u> </u>			25. 00
	0		0	13, 022, 506			_
4 00	Q - FMLA RECLASS	F 04	47.054				4 00
1.00	ADMITTING	5. 01	17, 954	0			1.00
2.00	OTHER ADMINISTRATIVE &	5. 06	18, 089	0	0		2. 00
2 00	GENERAL OF BLANT	7.00	050				2 00
3.00	OPERATION OF PLANT	7.00	859	0	0		3. 00
4.00	HOUSEKEEPI NG	9.00	14, 032	0	0		4. 00
5.00	DI ETARY	10.00	2, 684	0	0		5. 00
6.00	NURSING ADMINISTRATION	13.00	47, 160	0	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14.00	7, 181	0	0		7. 00
8. 00	PHARMACY	15.00		0	-		8. 00
9.00	SOCIAL SERVICE	17. 00	3, 063	0			9. 00
10.00	PATIENT TRANSPORT SERVICES	18.00	2, 242	0			10.00
11.00	ADULTS & PEDIATRICS	30.00	111, 787	0	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	16, 439	0	0		12.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	13, 399	0	0		13.00
14.00	OPERATING ROOM	50.00	14, 700	0	0		14. 00
15.00	RECOVERY ROOM	51.00	12, 071	0	0		15. 00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	26, 799	0	0		16.00
17. 00	ANESTHESI OLOGY	53.00	12, 983	0	0		17. 00
18.00	RADI OLOGY-DI AGNOSTI C	54.00	3, 964	0	0		18.00
19. 00	CARDI AC CATHETERI ZATI ON	59.00	18, 157	0	0		19. 00
20.00	RESPIRATORY THERAPY	65.00	14, 782	0	0		20.00
21. 00	PHYSI CAL THERAPY	66.00	1, 928	0	0		21. 00
22. 00	ELECTROCARDI OLOGY	69.00	6, 383	0	0		22. 00
23. 00	ASC (NON-DISTINCT PART)	75. 01	8, 692	0	0		23. 00
24.00	SLEEP CLINIC	90. 01	1, 083	0	0		24. 00
25.00	ARNETT CANCER CARE CENTER	90. 03	1, 854	0	0		25. 00
26. 00	EMERGENCY	91.00	34, 395		0		26. 00
27. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	14 <u>6, 6</u> 95		0		27. 00
	0		562, 166	0			
	R - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00					1. 00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	20, 464				2. 00
	lo		643, 484	62, 910			

RECLASSI FI CATIONS

Provider CCN: 15-0173

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

6/29/2020 8:33 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 U - CORPORATE ADMIN EXPENSE 1.00 PHYSICIANS' PRIVATE OFFICES 192.00 63, 715, 538 0 1.00 63, 715, 538 **TOTALS** V - GENERAL SURGERY LAF METRO - HOSPITAL 1.00 PHYSICIANS' PRIVATE OFFICES 192.00 139, 329 376, 761 0 1.00 2.00 0.00 0 2.00 TOTALS 139. 329 376, 761 W - MEDICAL DIRECTOR FEES 1.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 60, 925 0 1.00 2.00 0.00 0 0 2.00 3 00 0.00 0 3 00 0 60, 925 X - ARNETT TO WHITE ALLOCATION 1.00 OTHER ADMINISTRATIVE & 5.06 417, 411 362, 224 0 1.00 GENERAL 2 00 OPERATION OF PLANT 7.00 0 36, 713 14,002 2 00 3.00 DI ETARY 10.00 69, 066 0 3.00 NURSING ADMINISTRATION 27, 932 0 4.00 13.00 8, 687 4.00 0 15.00 201, 690 65, 763 5.00 PHARMACY 5.00 ADULTS & PEDIATRICS 0 6.00 30.00 44, 134 71.254 6.00 7.00 OPERATING ROOM 50.00 79, 210 51,861 0 7.00 0 8.00 ELECTROCARDI OLOGY 69.00 52, 838 31, 096 8.00 ASC (NON-DISTINCT PART) 9.00 75.01 6, 871 18.518 0 9.00 10.00 EMERGENCY 91.00 4<u>5, 4</u>30 37,077 0 10.00 TOTALS 912, 229 729, 548 Y - ARNETT TO FRANKFORT ALLOCATION 1.00 OTHER ADMINISTRATIVE & 5.06 259, 349 256, 058 0 1.00 GENERAL 2.00 OPERATION OF PLANT 7.00 43, 717 16, 602 0 2.00 NURSING ADMINISTRATION 0 3.00 13.00 14, 573 4,532 3.00 CENTRAL SERVICES & SUPPLY 0 4 00 14 00 27 891 48, 271 4 00 0 5.00 PHARMACY 15.00 100,658 39, 878 5.00 6.00 ADULTS & PEDIATRICS 30.00 23, 026 37, 196 0 6.00 7.00 OPERATING ROOM 50.00 41, 326 29, 736 0 7.00 8.00 FLECTROCARDLOLOGY 69.00 30, 193 0 8.00 17, 769 9.00 ASC (NON-DISTINCT PART) 75.01 14,641 28, 786 0 9.00 EMERGENCY 23, 702 19, 344 10.00 10.00 91.00 0 TOTALS 579, 076 498, 172 Z - RESIDENCY STAFF 1.00 PHYSICIANS' PRIVATE OFFICES 192. 00 513, 829 39, 308 0 1.00 **TOTALS** 513, 829 39, 308 AB - INTERNS AND RESIDENTS 1.00 I&R SERVICES-OTHER PRGM. 22 00 0 560, 470 0 1.00 COSTS APPRVD TOTALS 560, 470 AC - PARAMEDICAL EDUCATION 1.00 PHARMACY 15.00 90, 479 0 0 1.00 2.00 PHYSICIANS' PRIVATE OFFICES 192.00 9, 458 0 2.00 TOTALS 99, 937 500.00 Grand Total: Decreases 3, 826, 468 186 278 007 500 00

			To 12/31/2019		Part I Date/Time Prepared: 6/29/2020 8:33 am			
			Acqui si ti ons					
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	3, 661, 768	197, 798		0	197, 798	0	1. 00
2.00	Land Improvements	391, 496	17, 480		0	17, 480	0	2. 00
3.00	Buildings and Fixtures	190, 313, 862	824, 722		0	824, 722	0	3. 00
4.00	Building Improvements	20, 460, 771	3, 740, 422		0	3, 740, 422	0	4. 00
5.00	Fixed Equipment	0	0		0	0	0	5. 00
6.00	Movable Equipment	101, 087, 841	10, 957, 392		0	10, 957, 392	17, 081, 997	6. 00
7.00	HIT designated Assets	0	0		0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	315, 915, 738	15, 737, 814		0	15, 737, 814	17, 081, 997	8. 00
9.00	Reconciling Items	0	0		0	0	0	9. 00
10.00	Total (line 8 minus line 9)	315, 915, 738	15, 737, 814		0	15, 737, 814	17, 081, 997	10.00
		Endi ng Bal ance	Ful l y					
			Depreci ated					
			Assets					
		6.00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	3, 859, 566	0					1. 00
2.00	Land Improvements	408, 976	0					2. 00
3.00	Buildings and Fixtures	191, 138, 584	-1, 391, 859					3. 00
4.00	Building Improvements	24, 201, 193	1, 327, 415					4. 00
5.00	Fixed Equipment	0	0					5. 00
6.00	Movable Equipment	94, 963, 236	55, 325, 453					6. 00
7.00	HIT designated Assets	0	0					7. 00
8.00	Subtotal (sum of lines 1-7)	314, 571, 555	55, 261, 009					8. 00
9.00	Reconciling Items	0	0					9. 00
10.00	Total (line 8 minus line 9)	314, 571, 555	55, 261, 009					10. 00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-0173	Peri od: Worksheet A-7

	STEINTION OF GATTINE GOSTS GENTERS		Trovider ex		From 01/01/2019 To 12/31/2019	Part II Date/Time Prep 6/29/2020 8:33	
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1. 00	CAP REL COSTS-BLDG & FLXT	0	0		0	0	1. 00
1. 01	CAP REL COSTS-BLDG & FLXT - NONHOSP	0	0		0	0	1. 01
1. 02	CAP REL COSTS INTEREST EXPENSE	0	0		0	0	1. 02
2.00	CAP REL COSTS MYDLE EQUIP	0	0		0	0	2.00
2. 01 3. 00	CAP REL COSTS-MVBLE EQUIP - NONHOSP Total (sum of lines 1-2)	0	0		0	0	2. 01 3. 00
3.00	Total (Suill of Titles 1-2)	SUMMARY OF	F CAPITAL		0 0	U	3.00
	Sommer of Statistic						
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)	45.00				
	DART LL DECONCLITATION OF AMOUNTS FROM MOR	14.00	15. 00				
1. 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR CAP REL COSTS-BLDG & FIXT	KSHEET A, COLUM	N 2, LINES I a	na z			1. 00
1. 00	CAP REL COSTS-BLDG & FIXT - NONHOSP	0	0				1. 00
1. 02	CAP REL COSTS INTEREST EXPENSE		0				1. 02
2.00	CAP REL COSTS-MVBLE EQUIP	Ö	0				2.00
2. 01	CAP REL COSTS-MVBLE EQUIP - NONHOSP	l ol	0				2. 01
3.00	Total (sum of lines 1-2)	0	0				3. 00

	Financial Systems	IU HEALTH ARNI			In Lie	u of Form CMS-2	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		eri od:	Worksheet A-7	
					rom 01/01/2019		
					o 12/31/2019	Date/Time Prep 6/29/2020 8:33	
		COMPUTATION OF RATIOS ALLOCATION OF OT					Jaili
		COM	OTATION OF ICA	1103	ALLOCATION OF	OTHER GALLIAE	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
	·		Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	219, 608, 319	0	219, 608, 319	0. 698119	0	1. 00
1.01	CAP REL COSTS-BLDG & FIXT - NONHOSP	0	0	l c	0.000000	0	1. 01
1.02	CAP REL COSTS INTEREST EXPENSE	0	0		0. 000000	0	1. 02
2.00	CAP REL COSTS-MVBLE EQUIP	94, 963, 236	0	94, 963, 236	0. 301881	0	2. 00
2.01	CAP REL COSTS-MVBLE EQUIP - NONHOSP	0	l o		0. 000000	ol	2. 01
3.00	Total (sum of lines 1-2)	314, 571, 555	0	314, 571, 555		0	3. 00
			TION OF OTHER (F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	C	5, 720, 412	287, 870	1. 00
1. 01	CAP REL COSTS-BLDG & FLXT - NONHOSP	0	0	C	1, 546, 230	769, 955	1. 01
1.02	CAP REL COSTS INTEREST EXPENSE	0	0	C	0	0	1. 02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	C	11, 355, 262	294, 829	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - NONHOSP	0	0	C	2, 895, 585	6, 686	2. 01
3.00	Total (sum of lines 1-2)	0	0	C	21, 517, 489	1, 359, 340	3. 00
			Sl	JMMARY OF CAPIT	TAL		
			l	T - /	0.1	T + 1 (0) (
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	[Instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	DADT III DECONCILIATION OF CADITAL COSTS OF	11. 00	12.00	13. 00	14.00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT	INTERS	208, 470	-7, 261		6, 209, 491	1. 00
1.00	CAP REL COSTS-BLDG & FIXI		208, 470			0, 209, 491	

6, 570, 524

6, 570, 524

32, 564

12, 572

253, 606

0

-263, 342

-270, 603

2, 085, 407

6, 570, 524

11, 662, 663 2. 00 2, 902, 271 2. 01 29, 430, 356 3. 00

1.01

1.02

2. 00

1.01

1.02

2. 00

CAP REL COSTS-BLDG & FIXT - NONHOSP

CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - NONHOSP

CAP REL COSTS INTEREST EXPENSE

3.00 Total (sum of lines 1-2)

| Period: | Worksheet A-8 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-0173

				To	12/31/2019		pared:
				Expense Classification on	Worksheet A	6/29/2020 8: 33	3 alli
				To/From Which the Amount is	to be Adjusted		
	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)						
1. 01	Investment income - CAP REL COSTS-BLDG & FIXT - NONHOSP		0	CAP REL COSTS-BLDG & FIXT - NONHOSP	1. 01	0	1. 01
1. 02	(chapter 2) Investment income - CAP REL COSTS INTEREST EXPENSE	В	-4, 854, 743	CAP REL COSTS INTEREST EXPENSE	1. 02	11	1. 02
2. 00	(chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2. 01	COSTS-MVBLE EQUIP (chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - NONHOSP		0	CAP REL COSTS-MVBLE EQUIP - NONHOSP	2. 01	0	2. 01
3. 00	(chapter 2) Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	O	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	Tel evi si on and radio servi ce		0		0. 00	0	8. 00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -20, 799, 474		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0		0.00	0	
12. 00	(chapter 23) Related organization	A-8-1	51, 827, 967			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	Abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0. 00	O	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	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	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
26. 01	COSTS-BLDG & FLXT Depreciation - CAP REL COSTS BLDG & FLXT NONHOSE		0	CAP REL COSTS-BLDG & FIXT -	1. 01	0	26. 01
26. 02	COSTS-BLDG & FIXT - NONHOSP Depreciation - CAP REL COSTS		0	NONHOSP CAP REL COSTS INTEREST	1. 02	0	26. 02
27. 00	INTEREST EXPENSE Depreciation - CAP REL		0	EXPENSE CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP	1			l	l	

From 01/01/2019
To 12/31/2019 Date/Time Prepared:

				To	o 12/31/2019	Date/Time Pre 6/29/2020 8:3	
				Expense Classification on	Worksheet A	072972020 8.3	3 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	T- '	1.00	2. 00	3.00	4. 00	5. 00	
27. 01	Depreciation - CAP REL COSTS-MVBLE EQUIP - NONHOSP		0	CAP REL COSTS-MVBLE EQUIP - NONHOSP	2. 01	0	27. 01
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		Ö	Sost Senter Bereted	0.00	l e	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30. 00
	therapy costs in excess of						
20.00	limitation (chapter 14)		0	ADULTS & DEDLATRICS	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		U	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
20.00	limitation (chapter 14)				0.00		00.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33. 00	EMPLOYEE BENEFITS	A	-26, 756, 665	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
33. 01	UNWONTED SITUATIONS	A		OTHER ADMINISTRATIVE &	5. 06		1
				GENERAL			
33. 02	ACCRUED PTO	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	•	
33. 03 33. 04	ACCRUED PTO CONTRIBUTION EXPENSE	A A		ADULTS & PEDIATRICS OTHER ADMINISTRATIVE &	30. 00 5. 06	l e	
33. 04	CONTRIBUTION EXITENSE		-477,012	GENERAL	3.00	0	33.04
33. 05	HAF OFFSET	Α	-16, 421, 959	OTHER ADMINISTRATIVE &	5. 06	0	33. 05
		_		GENERAL		_	
33. 06	MI SCELLANEOUS I NCOME	В	-118, 202	OTHER ADMINISTRATIVE &	5. 06	0	33. 06
33. 07	MI SCELLANEOUS I NCOME	В	-8 421	GENERAL OPERATION OF PLANT	7. 00	0	33. 07
33. 08	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT -	7. 01	Ö	33. 08
				NONHOSPI TAL			
33. 09	MI SCELLANEOUS I NCOME	В		CAFETERI A	11. 00	l .	
33. 10	MI SCELLANEOUS I NCOME	В		NURSI NG ADMI NI STRATI ON	13.00	1	
33. 11 33. 12	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	l e	33. 11 33. 12
33. 12	MI SCELLANEOUS I NCOME	В		PARAMED ED PRGM - PHARMACY	23. 00	0	33. 12
33. 14	MI SCELLANEOUS I NCOME	В		ADULTS & PEDIATRICS	30.00	· -	33. 14
33. 15	MI SCELLANEOUS I NCOME	В		DELIVERY ROOM & LABOR ROOM	52.00	l e	33. 15
33. 16	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00	l e	33. 16
33. 17	MI SCELLANEOUS I NCOME	В		PHYSICIANS' PRIVATE OFFICES	192. 00	l .	1
33. 18	TELEPHONE EXPENSE	A		OTHER ADMINISTRATIVE &	5. 06	l e	ı
				GENERAL			
33. 19	NON-ALLOWABLE MARKETING	A	-29, 481	OTHER ADMINISTRATIVE &	5. 06	0	33. 19
33. 20	NON-ALLOWABLE MARKETING	A	-1 837	GENERAL DI ETARY	10. 00	0	33. 20
33. 21	NON-ALLOWABLE MARKETING	A		NURSING ADMINISTRATION	13. 00		ı
	NON-ALLOWABLE MARKETING	A		PHARMACY	15. 00	i e	1
33. 23	NON-ALLOWABLE MARKETING	A		ADULTS & PEDIATRICS	30.00		
33. 24	NON-ALLOWABLE MARKETING	A		ANESTHESI OLOGY	53.00		
33. 25	NON-ALLOWABLE MARKETING	A		ASC (NON-DISTINCT PART)	75. 01	Ö	1
33. 26	NON-ALLOWABLE MARKETING	A		SLEEP CLINIC	90. 01	Ö	ı
33. 27	NON-ALLOWABLE MARKETING	A		EMERGENCY	91. 00		ı
33. 28	RECRUI TMENT	A		OTHER ADMINISTRATIVE &	5. 06	l	33. 28
				GENERAL			
33. 29	RECRUI TMENT	A		HOUSEKEEPI NG	9. 00	0	
33. 30	RECRUI TMENT	A		NURSING ADMINISTRATION	13. 00	l e	
33. 31	RECRUI TMENT	A		ADULTS & PEDIATRICS	30. 00	0	33. 31
50. 00	TOTAL (sum of lines 1 thru 49)		-20, 956, 603				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						L

⁽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: 15-0173 Peri od: Worksheet A-8-1 From 01/01/2019
To 12/31/2019 Date/Time Prepared: OFFICE COSTS

				10 12/31/2019	6/29/2020 8: 3	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1, 245, 039	0	1.00
2.00	1. 02	CAP REL COSTS INTEREST EXPEN	HOME OFFICE ALLOCATION	88, 884	0	2.00
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	7, 249, 944	0	3.00
4.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	41, 703, 472	0	4.00
4.01	5. 06	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOCATION	67, 649, 300	66, 108, 672	4. 01
4.02	1. 02	CAP REL COSTS INTEREST EXPEN	RELATED PARTY	11, 336, 383	11, 336, 383	4. 02
4.03	4. 00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	38, 976	38, 976	4. 03
4.04	5. 06	OTHER ADMINISTRATIVE & GENER	RELATED PARTY	686, 734	686, 734	4.04
4.05	7. 00	OPERATION OF PLANT	RELATED PARTY	396, 841	396, 841	4.05
4.06	7. 01	OPERATION OF PLANT - NONHOSP	RELATED PARTY	290, 264	290, 264	4.06
4.07	13. 00	NURSING ADMINISTRATION	RELATED PARTY	15, 176	15, 176	4. 07
4.08	50.00	OPERATING ROOM	RELATED PARTY	367, 735	367, 735	4. 08
4.09	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	17, 500	17, 500	4. 09
4. 10	60.00	LABORATORY	RELATED PARTY	10, 419, 667	10, 419, 667	4. 10
4. 11	66.00	PHYSI CAL THERAPY	RELATED PARTY	16, 186	16, 186	4. 11
4. 12	70.00	ELECTROENCEPHALOGRAPHY	RELATED PARTY	12, 000	12, 000	4. 12
4. 13	192.00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY	5, 934, 325	5, 934, 325	4. 13
5.00	0		0	147, 468, 426	95, 640, 459	5. 00

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

	Related Organization(s) and/or Home C		or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1. 00	2. 00	3.00	4. 00	5. 00	
•	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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 iiibui .	sement under title Aviii.					
6.00	В	IU HEALTH	100.00	IU HEALTH	100. 00	6. 00
7. 00			0.00		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
l	non-financial) specify:				1	

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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 organi zati on.
- 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 provi der.

					To 12/31/2019	Date/Time Pro	epared:
						6/29/2020 8:	33 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED O	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:					
1.00	1, 245, 039	9					1.00
2.00	88, 884	11					2.00
3.00	7, 249, 944	9					3.00
4.00	41, 703, 472	2 0					4.00
4.01	1, 540, 628	0					4. 01
4.02	0	11					4. 02
4.03	0	0					4. 03
4.04	0	0					4.04
4.05		0					4. 05
4.06		0					4.06
4.07		0					4. 07
4.08		0					4. 08
4.09		0					4. 09
4. 10		0					4. 10
4. 11		o					4. 11
4. 12		0					4. 12
4. 13							4. 13
5. 00	51, 827, 967	,					5. 00
	1 2., 22., 70.	1	1				

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

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

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

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

i ci ilibui	Termbur Schieft under tritte Avitt.								
6.00	HEALTHCARE		6. 00						
7.00			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.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0173

					[1	To 12/31/2019	Date/Time Pre 6/29/2020 8:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	WKSt. A LITTO #	I denti fi er	Remuneration	Component	Component	NOL AMOUNT	ider Component	
		Tuerrer Tres	Romanor a tron	Component	Component		Hours	
	1. 00	2.00	3. 00	4, 00	5. 00	6. 00	7. 00	
1.00		OTHER ADMINISTRATIVE &	285, 311	285, 311	0	211, 500		1. 00
		GENERAL						
2.00	22. 00	I&R SERVICES-OTHER PRGM.	673	673	0	179, 000	0	2. 00
		COSTS APPRVD						
3.00		ADULTS & PEDIATRICS	8, 155, 942			211, 500		3. 00
4.00		INTENSIVE CARE UNIT	1, 180, 600	0	1, 180, 600	211, 500	8, 760	4. 00
5.00		NEONATAL INTENSIVE CARE UNIT	974, 751		0	211, 500		5. 00
6.00		ANESTHESI OLOGY	10, 008, 623	10, 008, 623	0	239, 400	0	6. 00
7.00		EMERGENCY	1, 430, 035	818, 035	612, 000	211, 500	3, 400	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			22, 035, 935					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identi fi er	Li mi t	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
4 00	1.00	2.00	8.00	9.00	12. 00	13. 00	14. 00	4 00
1. 00	5.06	OTHER ADMINISTRATIVE & GENERAL	0	0	0	0	0	1. 00
2.00	22 00	I&R SERVICES-OTHER PRGM.	0	0	0	0	0	2. 00
2.00		COSTS APPRVD				ŭ	Ĭ	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3. 00
4.00	31.00	INTENSIVE CARE UNIT	890, 740	44, 537	0	0	0	4.00
5.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	5. 00
6.00	53.00	ANESTHESI OLOGY	0	0	0	0	0	6. 00
7.00	91. 00	EMERGENCY	345, 721	17, 286	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			1, 236, 461	61, 823	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
1 00	1.00	2.00	15. 00	16. 00	17. 00	18. 00		1 00
1. 00	5.06	OTHER ADMINISTRATIVE & GENERAL	0	0	0	285, 311		1. 00
2.00	22 00	I&R SERVICES-OTHER PRGM.	0	0	0	673		2. 00
2.00	22.00	COSTS APPRVD				073		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	8, 155, 942		3. 00
4. 00		INTENSIVE CARE UNIT	0	890, 740	289, 860	289, 860		4. 00
5. 00		NEONATAL INTENSIVE CARE UNIT		n 375, 740	257,300	974, 751		5. 00
6. 00		ANESTHESI OLOGY	١	l o	l o	10, 008, 623		6. 00
7. 00		EMERGENCY	١	345, 721	266, 279	1, 084, 314		7. 00
8. 00	0.00		١	010, 721	200, 277	1,004,314		8. 00
9. 00	0.00	4		0		n		9. 00
10. 00	0.00					0		10. 00
200.00	3.00		0	1, 236, 461	556, 139	20, 799, 474		200. 00
200.00	ı	1	۰	1, 200, 401	000, 107	20, , , , , , , , ,	1	230.00

Provider CCN: 15-0173

				1	0 12/31/2019	Date/lime Pre 6/29/2020 8:3	
			<u>'</u>	CAPITAL RE	LATED COSTS		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - NONHOSP	CAP REL COSTS INTEREST EXPENSE	MVBLE EQUIP	
	OFNEDAL CEDIUSE COCT CENTERS	0	1. 00	1. 01	1. 02	2. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	6, 209, 491	6, 209, 491	I			1.00
1. 01 1. 02 2. 00 2. 01	00100 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP	2, 085, 407 6, 570, 524 11, 662, 663 2, 902, 271	0, 209, 491 0 0	2, 085, 407 0	l .	11, 662, 663 0	1. 00 1. 01 1. 02 2. 00 2. 01
4. 00 5. 01 5. 06 7. 00 7. 01 8. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - NONHOSPITAL 00800 LAUNDRY & LINEN SERVICE	42, 836, 647 3, 953, 831 76, 529, 371 10, 076, 008 4, 686, 786 19, 181	0 42, 974 184, 542 1, 157, 123 0	102, 301	195, 271 1, 224, 401 0	0 80, 714 346, 606 2, 173, 309 0	4. 00 5. 01 5. 06 7. 00 7. 01 8. 00
9. 00 10. 00 11. 00 13. 00 14. 00	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	3, 865, 612 1, 634, 614 -153, 209 3, 975, 285 12, 360, 239	84, 372 138, 492 97, 360 107, 412 327, 280	943 0 0 0	89, 278 146, 544 103, 020 113, 658	158, 468 260, 116 182, 861 201, 742 614, 696	9. 00 10. 00 11. 00 13. 00
15. 00 16. 00 17. 00 18. 00 21. 00 22. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCI AL SERVICE 01850 PATIENT TRANSPORT SERVICES 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	3, 841, 855 0 496, 463 725, 863 560, 470 1, 018, 759	68, 934 0 0 21, 682 0	0 0 0	0 0 22, 943 0	129, 471 0 0 40, 724 0 0	16. 00 17. 00 18. 00
23. 00		165, 965	2, 014	97	2, 131	3, 782	23. 00
30. 00 31. 00 33. 00 33. 01 35. 00	INPATIENT ROUTINE SERVICE COST CENTERS	22, 160, 390 3, 542, 116 0 0 2, 745, 003	1, 770, 630 172, 896 0 0 139, 460	0 0 0	182, 949 0 0	3, 325, 592 324, 734 0 0 261, 933	31. 00 33. 00 33. 01
43. 00	04300 NURSERY	706, 394	65, 203	0	68, 994	122, 464	43. 00
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00	06300 BLOOD STORING, PROCESSING & TRANS.	5, 436, 803 691, 090 2, 485, 327 3, 097, 296 4, 856 4, 124, 864 0 312, 529 1, 826, 740 10, 499, 537 686, 132 1, 914, 549 634, 646 411, 124 247, 482 1, 386, 329 86, 640 7, 590, 764 9, 294, 120 38, 589, 315 839, 812 0 4, 490, 416 0 518, 339	443, 558 65, 562 223, 332 19, 715 0 245, 218 0 29, 987 122, 461 148, 779 10, 927 15, 797 12, 191 5, 307 4, 683 35, 716 0 0 24, 102	0 931 718 0 0 0 7, 447 0 0 0 0 0 0	69, 374 236, 317 20, 862 0 259, 475 0 31, 730 129, 581 157, 429 11, 562 16, 716 12, 900 5, 616 4, 955 37, 792 0 0 0 25, 503 0 0 0 0		51. 00 52. 00 53. 00 53. 01 54. 00 55. 00 60. 00 63. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 01 76. 00
90. 00 90. 01 90. 03 90. 04 91. 00 92. 00 92. 01 93. 00	04950 SLEEP CLINIC 09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART) 04951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS	0 517, 212 1, 244, 232 23, 222 5, 841, 042 0 0	0 0 9, 959 291, 642 0	0 0	0 10, 538 308, 599 0 0	0 0 0 18, 705 547, 762 0	90. 01 90. 03 90. 04 91. 00 92. 00 92. 01 93. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	327, 972, 417	6, 089, 310	495, 578	6, 443, 355	11, 436, 938	118. 00

				o 12/31/2019	Date/Time Pre 6/29/2020 8:3	pared: 3 am
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - NONHOSP	CAP REL COSTS I NTEREST EXPENSE	MVBLE EQUIP	
	0	1.00	1. 01	1. 02	2. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	166, 539	38, 869	0	41, 129	73, 004	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	103, 022, 007	19, 450	1, 575, 070	20, 581	36, 531	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 RETALL PHARMACY	5, 023, 771	17, 140	0	18, 136	32, 192	193. 01
193. 02 19302 WHI TE HOSPI TAL	1, 641, 777	23, 758	7, 477	25, 140	44, 623	193. 02
193. 03 19303 HOSPI CE	2, 572	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	1, 077, 248	20, 964	7, 282	22, 183	39, 375	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	438, 906, 331	6, 209, 491	2, 085, 407	6, 570, 524	11, 662, 663	202. 00

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0173

			To	12/31/2019	Date/Time Prep 6/29/2020 8:3	
Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP - NONHOSP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	Subtotal	OTHER ADMINISTRATIVE & GENERAL	<i>y</i> a
	2. 01	4.00	5. 01	5A. 01	5. 06	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 1.02 00102 CAP REL COSTS INTEREST EXPENSE 2.00 00200 CAP REL COSTS-MVBLE EQUIP NONHOSP 1.00201 CAP REL COSTS MVBLE EQUIP 1.00201 CAP REL COSTS MVBLE 1.00201 CAP REL COSTS MVBLE 1.00201 CAP REL COSTS MVBLE 1.00201 CA	2 000 074					1. 00 1. 01 1. 02 2. 00
2.01 OO201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT 5.01 OO570 ADMITTING 5.06 OO590 OTHER ADMINISTRATIVE & GENERAL 7.00 OO700 OPERATION OF PLANT 7.01 OO701 OPERATION OF PLANT - NONHOSPITAL 8.00 OO800 LAUNDRY & LINEN SERVICE	2, 902, 271 0 25, 604 142, 372 6, 520 14, 233 0	42, 836, 647 759, 072 1, 184, 075 327, 470 77, 649	4, 926, 066 0 0 0 0	78, 684, 538 14, 969, 516 4, 788, 895 19, 181	3, 269, 851 1, 046, 057 4, 190	2. 01 4. 00 5. 01 5. 06 7. 00 7. 01 8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 312 0 0 0 0 669 440 0	589, 210 118, 912 88, 371 769, 227 64, 507 765, 532	0 0 0 0 0	4, 789, 195 2, 298, 678 318, 403 5, 167, 324 13, 714, 180 4, 879, 490	502, 109 69, 550 1, 128, 719 2, 995, 643	9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
17. 00 01700 SOCI AL SERVI CE 18. 00 01850 PATI ENT TRANSPORT SERVI CES 21. 00 02100 I&R SERVI CES-SALARY & FRI NGES APPRVD 22. 00 02200 I&R SERVI CES-OTHER PRGM. COSTS APPRVD 23. 00 PARAMED ED PRGM - PHARMACY INPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 15, 088 135	106, 856 111, 816 0 204, 710 40, 577	0 0 0 0 0	603, 319 923, 028 560, 470 1, 249, 399 214, 701	201, 621 122, 426	1
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 33. 01 03301 BURN INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	0 0 0 0 0	6, 140, 171 569, 839 0 0 751, 505 151, 069	437, 819 50, 638 0 0 51, 178 11, 757	35, 708, 180 4, 843, 172 0 4, 096, 647		31. 00 33. 00 33. 01 35. 00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	2, 947	1, 054, 967	428, 287	1, 125, 881 8, 671, 118	1, 894, 067	50. 00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 53. 01 05301 ASC ANESTHESI OLOGY 54. 00 05400 RADI OLOGY – THERAPEUTI C	0 0 1, 295 999 0	147, 842 523, 594 2, 122, 201 0 848, 356	41, 053 76, 698 78, 002 13, 413 273, 481	1, 138, 060 3, 964, 731 5, 377, 332 19, 986 6, 211, 962	866, 032 1, 174, 592 4, 366	51. 00 52. 00 53. 00 53. 01 54. 00 55. 00
56. 00	0 0 10, 364 0 0 0	50, 452 311, 462 3, 130 0 411, 418 133, 619 86, 984	43, 590 177, 192 222, 478 14, 791 39, 582 12, 395 5, 405	524, 609 2, 797, 441 11, 328, 601 743, 935 2, 427, 733 828, 649 524, 404	611, 056 2, 474, 552 162, 501	65. 00 66. 00
68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDIOLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46, 788 286, 113 19, 156 0 0	4, 756 89, 586 4, 694 129, 186 263, 863 575, 752 9, 461	317, 460 1, 902, 617 110, 490 7, 719, 950 9, 557, 983 39, 165, 067 944, 146	415, 596 24, 135 1, 686, 300 2, 087, 788 8, 554, 982	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART) 75. 01 07501 ASC (NON-DISTINCT PART) 76. 00 03950 CARDIAC CATHERIZATION 76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	287, 742 0 24, 097	780, 889 0 71, 473	379, 525 0 339, 525	6, 145, 327 0 6, 145, 327 0 631, 563	0 1, 342, 348 0 137, 955	75. 00 75. 01 76. 00 76. 97
90. 00 09000 CLINI C 90. 01 04950 SLEEP CLINI C 90. 03 09002 ARNETT CANCER CARE CENTER 90. 04 09003 0UTPATI ENT INFUSION CENTER 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART)	0 48, 431 107, 446 0 0	0 103, 402 179, 438 3, 930 1, 008, 432	0 21, 596 69, 486 2, 404 543, 337	0 725, 441 1, 677, 807 68, 758 8, 540, 814 0 0	0 158, 461 366, 490 15, 019 1, 865, 604	90. 00 90. 01 90. 03 90. 04 91. 00 92. 00 92. 01
93.00 04951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	689, 694	21, 014, 214	4, 071, 744	301, 020, 181	48, 565, 663	93. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0 0	7, 421 0	0	326, 962 0	71, 420	

| 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 8:33 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH ARNETT HOSPITAL Provider CCN: 15-0173

					6/29/2020 8: 3	<u>3 am </u>
	CAPITAL RELATED COSTS					
Cost Center Description	MVBLE EQUIP -	EMPLOYEE	ADMI TTI NG	Subtotal	OTHER	
	NONHOSP	BENEFITS			ADMI NI STRATI VE	
		DEPARTMENT			& GENERAL	
	2. 01	4.00	5. 01	5A. 01	5. 06	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 192, 036	21, 322, 752	838, 187	129, 026, 614	28, 183, 651	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 RETAIL PHARMACY	0	142, 151	16, 135	5, 249, 525	1, 146, 675	193. 01
193. 02 19302 WHI TE HOSPI TAL	10, 406	214, 161	0	1, 967, 342	429, 734	193. 02
193. 03 19303 HOSPI CE	0	0	0	2, 572	562	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	10, 135	135, 948	0	1, 313, 135	286, 833	193. 04
194.00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 902, 271	42, 836, 647	4, 926, 066	438, 906, 331	78, 684, 538	202. 00

Provider CCN: 15-0173

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part |
| To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:33 am

				''	0 12/31/2019	6/29/2020 8: 3	
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT	PLANT -	LINEN SERVICE			
		7. 00	NONHOSPI TAL 7. 01	8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	7.00	7.01	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01	OO101 CAP REL COSTS-BLDG & FLXT - NONHOSP						1. 01
1. 02	00102 CAP REL COSTS INTEREST EXPENSE						1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01	00201 CAP REL COSTS-MVBLE EQUI P - NONHOSP						2. 01
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING						4. 00 5. 01
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL			•			5. 06
7. 00	00700 OPERATION OF PLANT	18, 239, 367					7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL	0	5, 834, 952			•	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	23, 371			8. 00
9. 00	00900 HOUSEKEEPI NG	318, 952	2, 822		., . ,		9. 00
10.00	01000 DI ETARY	523, 541	0	0	87, 540		1
11. 00 13. 00	01100 CAFETERI A	368, 048	0		61, 540	0 0	
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	406, 051 1, 237, 213	1, 438		67, 895 207, 651		1
15. 00	01500 PHARMACY	260, 590	947		44, 086		1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	Ö	1
17. 00	01700 SOCIAL SERVICE	0	0	o	0	0	17. 00
18. 00	01850 PATIENT TRANSPORT SERVICES	81, 966	0	0	13, 705	0	18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	32, 444		17, 583		22. 00
23. 00	O2300 PARAMED ED PRGM - PHARMACY	7, 612	291	0	1, 421	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	6, 693, 499	0	18, 771	1, 119, 201	3, 115, 402	30.00
31. 00	03100 NTENSI VE CARE UNIT	653, 600			109, 287	224, 243	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	Ö	0	0	0	1
33. 01	03301 BURN INTENSIVE CARE UNIT	0	0	o	0	0	1
35.00	02060 NEONATAL INTENSIVE CARE UNIT	527, 199	0	1, 464	88, 152	0	35. 00
43.00	04300 NURSERY	246, 487	0	1, 350	41, 214	0	43. 00
	ANCILLARY SERVICE COST CENTERS	1 (7, 700		1	200 001		
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 676, 782		1		0 0	
51.00	05200 DELIVERY ROOM & LABOR ROOM	247, 844 844, 263	0				
53. 00	05300 ANESTHESI OLOGY	74, 530	_			72, 223	1
53. 01	05301 ASC ANESTHESI OLOGY	0	2, 148		1, 164		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	926, 995	0		155, 000		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	113, 359		0	18, 954	0	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	462, 937	0	_	77, 406		
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	562, 429 41, 307	22, 285 0		106, 109 6, 907	0 0	
65. 00	06500 RESPIRATORY THERAPY	59, 719	0	0	9, 985		1
66. 00	06600 PHYSI CAL THERAPY	46, 087	Ö	ő	7, 706		66.00
67.00	06700 OCCUPATI ONAL THERAPY	20, 064	0	o			1
68. 00	06800 SPEECH PATHOLOGY	17, 703		0	-1	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	135, 016	0	0	22, 576	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0		
74. 00	07400 RENAL DIALYSIS	91, 112	0		15, 235		
75. 00	07500 ASC (NON-DISTINCT PART)	0	Ö	ő	0	Ö	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	0	618, 734	0	335, 319	0	75. 01
76.00	03950 CARDI AC CATHERI ZATI ON	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	51, 816	0	28, 081	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	_		1			
90.00	09000 CLI NI C 04950 SLEEP CLI NI C	0	104 143		-	-	1
90. 01 90. 03	09002 ARNETT CANCER CARE CENTER	0	104, 142 231, 042	1	56, 439 125, 212		
90. 04	09003 OUTPATIENT INFUSION CENTER	37, 649	231, 042	0	6, 295		1
91. 00	09100 EMERGENCY	1, 102, 492	Ö	l ő	184, 345		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				,		92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0		
93. 00	04951 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93. 00
140 5	SPECIAL PURPOSE COST CENTERS	47 705 0 : :	4 077 071		0 500 75	0 444 0:-	110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	17, 785, 046	1, 077, 231	23, 371	3, 502, 707	3, 411, 868	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	146, 936	0	0	24, 569	0	190. 00
	19100 RESEARCH	140, 730	0	0			191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	73, 527	4, 713, 552		_		192. 00
	19300 NONPALD WORKERS	0	0				193. 00
					'		

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0173	Peri od: Worksheet B From 01/01/2019 Part I Date/Time Prepared: 6/20/2020 8:33 am

					6/29/2020 8:3	<u>3 am</u>
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT -	LINEN SERVICE			
		NONHOSPI TAL				
	7.00	7. 01	8.00	9. 00	10.00	
193. 01 19301 RETAIL PHARMACY	64, 793	0	0	10, 834	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	89, 814	22, 376	0	27, 144	0	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	79, 251	21, 793	0	25, 062	0	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 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)	18, 239, 367	5, 834, 952	23, 371	6, 157, 092	3, 411, 868	202. 00

Provider CCN: 15-0173

| 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 8:33 am

					6/29/2020 8: 3	3 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11.00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1.01 O0101 CAP REL COSTS-BLDG & FLXT - NONHOSP						1. 01
1. 02 00102 CAP REL COSTS INTEREST EXPENSE						1. 02
2.00 OO200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01 00201 CAP REL COSTS-MVBLE EQUI P - NONHOSP						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00570 ADMI TTI NG						5. 01
5.06 00590 OTHER ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						5. 06 7. 00
7. 01 00700 OPERATION OF PLANT 7. 01 00701 OPERATION OF PLANT - NONHOSPITAL						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A	817, 541					11. 00
13.00 01300 NURSING ADMINISTRATION	38, 097	6, 808, 086				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	6, 159	o	18, 162, 284			14.00
15. 00 01500 PHARMACY	33, 642	0	72, 500	6, 357, 102		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	C		0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	7, 099	l .	0	0	0	17. 00
18. 00 01850 PATIENT TRANSPORT SERVICES	14, 048		4, 061	0	0	18. 00
21. 00 02100 1&R SERVI CES-SALARY & FRINGES APPRVD	5, 893	0	0	0	0	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	3, 807		0	0	0	22. 00
23. 00 O2300 PARAMED ED PRGM - PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 219	l ol	U	U	U	23. 00
30. 00 03000 ADULTS & PEDIATRICS	276, 781	3, 741, 531	1, 305, 746	24, 423	0	30. 00
31. 00 03100 NTENSI VE CARE UNI T	30, 900		239, 483	3, 450	0	31. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	007,700		0	0	0	33. 00
33.01 03301 BURN INTENSIVE CARE UNIT	C	o	0	o	0	33. 01
35.00 02060 NEONATAL INTENSIVE CARE UNIT	27, 058	351, 391	81, 469	2, 217	0	35. 00
43. 00 04300 NURSERY	8, 093	104, 646	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	57, 514		1, 904, 117	6, 131	0	50. 00
51. 00 05100 RECOVERY ROOM	8, 342		19, 437	46	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	28, 735 26, 223		191, 985 180, 919	298 3, 810	0	52. 00 53. 00
53. 00 03300 ANESTHEST OLOGY 53. 01 05301 ASC ANESTHEST OLOGY	20, 223	1	60, 833	287	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	43, 732		612, 485	5, 141	0	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	.0, 702	0	0.2, .00	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	2, 458	o	7, 542	327	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	15, 991	163, 640	347, 408	3, 088	0	59. 00
60. 00 06000 LABORATORY	33, 589	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	0	0	0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	23, 623	l .	205, 984	2, 628	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 434		889	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 206		113	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	2, 192	l .	717	(F1	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	18, 636 976		9, 437 658	651	0	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	470		4, 740, 690	0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			5, 804, 486	Ö	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	C		0	6, 274, 151	0	73. 00
74. 00 07400 RENAL DIALYSIS	C	O	6, 997	839	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	C	o	0	o	0	75. 00
75.01 07501 ASC (NON-DISTINCT PART)	C	O	820, 418	12, 433	0	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	C	0	0	0	0	76. 00
76. 97 O7697 CARDIAC REHABILITATION	C	0	2, 957	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS		1	ما	ما		
90. 00 09000 CLI NI C	C		17 500	0	0	90.00
90. 01 04950 SLEEP CLINIC 90. 03 09002 ARNETT CANCER CARE CENTER	0.473		17, 583	6, 971	0	90. 01 90. 03
90. 03 09002 ARNETT CANCER CARE CENTER 90. 04 09003 OUTPATIENT INFUSION CENTER	9, 673 160	1	92, 010 1, 325	6, 971 51	0	90. 03
91. 00 09100 EMERGENCY	65, 874		557, 289	10, 005	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	03, 074	072, 173	337, 207	10, 003	O	92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	C	o	0	o	0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	C	1	0	ol	0	93. 00
SPECIAL PURPOSE COST CENTERS				-		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	802, 154	6, 808, 086	17, 289, 538	6, 356, 947	0	118. 00
NONREI MBURSABLE COST CENTERS			T			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	887	0	48	0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	C		0 871, 579	0 155		191. 00 192. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES 193.00 19300 NONPAID WORKERS	C		0/1,5/9	155		192. 00 193. 00
		<u>, </u>	٥١	<u> </u>	0	

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0173
Form 01/01/2019
To 12/31/2019
Date/Time Prepared:
6/29/2020 8: 33 am

					6/29/2020 8:3	3 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15. 00	16.00	
193. 01 19301 RETAIL PHARMACY	0	0	1, 119	0	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	8, 723	0	0	0	0	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	5, 777	0	0	0	0	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 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)	817, 541	6, 808, 086	18, 162, 284	6, 357, 102	0	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part |
| To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:33 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0173

Cost Centries Pensari pit in Cost A STREET							10 12/31/2019	6/29/2020 8:3	
COLAL STRYLE STRYLES SALARSTRYLES (TRIES PASAULTS TRIVES PASAULTS PASAUL						AL INTERNS 8	RESI DENTS		
TRANSFORT V & FRINCES PROM. PHANACY			Cost Center Description	SOCIAL SERVIC		SERVI CES-SALAI	RISERVI CES-OTHER	PARAMED ED	
DEMENDER SERVICE COST CLUTTERS 17.00 18.00 21.00 22.00 23.00			oost conten bescription	SOUTHE SERVI OF					
Company Comp				47.00		04.00	00.00		
1.00 0.0000 CAR PEL COSTS-BILDS A FIXT MINNINSP 1.00		GENER	AL SERVICE COST CENTERS	17.00	18.00	21.00	22.00	23.00	
1.02 00 0020 CAP REL OSTS AMBREE STAPPINE	1.00								1.00
2.00		1							ı
2.01 0.0701 CAP FILL DOSTS MANUE FOULD F - MANUESP									1
4.00									
0.00990 OTHER ADMINISTRATIVE & GENERAL									1
0.0000 DOZOO DERATION OF PLANT - NONHOSPITAL									
7. 0.01 0.0701 0.0701 0.0FEATION OF PLANT - MONINGSPITAL									1
8.00 00000 LININDRY & ILINEN SERVICE 8.00 0.00 0.00 0.00 0.00 ETARY 1.00 1.00 0.00 0.00 1.10 0.00 1.00 0.00 1.10 0.00 0.00 1.10 0.00 0.00 1.10 0.00 0.00 1.10 0.00		1	l e e e e e e e e e e e e e e e e e e e						1
10.00 01000 DETARY		1							1
11.00 01300 CAFETERIA		1							1
13.00		1	l e e e e e e e e e e e e e e e e e e e						1
14.00 01400 CENTRAL SERVICES & SUPPLY		1	l e e e e e e e e e e e e e e e e e e e						1
16.00 1600 MEDICAL RECORDS & LIBRARY 742, 203 17.00 1700 1700 1700 1700 1700 1700 1700 1700 1700 18.00 18.50 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19.00 19.50 18.00 19.00 19.50 18.00 19.00 19.50 18.00 19.00 19.50 18.00 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00 19.50 19.00		1							1
17.00 01700 SOCIAL SERVICE 742,203 1.238,429 1.70									1
18. 00 01850 PATIENT TRANSPORT SERVICES 0 1, 238, 499 21, 00 220 01 08 SERVICES-SALARY & FININGES APPRVD 0 0 0 0 1, 576, 144 273, 142 22, 00 0200 18 SERVICES-SOTHER PREM. COSTS APPRVD 0 0 0 0 1, 576, 144 273, 142 23, 00 0200 18 SERVICES-OTHER PREM. COSTS APPRVD 0 0 0 0 0 0 273, 142 23, 00 0200 0200 0200 18 SERVICES-OTHER PREM. COSTS APPRVD 0 0 0 0 0 0 0 0 0				742 20	2				1
21.00 02100 RAT SERVICES - SALARY & FRINCES APPRVD 0 0 0 0 1.576, 144 22.00 220 02300 PARAMED ED PROJE - PHARMACY 0 0 0 0 1.576, 144 22.00 220 23.00 23000 PARAMED ED PROJE - PHARMACY 0 0 0 0 0 0 273, 142 23.00 273, 142 273, 143 273,		1	ł company of the comp	742, 20	lt .	29			1
23 00 02300 PARAMED ED PRGM - PHARMACY 0 0 0 273,142 23 00		1				1			1
INPATI ENT ROUTH NE SERVICE COST CENTERS 596,096 110,003 551,276 1,261,476 0 0 0 0 0 0 0 0 1 0 0 0 1 0 0 0 0 0 0		1					1, 576, 144	070 440	
30. 00	23. 00	-)	0		273, 142	23.00
31.00 03100 INTERSIVE CARE UNIT	30. 00			596, 09	5 110, C	03 551, 276	1, 261, 476	0	30.00
33.01 0.3301 0.3400 0.0 0 0 0 0 0 33.01 35.00 0.2600 NEONATAL INTENSIVE CARE UNIT	31. 00					1		0	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		1					0		1
A3. 00 04300 NURSERY A2, 876 2, 954 0 0 0 0 0 0 0 0 0		1		46 50) 5 12.9	- 1			1
50,00 05000 0FEATI NG ROOM 0 107, 608 273 624 0 50,00 51,00 05100 RCDVERY ROOM 0 10,315 0 0 0 0 51,00 52,00 05200 05200 DELIVERY ROOM & LABOR ROOM 13,819 19,271 117,615 269,136 0 52,00 53,00 05300 ASSTHESI OLOGY 0 3,370 0 0 0 0 53,00 53,00 05300 ASSTHESI OLOGY 0 3,370 0 0 0 0 53,00 54,00 05400 RADI OLOGY-UJ AGNOSTI C 0 68,713 0 0 0 0 0 55,00 55,00 05500 RADI OLOGY-THERAPPUTI C 0 0 0 0 0 0 0 0 0		1				1			
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S2.00 05200 DELIVERY ROOM & LABOR ROOM 13,819 19,271 117,615 269,136 0 52.00 0 53.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 055.00						1	1		1
53.00 05300 AMESTHESI OLOGY 0 19,598 0 0 0 53.00 53.01 05301 ASC AMESTHESI OLOGY 0 3,370 0 0 0 53.00 53.01 05301 ASC AMESTHESI OLOGY 0 0 0 0 0 54.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 59.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 59.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 50.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 60.00 05000 LABORATORY 0 0 0 0 0 0 0 60.00 05000 05000 0 0 0 0 0				13. 81		ı	1 1		1
54.00 05400 RADI OLOGY-DI ACNOSTIC 0 68, 713 0 0 0 54.00 055.00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 55.00 055.00 05600 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0		1					· · ·		1
55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 55.00		1		(1	0		1
56.00 05900 CARDI AC CATHETERI ZATI ON 0 10, 952 0 0 0 56.00		1) 68, <i>/</i>	1			1
59.00 0590		1			10. 9			-	
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 3,716 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0 9,945 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 3,114 0 0 0 66.00 67.00 06700 0CCUPATI (ONAL THERAPY 0 1,358 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 1,358 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 1,195 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 1,179 0 0 0 0 0 0 71.00 070100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 32,458 0 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 66,296 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 66,296 0 0 0 0 0 0 74.00 07400 ENABLE DIALYSIS 0 144,659 0 0 273,142 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76.00 03950 CARDI AC CATHERI ZATION 0 95,357 0 0 0 0 0 76.00 03950 CARDI AC CATHERI ZATION 0 95,357 0 0 0 0 0 76.00 03900 CLINIC 0 5,426 0 0 0 0 0 90.01 04950 SLEEP CLINIC 0 5,426 0 0 0 0 0 90.02 07000 07000 07000 07000 0 0	59. 00	1	l e e e e e e e e e e e e e e e e e e e		1		o	0	59. 00
65. 00 06500 RESPIRATORY THERAPY 0 9,945 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 3,114 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 1,358 0 0 0 67. 00 68. 00 06800 SPECCH PATHOLOGY 0 1,358 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 22,509 0 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 1,179 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 32,458 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 66,296 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 144,659 0 0 273,142 74. 00 07400 RENAL DIALYSIS 0 2,377 0 0 273,142 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 01 07501 ASC (NON-DISTINCT PART) 0 95,357 0 0 0 0 76. 07 07697 CARDI AC CATHERI ZATION 0 95,357 0 0 0 0 76. 07 07697 CARDI AC REHABILITATION 0 85 0 0 0 0 76. 07 07697 CARDI AC REHABILITATION 0 85 0 0 0 0 76. 07 07697 CARDI AC REHABILITATION 0 54,426 0 0 0 0 76. 07 07697 CARDI AC REHABILITATION 0 54,426 0 0 0 0 76. 07 07697 CARDI AC REHABILITATION 0 54,426 0 0 0 0 76. 07 07697 CARDI AC REHABILITATION 0 54,426 0 0 0 0 76. 07 07697 CARDI AC REHABILITATION 0 604 0 0 0 77 07697 CARDI AC REHABILITATION 0 604 0 0 0 78 07697 07697 07697 07697 07697 07697 07697 79 07697 07697 07697 07697 07697 07697 07697 07697 79 07697 0769		1	ł company of the comp		1	1	0		1
66. 00 06600 06400 0CUPATI ONAL THERAPY 0 3, 114 0 0 0 66. 00 67. 00 06700 0CUPATI ONAL THERAPY 0 1, 358 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 1, 195 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 22, 509 0 0 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 22, 509 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 32, 458 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 66. 296 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 66. 296 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 2, 377 0 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 76. 01 07501 ASC (NON-DI STINCT PART) 0 95, 357 0 0 0 0 0 76. 02 07697 CARDI AC CATHERI ZATI ON 0 95, 357 0 0 0 0 76. 07 07697 CARDI AC CATHERI ZATI ON 0 0 0 0 0 76. 07 07697 CARDI AC REHABI LITATI ON 0 5, 426 0 0 0 0 90. 01 04950 SLEEP CLI NI C 0 5, 426 0 0 0 0 90. 02 09002 ARNETT CANCER CARE CENTER 0 17, 459 0 0 0 0 90. 04 09003 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 90. 00 09201 0DSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 90. 00 09201 0DSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 90. 01 09201 0DSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 91. 00 09201 0DSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 91. 00 09201 0DSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 91. 00 09000 0THERCENCY 0 0 0 0 0 0 91. 00 09000 0THERCENCY 0 0 0 0 0 0 91. 00 09000 0THERCENCY 0 0 0 0						1		-	1
67. 00 06700 OCCUPATIONAL THERAPY 0 1,358 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 1,195 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 22,509 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALLOGRAPHY 0 1,179 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 32,458 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 66,296 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 144,659 0 0 273,142 74. 00 07400 RENAL DI ALYSIS 0 2,377 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 01 07501 ASC (NON-DISTINCT PART) 0 95,357 0 0 0 0 76. 97 07697 CARDIA C REHABLI LITATI ON 0 85 0 0 0 76. 97 07697 CARDIA C REHABLI LITATI ON 0 85 0 0 0 76. 97 00450 SLEEP CLINIC 0 0 5,426 0 0 0 79. 03 09002 ARNETT CANCER CARE CENTER 0 17,459 0 0 0 0 79. 04 09003 OUTPATI ENT INFUSION CENTER 0 604 0 0 0 79. 00 09000 CLLINIC 0 0 0 0 79. 00 09000 DISSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 79. 00 09000 DISSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 79. 01 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 79. 01 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 79. 00 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 70. 00 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 70. 00 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 70. 00 09201 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 70. 00 09201 09501 05									
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70. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 179 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 32, 458 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 66, 296 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 144, 659 0 0 273, 142 73. 00 07400 RENAL DI ALYSIS 0 2, 377 0 0 0 0 74. 00 75. 01 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 76. 01 07501 ASC (NON-DI STINCT PART) 0 95, 357 0 0 0 0 0 76. 00 03950 CARDI AC CATHERI ZATI ON 0 95, 357 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATI ON 0 85 0 0 0 0 76. 97 00000 CLINIC 0 0 0 0 0 79. 01 04950 SLEEP CLINIC 0 5, 426 0 0 0 0 79. 04950 SLEEP CLINIC 0 5, 426 0 0 0 79. 04950 SLEEP CLINIC 0 5, 426 0 0 0 79. 04950 ARNETT CANCER CARE CENTER 0 17, 459 0 0 0 79. 04 09003 00TPATI ENT INFUSI ON CENTER 0 136, 515 19, 625 44, 908 0 79. 04 09003 00TPATI ENT INFUSI ON CENTER 0 136, 515 19, 625 44, 908 0 79. 04 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0 70. 04 09500 OBSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 70. 04 09500 OBSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 70. 04 09000 OBSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 70. 04 09000 OBSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 70. 04 09000 OFF (CANCER) 0 0 0 0 70. 00 09000 00 00 00 00 00							0	-	
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75. 01 07501 ASC (NON-DISTINCT PART) 0 95, 357 0 0 0 75. 01 76. 00 03950 CARDI AC CATHERI ZATI ON 0 0 0 0 0 0 75. 01 76. 00 07697 CARDI AC REHABILI TATI ON 0 85 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABILI TATI ON 0 85 0 0 0 0 76. 97 001TPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 90. 00 90. 01 04950 SLEEP CLI NI C 0 5, 426 0 0 0 0 0 90. 01 90. 03 09002 ARNETT CANCER CARE CENTER 0 17, 459 0 0 0 0 90. 03 90. 04 09003 OUTPATIENT INFUSION CENTER 0 604 0 0 0 90. 03 90. 04 09003 OUTPATIENT INFUSION CENTER 0 604 0 0 0 90. 04 91. 00 09100 EMERGENCY 0 136, 515 19, 625 44, 908 0 91. 00 92. 01 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 92. 01 93. 00 04951 OTHER OUTPATIENT SERVICES 0 0 0 0 0 0 93. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 742, 203 1, 023, 036 688, 789 1, 576, 144 273, 142 118. 00 NONREI MBURSABLE COST CENTERS		1) 2, 3)	i			
76. 97 07697 CARDI AC REHABILITATION 0 85 0 0 0 76. 97					95, 3				
OUTPATI ENT SERVI CE COST CENTERS OUTPATI ENT SERVI CE COST CENTERS 90. 00				(0	0	1		1
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92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 92. 01 93. 00 04951 OTHER OUTPATI ENT SERVI CES 0 0 0 0 0 93. 00					130, 5	19, 023	44, 908	0	
SPECIAL PURPOSE COST CENTERS					o	0	o o	0	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 742, 203 1, 023, 036 688, 789 1, 576, 144 273, 142 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00	93. 00				0	0 (0	0	93. 00
NONREI MBURSABLE COST CENTERS 0 0 0 0 190.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00	118 00			7/12 20	3 1 023 0	36 699 700	1 576 1/4	272 1/2	118 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00	110.00			142, 20	J 1, 023, C	JOI 000, 76	7, 1, 570, 144	273, 142	1. 10. 00
191. 00 19100 RESEARCH 0 0 0 0 0 191. 00		19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		-	1			
	191. 00) 19100	RESEARCH)	U () O	0	1191. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH ARNETT HOSPITAL Provider CCN: 15-0173

		OTHER GENERAL	INTERNS &	RESI DENTS		
		SERVI CE				
Cost Center Description	SOCIAL SERVICE	PATI ENT	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
		TRANSPORT	Y & FRINGES	PRGM. COSTS	PRGM -	
		SERVI CES			PHARMACY	
	17.00	18. 00	21. 00	22. 00	23.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	211, 339	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 RETAIL PHARMACY	0	4, 054	0	0	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	0	0	0	0	0	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPITAL	0	0	0	0	0	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	742, 203	1, 238, 429	688, 789	1, 576, 144	273, 142	202. 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: 15-0173

				To	12/31/2019	Date/Time Prepared: 6/29/2020 8:33 am
	Cost Center Description	Subtotal	Intern &	Total		072772020 0. 33 dill
			Residents Cost & Post			
			Stepdown			
		24. 00	Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS	21.00	20.00	20.00		
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP					1. 00 1. 01
1.01	00101 CAP REL COSTS INTEREST EXPENSE					1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
2. 01 4. 00	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 01 4. 00
5. 01	00570 ADMI TTI NG					5. 01
5.06	00590 OTHER ADMINISTRATIVE & GENERAL					5. 06
7. 00 7. 01	OO700 OPERATION OF PLANT OO701 OPERATION OF PLANT - NONHOSPITAL					7. 00 7. 01
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					16. 00
17. 00	01700 SOCI AL SERVI CE					17. 00
18. 00 21. 00	01850 PATIENT TRANSPORT SERVICES 02100 L&R SERVICES-SALARY & FRINGES APPRVD					18. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD					22. 00
23. 00	02300 PARAMED ED PRGM - PHARMACY					23. 00
30. 00	O3000 ADULTS & PEDIATRICS	62, 322, 266	-1, 812, 752	60, 509, 514		30.00
31. 00	03100 I NTENSI VE CARE UNI T	7, 699, 820		7, 699, 820		31. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0		33.00
33. 01 35. 00	03301 BURN INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	6, 129, 809	0	0 6, 129, 809		33. 01 35. 00
43. 00	04300 NURSERY	1, 819, 432	0	1, 819, 432		43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	15, 123, 083	-897	15, 122, 186		50. 00
51. 00	05100 RECOVERY ROOM	1, 865, 177	-897	1, 865, 177		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 874, 832	-386, 751	6, 488, 081		52.00
53. 00 53. 01	05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY	6, 890, 158 92, 154	0	6, 890, 158 92, 154		53. 00 53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 463, 556	0	9, 463, 556		54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	702 702	0	702 702		55. 00
56. 00 59. 00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	792, 793 4, 523, 487	0	792, 793 4, 523, 487		56. 00 59. 00
60.00	06000 LABORATORY	14, 583, 463	0	14, 583, 463		60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	958, 366		958, 366		63.00
65. 00 66. 00	06600 PHYSI CAL THERAPY	3, 269, 916 1, 073, 884	0	3, 269, 916 1, 073, 884		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	668, 048	0	668, 048		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	411, 571 2, 588, 765	0	411, 571 2, 588, 765		68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	137, 438		137, 438		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 179, 398	0	14, 179, 398		71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	17, 516, 553 54, 412, 001	0	17, 516, 553 54, 412, 001		72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	1, 266, 940	0	1, 266, 940		74. 00
75. 00 75. 01	07500 ASC (NON-DISTINCT PART) 07501 ASC (NON-DISTINCT PART)	9, 369, 936	0	0 9, 369, 936		75. 00 75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON	9, 309, 930	0	9, 309, 930		76. 00
76. 97	07697 CARDIAC REHABILITATION	852, 457	0	852, 457		76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	0		90.00
90. 01	04950 SLEEP CLINIC	1, 067, 492	0	1, 067, 492		90. 01
90. 03	09002 ARNETT CANCER CARE CENTER	2, 626, 005	0	2, 626, 005		90. 03
90. 04 91. 00	09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY	132, 754 13, 219, 644	-64, 533	132, 754 13, 155, 111		90. 04 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	.5,2.7,544	04, 333			92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0		92. 01
93. 00	O4951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0		93. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	261, 931, 198	-2, 264, 933	259, 666, 265		118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	570, 822	0	570, 822		190. 00
	19100 RESEARCH	0	· · · · · · · · · · · · · · · · · · ·	0		191. 00
			<u> </u>	<u>'</u>		

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0173
Period: From 01/01/2019 Form CMS-2552-10

Provider CCN: 15-0173
To 12/31/2019 Date/Time Prepared:

			'	12/31/201	6/29/2020 8: 33 am
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	165, 647, 193	0	165, 647, 193	3	192. 00
193.00 19300 NONPALD WORKERS	0	0	C		193. 00
193.01 19301 RETAIL PHARMACY	6, 477, 000	0	6, 477, 000		193. 01
193. 02 19302 WHI TE HOSPI TAL	2, 545, 133	0	2, 545, 133	3	193. 02
193. 03 19303 HOSPI CE	3, 134	0	3, 134	1	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	1, 731, 851	0	1, 731, 851		193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	C		194. 00
200.00 Cross Foot Adjustments	0	0	C		200. 00
201.00 Negative Cost Centers	0	0	C		201. 00
202.00 TOTAL (sum lines 118 through 201)	438, 906, 331	-2, 264, 933	436, 641, 398	3	202. 00

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 8:33 am Provider CCN: 15-0173

Control Content Description							6/29/2020 8: 3	
Part					CAPITAL REI	LATED COSTS		
CAMBRICAL STRUCT COST CENTRES CONTROL STRUCT COST CENTRES CO		Cost Center Description	Assigned New Capital	BLDG & FIXT		INTEREST	MVBLE EQUIP	
DEFENDED SERVICE COST CERTIESS				1. 00	1. 01	1. 02	2.00	
1.01 1.02			-					
1.02 001002 CAP REL COSTS INTERST LEPTINGS								•
2.00		00102 CAP REL COSTS INTEREST EXPENSE						•
0.000 DO 0000 DO 0000 DO 0								•
0.0570 AMILTING								•
0.000 0.000 OTHER ADMINISTRATIVE & GENERAL 0 184, 542 10.2, 301 199, 277 346, 600 7.00 7.01 7.00 2070 0.00710		1 1	0	0 42 974	19 309	0 45 473	-	•
0.000 0.00			0		·	· · ·	•	ı
8.00 0.0800 AUNIDRY & LINEN SERVICE 0 0 0 8 8.00		00700 OPERATION OF PLANT	0			l		•
9.00 0.0900 IUSEREEPING			0	0		0		•
10.00 01000 DETARY 0 138,492 0 146,544 200,116 10.00			0	0 84 372		0 89 278	-	•
13.00 01300 MIRES INC. ADMINISTRATION 0 107, 412 0 113, 658 201, 742 13.00 14.00 14000 (CHENTAL SERVICES & SUPPLY) 0 327, 280 481 346, 308 614, 696 14.00 14.00 14000 (CHENTAL SERVICES & SUPPLY) 0 0 0 0 0 0 0 0 0		1 1	0					1
14.00 01400 CENTRAL SERVICES & SUPPLY 0 327, 280 481 346, 308 614, 696 14.00 15.00 16.00 01600 MEDICAL, RECORDS & LIBRARY 0 68, 934 316 72, 942 17.00 10.00 10.00 0 0 0 0 0 0 0 10.00 17.00 18.00 18.50			0					1
15.00 01500 PHARMACY 0 0 0 0 0 0 0 16.00			0	•				1
16.00 16.00 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 17.00 170.00 170.00 180.00 185.00 1		1 1	0			· · ·		1
18.00 01850 PATIENT TRANSPORT SERVICES 0 21,682 0 22,943 40,724 18.00 21.00 2010 018 SERVICES-SALARY & FINNESS APPRVD 0 0 0 0 0 21.00 20		1 1	0			l		•
21.00			0	-	_	0	-	•
22 00 02200 RAY SERVI CES-OTHER PRGM. COSTS APPRVD 0 0 0 10, 842 0 0 22 00			0			22, 943		•
INPATI ENT ROUTINE SERVICE COST CENTERS 1,770,630 0 1,873,578 3,325,592 30.00 30.0		02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	o			o	-	1
30. 00 303000 JOULTS & PEDIATRICS 0 1,770,630 0 1,875,578 3,325,592 30. 00 33. 00 33.00 INTENSIVE CARE UNIT 0 0 0 0 0 34.734 31. 30. 00 33.00	23. 00		0	2, 014	97	2, 131	3, 782	23. 00
31.00 03100 INTERSIVE CARE UNIT	30.00		0	1 770 420	1 0	1 072 570	2 225 502	20.00
133.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00			0					1
130 02060 NEONATAL INTENSIVE CARE UNIT 0 139, 460 0 147, 568 261, 933 35, 00			0					1
A3 .00 O4300 NURSEREY			0	-	_	0		•
ANCILLARY SERVICE COST CENTERS			0	•		I		
15.1 0.0 0.5100 RECOVERY ROOM 0.0 0.5 5.52 0.0 0.9 374 123, 139 51.0 0.52 0.0 0.53 0.0 0.53 0.0 0.53 0.0 0.53 0.0 0.53 0.0 0.53 0.0 0.53 0.0 0.53 0.0 0.53 0.0 0.53 0.0	43.00		0	03, 203		00, 774	122, 404	73.00
1.0 1.0		1 1	0			I	•	ı
53.00 05300 ANESTHESI OLOGY 0 19,715 931 20,862 37,030 53,00 53.01 05301 ASC ANESTHESI OLOGY 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 245,218 0 259,475 460,568 54,00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55,00 50.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 29,987 0 31,730 55,321 56.00 05600 RADIO OLOGO RADIO OLOGO RADIO AGNOTORY 150,000 18,750 17,429 279,437 56.00 05600 RADIO RADIO RESPIRATORY 0 12,461 0 129,581 230,005 59,000 63.00 05000 LABORATORY RADIO RESPIRATORY 0 11,562 20,523 63,000 63.00 05000 RADIO RADIO RESPIRATORY 14,777 0 11,562 20,523 63,000 65.00 05600 RESPIRATORY 14ERAPY 0 12,191 0 12,900 22,898 66,000 66.00 06600 06600 PHYSI CAL THERAPY 0 5,307 0 5,616 9,968 66,000 68.00 06800 SPEECH PATHOLOGY 0 4,683 0 4,955 8,796 68,000 69.00 06900 ELECTROCARD IOLOGY 0 35,716 0 37,792 67,081 69,000 71.00 0700 DELECTROCARD IOLOGY 0 35,716 0 37,792 67,081 69,000 71.00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 71.00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 70.00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 70.00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 70.00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 70.00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 70.00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0			0			l		•
SALO 05400 RADI OLOGY-DI AGNOSTIC 0 245,218 0 259,475 460,568 54,00 55.00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTIC 0 0 29,987 0 31,730 56,321 56,00 05600 RADIO ISOTOPE 0 129,987 0 31,730 56,321 56,00 05600 RADIO ISOTOPE 0 129,987 0 31,730 56,321 56,00 05000 CABORATORY 0 148,779 7,447 157,429 279,437 60.00 06000 LABORATORY 0 148,779 7,447 157,429 279,437 60.00 06000 LABORATORY 157,479 0 11,562 20,523 63.00 06300 RESPIRATORY THERAPY 0 15,797 0 16,716 29,671 65.00 05600 RESPIRATORY THERAPY 0 12,191 0 12,900 22,898 66.00 06000 PHYSI CAL THERAPY 0 5,307 0 5,616 9,968 67.00 06000 SPECEH PATHOLOGY 0 4,683 0 4,955 8,796 68.00 06000 SPECEH PATHOLOGY 0 35,716 0 37,792 67,081 69.00 00000 ELECTROCARDI OLOGY 0 35,716 0 37,792 67,081 69.00 0000 ELECTROCARDI OLOGY 0 35,716 0 37,792 67,081 69.00 0 0 0 0 0 0 0 0 0			0			· · ·		1
55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 55.00	53. 01	05301 ASC ANESTHESI OLOGY	0	0	718	o	0	53. 01
56.00 05900 CARDI AC CATHETERI ZATI ON 0 29, 987 0 31, 730 56, 321 56, 00			0			259, 475		1
59.00 05900 CARDI AC CATHETERI ZATI ON 0 122, 461 0 129, 581 230, 005 59.00			0	O		31, 730		•
63.00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 10, 927 0 11, 562 20, 523 63.00			0	•		· · ·		1
65.00 06500 RESPIRATORY THERAPY 0 15,797 0 16,716 29,671 65.00 66.00 06600 PHYSI CAL THERAPY 0 12,191 0 12,900 22,898 66.00 66.00 060700 0CUPATI IONAL THERAPY 0 5,307 0 5,616 9,968 67.00 67.00 0607000 06070000 06070000 06070000 06070000 06070000 060700000 0607000000 060700000000 06070000000000			0			l		•
66. 00 06600 PHYSI CAL THERAPY 0 12, 191 0 12, 900 22, 898 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 5, 307 0 5, 616 9, 968 67. 00 68. 00 06800 SPEECT PATHOLOGY 0 4,683 0 4,955 8,796 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 69. 00			0	•		l		
68. 00 06800 SPEECH PATHOLOGY 0 4, 683 0 4, 955 8, 796 68. 00 69. 00 00 00 00 37, 792 67, 081 69. 00 70. 00 70. 00 00 0 0 0 0 0 0 0		1 1	o				·	1
69. 00 06900 ELECTROCARDIOLOGY 0 35, 716 0 37, 792 67, 081 69. 00 70. 00			0					
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70. 00 71. 00 71. 00 71. 00 710.			0			l		1
71. 00		1 1	0			37, 742		1
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	o	0	
74. 00 07400 RENAL DIALYSIS 0 24, 102 0 25, 503 45, 268 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 75. 00 75. 00 75. 01 70. 00 75. 01 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 75. 01 76. 00 03950 CARDIAC CATHERIZATION 0 0 0 0 17, 315 0 0 0 76. 00 76. 00 76. 00 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	-	1
75. 00			0	24. 102	0	25, 503	-	
76. 00			Ö			0		1
76. 97 O7697 CARDI AC REHABILITATION O O O 17, 315 O O 76. 97 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLI NI C O O O O O O O O O O O O O O O O O O			0			0		1
OUTPATIENT SERVICE COST CENTERS O		1 1	0			0		1
90. 01	70. 77		0		17,313	<u> </u>		70.77
90. 03		1 1	0			0		•
90. 04			0	0		0	-	
92. 00 09200 08SERVATION BEDS (NON-DISTINCT PART) 92. 00 09201 08SERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 92. 01 093. 00 04951 07HER OUTPATIENT SERVICES 0 0 0 0 0 0 0 0 93. 00 05 05 05 05 05 05 05		1 1	0	9, 959		10, 538	-	•
92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 93. 00 04951 OTHER OUTPATIENT SERVICES 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 6, 089, 310 495, 578 6, 443, 355 11, 436, 938 NONREI MBURSABLE COST CENTERS	91.00	09100 EMERGENCY	o	•				91. 00
93. 00 04951 OTHER OUTPATIENT SERVICES 0 0 0 0 0 0 93. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 6, 089, 310 495, 578 6, 443, 355 11, 436, 938 118. 00 NONREI MBURSABLE COST CENTERS				2	_		^	•
SPECIAL PURPOSE COST CENTERS			0			-		1
NONREI MBURSABLE COST CENTERS		SPECIAL PURPOSE COST CENTERS	-		_			
	118.00		0	6, 089, 310	495, 578	6, 443, 355	11, 436, 938]118. 00
	190.00		0	38, 869	0	41, 129	73, 004	190. 00

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 8:33 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS IU HEALTH ARNETT HOSPITAL Provider CCN: 15-0173

					6/29/2020 8: 3	3 am
			CAPITAL RE	LATED COSTS		
			I			
Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT -		MVBLE EQUIP	
	Assigned New		NONHOSP	INTEREST		
	Capi tal			EXPENSE		
	Related Costs					
	0	1. 00	1. 01	1. 02	2. 00	
191. 00 19100 RESEARCH	0	0	C	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	19, 450	1, 575, 070	20, 581	36, 531	192. 00
193. 00 19300 NONPALD WORKERS	0	0	C	0	0	193. 00
193. 01 19301 RETAIL PHARMACY	0	17, 140	C	18, 136	32, 192	193. 01
193. 02 19302 WHI TE HOSPI TAL	0	23, 758	7, 477	25, 140	44, 623	193. 02
193. 03 19303 HOSPI CE	0	0	C	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	0	20, 964	7, 282	22, 183	39, 375	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	C	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	6, 209, 491	2, 085, 407	6, 570, 524	11, 662, 663	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0173

					lo	12/31/2019	Date/lime Prep 6/29/2020 8:3	
		Cost Center Description	CAPI TAL RELATED COSTS MVBLE EQUI P - NONHOSP	Subtotal 2A	EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMI TTI NG	OTHER ADMI NI STRATI VE & GENERAL 5. 06	
	GENER	AL SERVICE COST CENTERS					J. 33	
1.00 1.01 1.02 2.00 2.01 4.00 5.01 5.06 7.00 7.01 8.00 9.00 10.00 11.00	00101 00102 00200 00201 00400 00570 00590 00701 00800 00900 01100 01300	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - NONHOSP CAP REL COSTS INTEREST EXPENSE CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - NONHOSP EMPLOYEE BENEFITS DEPARTMENT ADMITTING OTHER ADMINISTRATIVE & GENERAL OPERATION OF PLANT OPERATION OF PLANT - NONHOSPITAL LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION	0 25, 604 142, 372 6, 520 14, 233 0 1, 312 0 0	0 213, 163 971, 092 4, 566, 038 24, 460 0 334, 373 545, 152 383, 241 422, 812	0 0 0 0 0 0	213, 163 0 0 0 0 0 0 0	971, 092 40, 358 12, 911 52 12, 912 6, 197 858 13, 931	1. 00 1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	669 440	1, 289, 434		0	36, 973 13, 155	14.00
15. 00 16. 00 17. 00 18. 00 21. 00 22. 00 23. 00	01600 01700 01850 02100 02200 02300	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE PATIENT TRANSPORT SERVICES I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM - PHARMACY IENT ROUTINE SERVICE COST CENTERS	440 0 0 0 0 0 15, 088 135	272, 103 0 0 85, 349 0 25, 930 8, 159	0 0 0 0	0 0 0 0 0 0	13, 155 0 1, 627 2, 488 1, 511 3, 368 579	
30. 00		ADULTS & PEDIATRICS	0	6, 969, 800	0	19, 017	96, 269	30. 00
31. 00 33. 00 33. 01 35. 00	03300 03301 02060	INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0 0 0 0	680, 579 0 0 548, 961	0 0 0	2, 199 0 0 2, 223	0 0 11, 045	
43. 00		NURSERY LARY SERVICE COST CENTERS	0	256, 661	0	511	3, 035	43. 00
67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 75. 01 75. 01 76. 00 76. 97	05000 05100 05200 05300 05300 05400 05500 05600 06600 06600 06700 07100 07100 07500 07501 07501 07501 07501 07501	LARY SERVICE COST CENTERS OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM ANESTHESI OLOGY ASC ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C RADI AC CATHETERI ZATI ON LABORATORY BLOOD STORING, PROCESSING & TRANS. RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY MEDI CAL SUPPLI ES CHARGED TO PATI ENTS IMPL. DEV. CHARGED TO PATI ENTS DRUGS CHARGED TO PATI ENTS RENAL DI ALYSI S ASC (NON-DI STI NCT PART) ASC (NON-DI STI NCT PART) CARDI AC CATHERI ZATI ON CARDI AC REHABI LI TATI ON TI ENT SERVI CE COST CENTERS CLI FILE CLI NI C	2, 947 0 1, 295 999 0 0 10, 364 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 751, 061 258, 075 879, 112 79, 833 1, 717 965, 261 0 118, 038 482, 047 603, 456 43, 012 62, 184 47, 989 20, 891 18, 434 140, 589 0 0 94, 873 0 494, 497 0 41, 412	000000000000000000000000000000000000000	18, 603 1, 783 3, 331 3, 388 583 11, 879 0 1, 893 7, 696 9, 663 642 1, 719 538 235 207 3, 891 204 5, 611 11, 461 25, 008 411 0 16, 485 0 15	2, 234 1, 414 856 5, 129 298 20, 813 25, 768 105, 589 2, 545 0 16, 568 0 1, 703	52. 00 53. 00 53. 01 54. 00 55. 00 56. 00 60. 00 63. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 01 76. 00 76. 97
90. 00 90. 01 90. 03 90. 04 91. 00 92. 00 92. 01 93. 00	04950 09002 09003 09100 09200 09201 04951	SLEEP CLINIC ARNETT CANCER CARE CENTER OUTPATIENT INFUSION CENTER EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART) OTHER OUTPATIENT SERVICES AL PURPOSE COST CENTERS	48, 431 107, 446 0 0	83, 231 184, 651 39, 202 1, 148, 003 0	0 0 0 0	938 3, 018 104 23, 600 0	1, 956	90. 01 90. 03 90. 04
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	689, 694	25, 154, 875	0	176, 856	599, 414	118. 00
	19000	I MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	0	153, 002 0	1	0		190. 00 191. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS IU HEALTH ARNETT HOSPITAL Provider CCN: 15-0173

					6/29/2020 8: 3	<u>3 am</u>
	CAPI TAL RELATED COSTS					
Cost Center Description	MVBLE EQUIP -	Subtotal	EMPLOYEE	ADMI TTI NG	OTHER	
	NONHOSP		BENEFITS		ADMI NI STRATI VE	
			DEPARTMENT		& GENERAL	
	2. 01	2A	4.00	5. 01	5. 06	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 192, 036	3, 843, 668	0	35, 606	347, 793	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 RETAIL PHARMACY	0	67, 468	0	701	14, 153	193. 01
193. 02 19302 WHI TE HOSPI TAL	10, 406	111, 404	0	0	5, 304	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	7	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	10, 135	99, 939	0	0	3, 540	193. 04
194.00 07950 MARKETI NG/PUBLI C RELATIONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments		0				200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 902, 271	29, 430, 356	0	213, 163	971, 092	202. 00

Provider CCN: 15-0173

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 8:33 am

			'	0 12/31/2019	6/29/2020 8: 3	
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT - NONHOSPITAL	LINEN SERVICE			
	7. 00	7. 01	8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	7.00	7.01	0.00	7. 00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 O0101 CAP REL COSTS-BLDG & FLXT - NONHOSP						1. 01
1.02 00102 CAP REL COSTS NTEREST EXPENSE						1. 02
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 O0201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00570 ADMI TTI NG						5. 01
5. 06 00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
7. 00 00700 OPERATION OF PLANT	4, 606, 396	07 074				7.00
7. 01 00701 OPERATION OF PLANT - NONHOSPITAL	0	37, 371				7. 01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	80, 552	0 18				8. 00 9. 00
10. 00 01000 DI ETARY	132, 221	0	1	6, 083	689, 653	10.00
11. 00 01100 CAFETERI A	92, 951	0		4, 276	007, 033	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	102, 549	0	0	4, 718	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	312, 461	9	0		0	14. 00
15. 00 01500 PHARMACY	65, 813	6	0	3, 064	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	Ö	Ö		0	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	o	0	17. 00
18.00 01850 PATIENT TRANSPORT SERVICES	20, 701	0	0	952	0	18. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	208	0	1, 222	0	22. 00
23.00 O2300 PARAMED ED PRGM - PHARMACY	1, 923	2	0	99	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 690, 459	0			629, 727	30.00
31. 00 03100 INTENSIVE CARE UNIT	165, 068	0	_	7, 594	45, 327	31.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
33. 01 03301 BURN INTENSIVE CARE UNIT	122 145	0	0	(12(0	33. 01
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	133, 145	0	3		0	35.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	62, 251	0	3	2, 864	0	43. 00
50. 00 05000 OPERATING ROOM	423, 475	41	0	19, 721	0	50.00
51. 00 05100 RECOVERY ROOM	62, 594	0		2, 880	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	213, 221	0		9, 810	14, 599	52.00
53. 00 05300 ANESTHESI OLOGY	18, 823	18		·	0	53.00
53. 01 05301 ASC ANESTHESI OLOGY	0	14	•		0	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	234, 115	0			0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	28, 629	0	0	1, 317	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	116, 916	0	0	5, 379	0	59. 00
60. 00 06000 LABORATORY	142, 043	143	0	7, 374	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	10, 432	0	0	480	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	15, 082	0	0		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	11, 639	0	0	535	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 067	0	1	233	0	67.00
68. 00 06800 SPEECH PATHOLOGY	4, 471	0	0		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	34, 099	0	0	1, 569	0	69.00
70.00 O7000 ELECTROENCEPHALOGRAPHY 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74. 00 07400 RENAL DIALYSIS	23, 011	0		1, 059	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	23,011	0	0	1,037	0	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	0	3, 963	0	23, 301	0	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	0	0,700	0	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	332	l o	1, 951	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 04950 SLEEP CLINIC	0	667	0	3, 922	0	90. 01
90.03 09002 ARNETT CANCER CARE CENTER	0	1, 480	0	8, 701	0	90. 03
90.04 09003 OUTPATIENT INFUSION CENTER	9, 508	0	0	437	0	90. 04
91. 00 09100 EMERGENCY	278, 437	0	0	12, 810	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)						92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0	1 0	<u> </u>	0	93. 00
SPECIAL PURPOSE COST CENTERS 119 00 SUBTOTALS (SUM OF LLNES 1 through 117)	4 401 / 5/	4 001	F2	242 402	400 (53	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	4, 491, 656	6, 901	52	243, 403	689, 653	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37, 109	0	0	1, 707	Ω	190. 00
191. 00 19100 RESEARCH	37, 109		0			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	18, 569	30, 187		_		192.00
193. 00 19300 NONPALD WORKERS	0		Ö			193. 00
	•			1		

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0173	Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am

					6/29/2020 8: 3	3 am
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT -	LINEN SERVICE			
		NONHOSPI TAL				
	7. 00	7. 01	8. 00	9. 00	10.00	
193. 01 19301 RETAIL PHARMACY	16, 364	0	0	753	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	22, 683	143	0	1, 886	0	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	20, 015	140	0	1, 742	0	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 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)	4, 606, 396	37, 371	52	427, 855	689, 653	202. 00

Provider CCN: 15-0173

| 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 8:33 am

		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	6/29/2020 8: 33 MEDI CAL	
				ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	CENED	AL SERVICE COST CENTERS	11. 00	13. 00	14. 00	15. 00	16.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
1.01		CAP REL COSTS-BLDG & FIXT - NONHOSP						1. 01
1.02	1	CAP REL COSTS INTEREST EXPENSE						1. 02
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01 4. 00		CAP REL COSTS-MVBLE EQUIP - NONHOSP EMPLOYEE BENEFITS DEPARTMENT						2. 01 4. 00
5. 01		ADMITTING						5. 01
5. 06		OTHER ADMINISTRATIVE & GENERAL						5. 06
7.00		OPERATION OF PLANT						7. 00
7. 01	1	OPERATION OF PLANT - NONHOSPITAL						7. 01
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10. 00		DI ETARY						10. 00
11. 00		CAFETERI A	405, 361					11. 00
13.00		NURSI NG ADMI NI STRATI ON	18, 890		4 (5) 0(4			13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	3, 054 16, 681	0	1, 656, 361 6, 612	377, 434		14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	10, 001		0, 012	377, 434	0	16. 00
17. 00	1	SOCIAL SERVICE	3, 520	o	0	0	0	17. 00
18. 00	1	PATIENT TRANSPORT SERVICES	6, 965		370	0	0	18. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	2, 922		0	0	0	21. 00
22. 00 23. 00		I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM - PHARMACY	1, 888 1, 100		0	0	0	22. 00 23. 00
20.00		IENT ROUTINE SERVICE COST CENTERS	1, 100	<u> </u>	<u> </u>	<u> </u>	0	20.00
30.00		ADULTS & PEDIATRICS	137, 236		119, 081	1, 450	0	30.00
31.00	1	INTENSIVE CARE UNIT	15, 321	39, 752	21, 840	205	0	31.00
33. 00 33. 01	1	BURN INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 33. 01
35. 00	1	NEONATAL INTENSIVE CARE UNIT	13, 416	1	7, 430	132	0	35. 00
43. 00		NURSERY	4, 013	8, 652	0	0	0	43. 00
		LARY SERVICE COST CENTERS						
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	28, 517 4, 136	42, 557 12, 493	173, 651 1, 773	364 3	0	50. 00 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	14, 248		17, 509	18	0	51.00
53. 00		ANESTHESI OLOGY	13, 002	1, 356	16, 499	226	0	53. 00
53. 01	1	ASC ANESTHESI OLOGY	0	0	5, 548	17	0	53. 01
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	21, 684		55, 857	305 O	0	54.00
56. 00		RADI OLOGI - THERAPEUTI C	1, 219	0	0 688	19	0	55. 00 56. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	7, 929		31, 683	183	Ö	59. 00
60.00		LABORATORY	16, 654		0	0	0	60.00
63.00		BLOOD STORING, PROCESSING & TRANS.	11 712	0	10.705	0	0	63. 00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	11, 713 3, 190		18, 785 81	156 0	0	65. 00 66. 00
67. 00		OCCUPATI ONAL THERAPY	2, 086		10	Ö	Ö	67. 00
68. 00	1	SPEECH PATHOLOGY	1, 087		65	0	0	68. 00
69. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	9, 240		861	39	0	69. 00
70. 00 71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	484 0	0	60 432, 340	0	0	70. 00 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö	529, 360	Ö	0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	o	0	372, 509	0	73.00
74.00	1	RENAL DIALYSIS	0	0	638	50	0	74. 00
75. 00 75. 01		ASC (NON-DISTINCT PART) ASC (NON-DISTINCT PART)	0		74, 820	0 738	0	75. 00 75. 01
76. 00		CARDI AC CATHERI ZATI ON	0	Ö	0	0	Ö	76. 00
76. 97		CARDIAC REHABILITATION	0	0	270	0	0	76. 97
00.00		TIENT SERVICE COST CENTERS		ا	0	٥	0	00.00
90. 00 90. 01	1	CLINIC SLEEP CLINIC	0	0	0 1, 603	0	0	90. 00 90. 01
90. 03	1	ARNETT CANCER CARE CENTER	4, 796	·	8, 391	414	Ö	90. 03
90. 04	1	OUTPATIENT INFUSION CENTER	79		121	3	0	90.04
91.00		EMERGENCY	32, 662	57, 230	50, 823	594	0	91.00
92. 00 92. 01		OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	0	0	0	o	0	92. 00 92. 01
93. 00	1	OTHER OUTPATIENT SERVICES	0		0	o	o	93. 00
	SPECI	AL PURPOSE COST CENTERS			-	-1	-	
118.00	-	SUBTOTALS (SUM OF LINES 1 through 117)	397, 732	562, 900	1, 576, 769	377, 425	0	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	440	O	1	ol	0	190. 00
		RESEARCH	0	1	0	0		191. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	O	79, 486	9	0	192. 00
193. 00	19300	NONPALD WORKERS	0	0	0	이	0	193. 00

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0173 | Period: From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared:

					6/29/2020 8: 3	3 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14. 00	15. 00	16. 00	
193. 01 19301 RETAIL PHARMACY	0	0	102	0	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	4, 325	0	0	0	0	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	2, 864	0	0	0	0	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	75, 965	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	481, 326	562, 900	1, 656, 361	377, 434	0	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part II |
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ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0173

					0 12/31/2019	6/29/2020 8: 3	
			OTHER GENERAL	INTERNS &	RESI DENTS		
	Coot Conton Decemintion	COCLAL CEDVICE	SERVI CE	CEDVICES SALAD	CEDVI CEC OTHER	DADAMED ED	
	Cost Center Description	SOCIAL SERVICE	PATI ENT TRANSPORT	Y & FRINGES	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM -	
			SERVI CES	I a randes	1 1.CM. 00010	PHARMACY	
		17. 00	18. 00	21.00	22. 00	23. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS - BLDG & FLXT - NONHOSP						1. 01
1. 02 2. 00	00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUIP						1. 02
2. 00	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 00 2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING						5. 01
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11.00
13. 00 14. 00	01400 CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY	•					15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00	01700 SOCIAL SERVICE	5, 147					17. 00
18.00	01850 PATIENT TRANSPORT SERVICES	C	116, 825	5			18. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	C	0				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	C	0		32, 616		22. 00
23.00	02300 PARAMED ED PRGM - PHARMACY	C	0)		11, 862	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1	T	1		
30.00	03000 ADULTS & PEDI ATRI CS	4, 133					30.00
31. 00	03100 NTENSI VE CARE UNI T	298		1			31.00
33. 00 33. 01	03300 BURN INTENSIVE CARE UNIT 03301 BURN INTENSIVE CARE UNIT	C	0	1			33. 00 33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	323	1	ł			35. 00
43. 00	04300 NURSERY	297	279				43. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	C	10, 160)			50. 00
51.00	05100 RECOVERY ROOM	C	974				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	96					52. 00
53. 00	05300 ANESTHESI OLOGY	C	1, 850				53. 00
53. 01	05301 ASC ANESTHESI OLOGY	C	318				53. 01
54.00	05400 RADI OLOGY - DI AGNOSTI C		6, 488				54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		1, 034				55. 00 56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		4, 203				59. 00
60. 00	06000 LABORATORY		5, 278				60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		351	1			63. 00
65.00	06500 RESPI RATORY THERAPY	C	939				65.00
66.00	06600 PHYSI CAL THERAPY	C	294				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	128	3			67. 00
68. 00	06800 SPEECH PATHOLOGY	C	113	1			68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	2, 125	1			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		111	1			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS		3, 065				71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS		6, 259 13, 658	1			72. 00 73. 00
74.00	07400 RENAL DIALYSIS		224	1			74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0	1			75. 00
75. 01	07501 ASC (NON-DISTINCT PART)		9, 003				75. 01
76.00	03950 CARDI AC CATHERI ZATI ON	C	O	i			76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	C	8	3			76. 97
	OUTPATIENT SERVICE COST CENTERS			,			
90.00	09000 CLI NI C	C	0				90. 00
	04950 SLEEP CLINIC	C	512				90. 01
90. 03	09002 ARNETT CANCER CARE CENTER		1, 648				90. 03
90. 04			12 990	1			90. 04
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)		12, 889	1			91. 00 92. 00
92. 00	09201 OBSERVATION BEDS (NON-DISTINCT PART)		O				92.00
93. 00	04951 OTHER OUTPATIENT SERVICES			1			93. 00
, 5. 55	SPECIAL PURPOSE COST CENTERS	,		1			1
118.00		5, 147	96, 588	0	0	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	•				190. 00
191.00	19100 RESEARCH	(C	0)			191. 00
							

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | Date/Time Prepared: | 6/29/2020 8:33 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS IU HEALTH ARNETT HOSPITAL Provider CCN: 15-0173

					0/29/2020 8:3	o alli
		OTHER GENERAL	INTERNS &	RESI DENTS		
		SERVI CE				
Cost Center Description	SOCIAL SERVICE	PATI ENT	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
		TRANSPORT	Y & FRINGES	PRGM. COSTS	PRGM -	
		SERVI CES			PHARMACY	
	17. 00	18. 00	21.00	22. 00	23. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	19, 854				192. 00
193. 00 19300 NONPALD WORKERS	0	0				193. 00
193. 01 19301 RETAIL PHARMACY	0	383				193. 01
193. 02 19302 WHI TE HOSPI TAL	0	0				193. 02
193. 03 19303 HOSPI CE	0	0				193. 03
193. 04 19304 FRANKFORT HOSPI TAL	0	0				193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0				194. 00
200.00 Cross Foot Adjustments			4, 433	32, 616	11, 862	200. 00
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	5, 147	116, 825	4, 433	32, 616	11, 862	202. 00

| 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 8:33 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0173

						6/29/2020 8:	33 am
		Cost Center Description	Subtotal	Intern &	Total		
				Residents Cost			
				& Post Stepdown			
				Adjustments			
			24. 00	25.00	26.00		
		AL SERVICE COST CENTERS			T		
1.00	1	CAP REL COSTS BLDG & FLXT					1.00
1.01		CAP REL COSTS-BLDG & FIXT - NONHOSP CAP REL COSTS INTEREST EXPENSE					1. 01
1. 02 2. 00		CAP REL COSTS INTEREST EXPENSE CAP REL COSTS-MVBLE EQUIP					1. 02 2. 00
2.00		CAP REL COSTS-MVBLE EQUIP - NONHOSP					2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00570	ADMI TTI NG					5. 01
5.06		OTHER ADMINISTRATIVE & GENERAL					5. 06
7.00	1	OPERATION OF PLANT					7. 00
7. 01	1	OPERATION OF PLANT - NONHOSPITAL					7. 01
8.00	1	LAUNDRY & LINEN SERVICE					8. 00
9.00		HOUSEKEEPI NG DI ETARY					9.00
10. 00 11. 00	1	CAFETERIA					10. 00 11. 00
13. 00	1	NURSI NG ADMI NI STRATI ON					13. 00
14. 00		CENTRAL SERVICES & SUPPLY					14. 00
15. 00	1	PHARMACY					15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700	SOCIAL SERVICE					17. 00
18. 00	1	PATIENT TRANSPORT SERVICES					18. 00
21. 00		I &R SERVI CES-SALARY & FRI NGES APPRVD					21. 00
22. 00		I &R SERVI CES-OTHER PRGM. COSTS APPRVD					22. 00
23. 00		PARAMED ED PRGM - PHARMACY I ENT ROUTINE SERVICE COST CENTERS					23. 00
30. 00		ADULTS & PEDIATRICS	10, 064, 727	ol	10, 064, 727		30.00
31. 00	1	INTENSIVE CARE UNIT	992, 444	o	992, 444		31. 00
33. 00		BURN INTENSIVE CARE UNIT	0	o	0		33. 00
33. 01	1	BURN INTENSIVE CARE UNIT	0	0	0		33. 01
35.00	02060	NEONATAL INTENSIVE CARE UNIT	753, 071	o	753, 071		35. 00
43.00		NURSERY	338, 566	0	338, 566		43. 00
FO 00		LARY SERVICE COST CENTERS	2 401 527	ما	2 401 527		
50.00		OPERATING ROOM	2, 491, 527	0	2, 491, 527		50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	347, 779 1, 192, 988	0	347, 779 1, 192, 988		51. 00 52. 00
53. 00	1	ANESTHESI OLOGY	150, 463	o	1, 192, 966		53. 00
53. 01	1	ASC ANESTHESI OLOGY	8, 332	o	8, 332		53. 01
54.00	1	RADI OLOGY-DI AGNOSTI C	1, 329, 938	o	1, 329, 938		54.00
55.00	05500	RADI OLOGY-THERAPEUTI C	0	O	0		55. 00
56. 00	1	RADI OI SOTOPE	154, 251	0	154, 251		56. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	677, 108	0	677, 108		59. 00
60.00		LABORATORY	815, 153	0	815, 153		60.00
63.00		BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	56, 923	0	56, 923		63. 00 65. 00
65. 00 66. 00	1	PHYSI CAL THERAPY	117, 817 66, 500	0	117, 817 66, 500		66.00
67. 00	1	OCCUPATI ONAL THERAPY	30, 064	o	30, 064		67. 00
68. 00		SPEECH PATHOLOGY	25, 439	o	25, 439		68. 00
69.00		ELECTROCARDI OLOGY	202, 646	o	202, 646		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1, 157	o	1, 157		70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	461, 829	0	461, 829		71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	572, 848	0	572, 848		72. 00
73.00		DRUGS CHARGED TO PATIENTS	516, 764	0	516, 764		73. 00
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	122, 811	0 0	122, 811 0		74. 00 75. 00
75. 00 75. 01	1	ASC (NON-DISTINCT PART)	639, 375	0	639, 375		75. 00
76. 00		CARDI AC CATHERI ZATI ON	037, 373	ő	037, 373		76. 00
76. 97	1	CARDI AC REHABI LI TATI ON	45, 691	Ö	45, 691		76. 97
	OUTPA	TIENT SERVICE COST CENTERS					
90.00		CLINIC	0	0	0		90. 00
90. 01		SLEEP CLINIC	92, 829	0	92, 829		90. 01
90. 03		ARNETT CANCER CARE CENTER	225, 836	0	225, 836		90. 03
90. 04 91. 00		OUTPATIENT INFUSION CENTER EMERGENCY	49, 935 1, 640, 074	0	49, 935 1, 640, 074		90. 04 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART)	1, 640, 074	0	1, 040, 074		92.00
92. 01		OBSERVATION BEDS (NON-DISTINCT PART)	0	o	0		92. 01
93. 00	1	OTHER OUTPATIENT SERVICES	0	o	0		93. 00
		AL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24, 184, 885	0	24, 184, 885		118. 00
		MBURSABLE COST CENTERS					
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	193, 143	0	193, 143		190.00
191.00	19100	RESEARCH	0	0	0		191. 00

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0173 | Period: From 01/01/2019 | Part II |
To 12/31/2019 | Date/Time Prepared:

				10 12/31/20	6/29/2020 8: 33 am
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	4, 553, 536	0	4, 553, 53	6	192. 00
193. 00 19300 NONPALD WORKERS	0	0	(0	193. 00
193.01 19301 RETAIL PHARMACY	99, 924	0	99, 92	4	193. 01
193. 02 19302 WHI TE HOSPI TAL	145, 745	0	145, 74	5	193. 02
193. 03 19303 HOSPI CE	7	0		7	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	128, 240	0	128, 24	0	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0		0	194. 00
200.00 Cross Foot Adjustments	48, 911	0	48, 91	1	200. 00
201.00 Negative Cost Centers	75, 965	0	75, 96	5	201. 00
202.00 TOTAL (sum lines 118 through 201)	29, 430, 356	o	29, 430, 35	6	202. 00

Provider CCN: 15-0173

Period: Worksheet B-1 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am

				'	0 12/31/2017	6/29/2020 8: 3	
			CAP	TAL RELATED CO	STS		
				I			
	Cost Center Description	BLDG & FIXT		CAP REL COSTS	MVBLE EQUIP	MVBLE EQUIP - NONHOSP	
		(SQUARE FEET)	NONHOSP (SQUARE FEET)	I NTEREST EXPENSE	(SQUARE FEET)	(SQUARE FEET)	
			(SQUARE TEET)	(SQUARE FEET)		(SQUARE FEET)	
		1.00	1. 01	1. 02	2. 00	2. 01	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT	397, 789					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP	0	342, 775	1			1. 01
1. 02 2. 00	00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUIP	0	U	397, 789	397, 789		1. 02 2. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP - NONHOSP			•	397, 709 O	342, 775	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	012,770	4. 00
5. 01	00570 ADMITTING	2, 753	3, 024	2, 753	2, 753	3, 024	5. 01
5.06	00590 OTHER ADMINISTRATIVE & GENERAL	11, 822	16, 815		11, 822	16, 815	5. 06
7.00	00700 OPERATION OF PLANT	74, 127	770	1	74, 127	770	7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL	0	1, 681	1	0	1, 681	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	· ·	0	0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	5, 405 8, 872	155 0	1		155 0	9. 00 10. 00
11. 00	01100 CAFETERI A	6, 237	0	1		0	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	6, 881	Ö	1	6, 881	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	20, 966	79			79	14. 00
15. 00	01500 PHARMACY	4, 416	52	4, 416	4, 416	52	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18. 00	01850 PATIENT TRANSPORT SERVICES	1, 389	0	1, 389	1, 389	0	18.00
21. 00 22. 00	02100 1&R SERVI CES-SALARY & FRINGES APPRVD 02200 1&R SERVI CES-OTHER PRGM. COSTS APPRVD	0	1, 782	0	0	1, 782	21. 00 22. 00
	02300 PARAMED ED PRGM - PHARMACY	129	1, 782	1	129	1, 782	1
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	127	10	127	127	10	20.00
30.00	03000 ADULTS & PEDI ATRI CS	113, 429	0	113, 429	113, 429	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	11, 076	0	11, 076	11, 076	0	31. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0 024	0	0 024	0 024	0	33. 01
35. 00 43. 00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	8, 934 4, 177) 0	8, 934 4, 177		0	35. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	4,177		4, 177	4, 177	0	43.00
50. 00	05000 OPERATI NG ROOM	28, 415	348	28, 415	28, 415	348	50.00
51. 00	05100 RECOVERY ROOM	4, 200	0	4, 200	4, 200	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	14, 307	0		14, 307	0	
53. 00	05300 ANESTHESI OLOGY	1, 263	153	l	1, 263	153	•
53. 01	05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	15 700	118	1	0 15 700	118	•
54. 00 55. 00	05500 RADI OLOGY-DI AGNOSTI C	15, 709) 	15, 709	15, 709 0	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	1, 921	0	1, 921	1, 921	0	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 845	0	7, 845		0	1
60.00	06000 LABORATORY	9, 531	1, 224	9, 531	9, 531	1, 224	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	700	0	, , , ,	700	0	
65. 00		1, 012	0	.,	· ·	0	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	781 340	0	781 340	781 340	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	300	0	300	300	0	68.00
69. 00		2, 288	Ö	2, 288	2, 288	Ö	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	1, 544	0	1, 544	1, 544	0	74. 00 75. 00
75. 00	07501 ASC (NON-DISTINCT PART)	0	33, 984		0	33, 984	ı
76. 00	03950 CARDI AC CATHERI ZATI ON		03, 704	Ö	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	2, 846		0	2, 846	1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0		0	
90. 01	04950 SLEEP CLINIC	0	5, 720	1	0	5, 720	1
90. 03 90. 04	09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER	0	12, 690	1	420	12, 690	1
91.00	09100 EMERGENCY	638 18, 683	0	638 18, 683		0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,003		10,003	10, 003		92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	О	О	0	0	1
93. 00	04951 OTHER OUTPATIENT SERVICES	0	0	0	0	0	•
	SPECIAL PURPOSE COST CENTERS						
118.00	3 /	390, 090	81, 457	390, 090	390, 090	81, 457	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 490	0	2, 490	2, 490	n	190. 00
	STATE OF THE STORE	2, 470	·	2, 470	2, 470	<u> </u>	1.75.66

			''	0 12/31/2019	6/29/2020 8: 3	3 am
		CAP	ITAL RELATED CO	OSTS		
		I	I			
Cost Center Description			CAP REL COSTS		MVBLE EQUIP -	
	(SQUARE FEET)		INTEREST	(SQUARE FEET)	NONHOSP	
		(SQUARE FEET)	EXPENSE (SQUARE FEET)		(SQUARE FEET)	
	1.00	1. 01	1. 02	2. 00	2. 01	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 246	258, 892	1, 246	1, 246	258, 892	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 RETAIL PHARMACY	1, 098	0	1, 098	1, 098	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	1, 522	1, 229	1, 522	1, 522	1, 229	193. 02
193. 03 19303 HOSPI CE	0	0	0	0		193. 03
193. 04 19304 FRANKFORT HOSPI TAL	1, 343	1, 197	1, 343	1, 343		193. 04
194. 00 07950 MARKETI NG/PUBLI C RELATIONS	0	0	0	0		194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	6, 209, 491	2, 085, 407	6, 570, 524	11, 662, 663	2, 902, 271	202. 00
Part I)	45 (40040	, ,,,,,,,,	4, 547,44	00 040747		
203.00 Unit cost multiplier (Wkst. B, Part I)	15. 610012	6. 083895	16. 517611	29. 318717		
204.00 Cost to be allocated (per Wkst. B,						204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part						205. 00
205.00 Unit cost multiprier (wkst. B, Part						203.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Provider Cust Provider Cus		Financial Systems	TU HEALTH ARNE				u of form CMS	
Case Center Description PREDITT CASE CENTERS CASE CENTERS CE	COST	ALLOCATION - STATISTICAL BASIS		Provider CC	F	rom 01/01/2019		pared:
CHINGEL STANCT CHEST CHITTEST CHINGE PILL COST CHITTEST PAPERS		Cost Center Description	BENEFITS DEPARTMENT (GROSS	(PATI ENT		ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	J um
1.00		T		5. 01	5A. 06	5. 06	7. 00	
1.01 0.0101 CAR PEL DOSTS-BLOB & FIRST - MONHOSP 1.02 0.0102 0.	1 00							1 1 00
16.00 0.600 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 10.00	1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - NONHOSPITAL 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	3, 233, 299 5, 043, 618 1, 394, 871 330, 749 0 2, 509, 763 506, 511 376, 418 3, 276, 554 274, 771	0 0 0 0 0 0	0 0 0 0 0 0 0	14, 969, 516 4, 788, 895 19, 181 4, 789, 195 2, 298, 678 318, 403 5, 167, 324 13, 714, 180	0 0 5, 405 8, 872 6, 237 6, 881 20, 966	1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
18.00 01850 PATIENT TRANSPORT SERVICES 476, 286 0 0 923, 028 1, 399 18, 00 121. 00 221. 00 220. 00 220. 01 &R SERVICES-CHIEF PROM. COSTS APPRVD 717, 2839 0 0 0 1, 124, 399 0 221. 00 220. 01 220. 00 220. 01 220. 00 220			0, 200, 017	0	ő	0		1
INPAIL ENT ROUTH INE SERVICE COST CENTERS 146, 281, 668 0 35, 708, 180 113, 429 30, 00 300, 00 300, 00 301, 00 501, 708, 180 113, 429 31, 00 310, 00 330, 00	18. 00 21. 00 22. 00	01850 PATIENT TRANSPORT SERVICES 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	476, 286 0 871, 969	0 0 0 0	0	923, 028 560, 470 1, 249, 399	1, 389 0 0	18. 00 21. 00 22. 00
31.00 03100 INTENSIVE CARE UNIT 0	20.00		172,007			211,701	127	20.00
A3. 00 04300 NURSERY A0. 0 0 1, 125, 881 4, 177 43. 00	31. 00 33. 00	03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	2, 427, 255		0	4, 843, 172 0	11, 076 0	31. 00 33. 00
ANCIL LLARY SERVICE COST CENTERS 50.00 CORO OPERATIN ROOM 4, 493, 676 143, 096, 297 0 8, 671, 118 28, 415 50.00 51.00 05100 PEGOVERY ROOM 4, 290, 739 13, 716, 404 0 1, 138, 060 4, 200 51.00 52.00 05200 DELIVERY ROOM 4, 290, 739 13, 716, 404 0 1, 138, 060 4, 200 51.00 52.00 05200 DELIVERY ROOM 4, 280, 272 25, 625, BS2 0 3, 964, 731 14, 307 52.00 53.00 05300 ARISTHESI OLOGY 9, 039, 606 26, 661, 318 0 5, 377, 332 1, 263 53.00 53.01 05301 ASC ANIESTHESI OLOGY 0 4, 481, 564 0 19, 986 0 53.01 05301 ASC ANIESTHESI OLOGY 0 0 0 0 0 0 0 0 0			1					
50.00	43.00		043, 464	3, 720, 140	0	1, 125, 661	4, 177	43.00
90. 04	51. 00 52. 00 53. 01 54. 00 55. 00 56. 00 56. 00 67. 00 68. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 01 76. 00 76. 97	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07501 ASC (NON-DI STI NCT PART) 03950 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C	629, 739 2, 230, 272 9, 039, 606 0 3, 613, 609 0 214, 903 1, 326, 685 13, 333 0 1, 752, 452 569, 156 370, 514 199, 294 1, 218, 710 81, 596 0 0 0 3, 326, 229 0 304, 443	13, 716, 404 25, 625, 852 26, 061, 318 4, 481, 564 91, 373, 464 0 14, 564, 007 59, 202, 039 74, 332, 624 4, 942, 007 13, 224, 849 4, 141, 290 1, 805, 896 1, 589, 095 29, 931, 791 1, 568, 327 43, 162, 723 88, 160, 050 192, 366, 075 3, 161, 116 0 126, 804, 135 0 113, 225	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 138, 060 3, 964, 731 5, 377, 332 19, 986 6, 211, 962 0 524, 609 2, 797, 441 11, 328, 601 743, 935 2, 427, 733 828, 649 524, 404 317, 460 1, 902, 617 110, 490 7, 719, 950 9, 557, 983 39, 165, 067 944, 146 0 6, 145, 327 0 631, 563	4, 200 14, 307 1, 263 0 15, 709 0 1, 921 7, 845 9, 531 700 1, 012 781 340 300 2, 288 0 0 0 1, 544 0 0 0 0 0	51. 00 52. 00 53. 01 54. 00 55. 00 56. 00 56. 00 60. 00 67. 00 68. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 01 76. 07 76. 07 76. 07 90. 00 90. 01
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 89, 510, 938 1, 360, 422, 439 -78, 684, 538 222, 335, 643 301, 388 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 31, 612 0 0 326, 962 2, 490 190. 00	90. 03 90. 04 91. 00 92. 00 92. 01	09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	764, 325 16, 739 4, 295, 461	23, 216, 254 803, 064	0	1, 677, 807 68, 758 8, 540, 814	0 638 18, 683 0	90. 03 90. 04 91. 00 92. 00 92. 01
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 31,612 0 0 326,962 2,490 190.00	118. 00		89, 510, 938	1, 360, 422, 439	-78, 684, 538	222, 335, 643	301, 388	118. 00
191. 00 19100 RESEARCH 0 0 0 0 191. 00	190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	326, 962	2, 490	190. 00
	191.00	19100 RESEARCH	0	0	0	0	0	191. 00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0173	Peri od:	Worksheet B-1

CUST AL	LUCATION - STATISTICAL BASIS		Provider C		From 01/01/2019	worksneet B-1	
					To 12/31/2019		
						6/29/2020 8: 3	3 am
	Cost Center Description	EMPLOYEE		Reconciliation		OPERATION OF	
		BENEFITS	(PATI ENT		ADMI NI STRATI VE		
		DEPARTMENT	CHARGES)		& GENERAL	(SQUARE FEET)	
		(GROSS			(ACCUM. COST)		
		SALARI ES) 4. 00	5. 01	5A. 06	5. 06	7. 00	
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	90, 825, 319	280, 193, 478		129, 026, 614		192. 00
	19300 NONPALD WORKERS	90, 023, 319	200, 193, 476)	129, 020, 014		193. 00
	19301 RETAIL PHARMACY	605, 497	5, 390, 890)	5, 249, 525	l	193. 00
	19302 WHI TE HOSPI TAL	912, 229	3, 370, 070 N		1, 967, 342		193. 02
	19303 HOSPI CE	712,227	0		2, 572	1	193. 03
	19304 FRANKFORT HOSPITAL	579, 076	0		1, 313, 135		193. 04
	07950 MARKETI NG/PUBLI C RELATI ONS	077,070	0	1	0 1,010,100		194. 00
200.00	Cross Foot Adjustments		· ·	Ì	1	Ĭ	200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	42, 836, 647	4, 926, 066		78, 684, 538	18, 239, 367	202.00
	Part I)	, , , , , , ,	.,		., ,	., ., .,	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 234767	0. 002993		0. 218434	59. 010463	203. 00
204.00	Cost to be allocated (per Wkst. B,	O	213, 163		971, 092	4, 606, 396	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000130		0. 002696	14. 903234	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
	Parts III and IV)						

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH ARNETT HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0173 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (PATIENT DAYS) PLANT -(FTFS) NONHOSPI TAL (PATIENT DAYS) (SQUARE FEET) 8.00 10.00 11.00 7.01 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 1.01 00102 CAP REL COSTS INTEREST EXPENSE 1.02 1 02 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5.01 5.01 5.06 00590 OTHER ADMINISTRATIVE & GENERAL 5.06 7.00 00700 OPERATION OF PLANT 7.00 00701 OPERATION OF PLANT - NONHOSPITAL 320, 485 7. 01 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 48,660 8.00 9.00 00900 HOUSEKEEPI NG 155 624, 010 9.00 01000 DI ETARY 8,872 42, 800 10.00 10.00 0 0 01100 CAFETERI A 0 92, 125 11.00 6, 237 11.00 13.00 01300 NURSING ADMINISTRATION 0 6,881 0 4, 293 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 21, 045 0 694 14.00 01500 PHARMACY 52 0 3, 791 15 00 15 00 4 468 16.00 01600 MEDICAL RECORDS & LIBRARY 0 \cap 0 Ω 16.00 01700 SOCIAL SERVICE 0 0 800 17.00 17.00 0 0 01850 PATIENT TRANSPORT SERVICES 0 18.00 1,583 18.00 1, 389 02100 | &R SERVICES-SALARY & FRINGES APPRVD 0 21 00 21 00 Ω 664 22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 1,782 C 1,782 0 429 22.00 02300 PARAMED ED PRGM - PHARMACY 23.00 250 23.00 16 144 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 39, 081 113, 429 39, 081 31, 189 30.00 11, 076 03100 INTENSIVE CARE UNIT 0 2, 813 3, 482 31.00 2,813 31.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 03301 BURN INTENSIVE CARE UNIT 33 01 O 0 33 01 0 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 3,049 8, 934 0 3,049 35, 00 04300 NURSERY 43.00 2.811 4.177 0 912 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50 00 348 28.763 0 6, 481 51.00 05100 RECOVERY ROOM 0 C 4, 200 0 940 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 906 14, 307 906 3.238 52.00 0 1, 416 53.00 05300 ANESTHESI OLOGY C 2, 955 53.00 153 05301 ASC ANESTHESI OLOGY 0 53.01 118 C 118 0 53.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 709 0 4, 928 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 Ω 55.00 0 05600 RADI OI SOTOPE 0 1.921 56,00 0 277 56, 00 05900 CARDIAC CATHETERIZATION 59.00 0 0 7,845 1,802 59 00 60.00 06000 LABORATORY 1, 224 10, 754 0 0 0 0 0 0 3, 785 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 700 63.00 06500 RESPIRATORY THERAPY 1, 012 65.00 0 0 2,662 65.00 06600 PHYSI CAL THERAPY 66.00 0 781 725 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 340 474 67.00 0 06800 SPEECH PATHOLOGY 300 247 68.00 68.00 06900 ELECTROCARDI OLOGY 69 00 2, 288 2, 100 69.00 07000 ELECTROENCEPHALOGRAPHY 0 110 70.00 70.00 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 1,544 0 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 07501 ASC (NON-DISTINCT PART) 75.01 33, 984 0 33, 984 Λ 75.01 76.00 03950 CARDI AC CATHERI ZATI ON C 0 0 76.00 07697 CARDIAC REHABILITATION 76. 97 2,846 0 2,846 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 90.01 04950 SLEEP CLINIC 5,720 5,720 0 0 90.01 09002 ARNETT CANCER CARE CENTER 0 90.03 12,690 0 12,690 1,090 90.03 0 90 04 09003 OUTPATIENT INFUSION CENTER Ω 638 90 04 0 18 91.00 09100 EMERGENCY 0 C 18,683 0 7, 423 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0 0 0 0 0 92.01 93.00 04951 OTHER OUTPATIENT SERVICES O 93.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 90, 391 118. 00 59, 167 48, 660 354, 993 42, 800 NONREI MBURSABLE COST CENTERS 100 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 490 191. 00 19100 RESEARCH 0 0 191.00

258.892

260, 138

0

0 192.00

192.00 19200 PHYSICIANS' PRIVATE OFFICES

| Peri od: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

				'	0 12/31/2019	6/29/2020 8: 3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	·	PLANT -	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(FTES)	
		NONHOSPI TAL	(PATIENT DAYS)				
		(SQUARE FEET)					
		7. 01	8. 00	9. 00	10.00	11. 00	
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301	RETAIL PHARMACY	0	0	1, 098	0	0	193. 01
193. 02 19302	WHITE HOSPITAL	1, 229	0	2, 751	0	983	193. 02
193. 03 19303	HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304	FRANKFORT HOSPITAL	1, 197	0	2, 540	0	651	193. 04
194.00 07950	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	5, 834, 952	23, 371	6, 157, 092	3, 411, 868	817, 541	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	18. 206631				8. 874258	
204. 00	Cost to be allocated (per Wkst. B,	37, 371	52	427, 855	689, 653	481, 326	204. 00
005 00	Part II)	0.44//00	0.004040	0 (05/54	47 440000	4 400440	005 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 116608	0. 001069	0. 685654	16. 113388	4. 400119	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
200.00	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	TU HEALTH ARNE				eu or Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CCI	F	eriod: rom 01/01/2019 o 12/31/2019		pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	3 alli
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)		(PATIENT DAYS)	
		(FTES)	(COSTED		(PATIENT		
		13.00	REQUIS.) 14. 00	15. 00	CHARGES) 16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP						1. 01
1. 02	00102 CAP REL COSTS INTEREST EXPENSE						1. 02
2.00	00200 CAP REL COSTS MYBLE EQUI P						2.00
2. 01 4. 00	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 01 4. 00
5. 01	00570 ADMI TTI NG						5. 01
5.06	00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL						7. 01
8. 00 9. 00	OO8OO LAUNDRY & LINEN SERVICE OO9OO HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION	42, 353					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	29, 081, 350				14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	116, 087	39, 099, 495			15.00
17. 00	01700 SOCIAL SERVICE		0	0	1, 646, 006, 807	48, 660	16. 00 17. 00
	01850 PATIENT TRANSPORT SERVICES	l o	6, 502	0	0	0	18. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	•
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM - PHARMACY	0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	23, 276	2, 090, 753	150, 211	146, 281, 068	39, 081	30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 991	383, 459	21, 217		l	1
	03300 BURN INTENSIVE CARE UNIT	0	0	. 0		0	ı
33. 01	03301 BURN INTENSIVE CARE UNIT	0	0	0	_	0	33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	2, 186	130, 448	13, 635			1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	651	0	0	3, 928, 140	2, 811	43.00
50.00	05000 OPERATING ROOM	3, 202	3, 048, 861	37, 708	143, 096, 297	0	50.00
51.00	05100 RECOVERY ROOM	940	31, 122	280		l .	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 147	307, 405	1, 835		l .	ı
53. 00 53. 01	05300 ANESTHESI OLOGY	102	289, 687	23, 432			
54. 00	05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	514	97, 406 980, 708	1, 767 31, 617			
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.70.7		Ö	ı
56.00	05600 RADI OI SOTOPE	0	12, 076	2, 010	14, 564, 007	0	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 018	556, 267	18, 991			
60.00	06000 LABORATORY	0	0	0	.,		
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0	329, 820	16, 163	4, 942, 007 13, 224, 849		•
66. 00	06600 PHYSI CAL THERAPY	0	1, 423	10, 103	4, 141, 290	1	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	181	0	1, 805, 896		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1, 148	0	1, 589, 095	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	384	15, 110	4, 003			69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 053 7, 590, 764	0	1, 568, 327 43, 162, 723		70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		9, 294, 120	0	88, 160, 050		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	38, 589, 315		l .	73. 00
	07400 RENAL DIALYSIS	0	11, 204	5, 163	3, 161, 116	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	_	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	0	1, 313, 648	76, 471	126, 804, 135		75. 01
76. 00 76. 97	03950 CARDI AC CATHERI ZATI ON 07697 CARDI AC REHABI LI TATI ON	0	4, 735	0	113, 225	0	
, 0, ,,	OUTPATIENT SERVICE COST CENTERS	<u> </u>	1,700		1.0,220		70.77
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01	04950 SLEEP CLINIC	0	28, 153	0	7, 215, 508	l .	
90. 03	09002 ARNETT CANCER CARE CENTER	618	147, 326	42, 875			90. 03
90. 04 91. 00	O9003 OUTPATIENT INFUSION CENTER O9100 EMERGENCY	18 4, 306	2, 122 892, 327	313 61, 538			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 300	072, 327	01, 550	101, 333, 737		92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	ı
93. 00	04951 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93. 00
140 0-	SPECIAL PURPOSE COST CENTERS	40.055	07 (00 01=	20,000,5::	1 2/0 400 155	40.41=	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	42, 353	27, 683, 915	39, 098, 544	1, 360, 422, 439	48, 660	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	77	0			190. 00
191.00	19100 RESEARCH	0	o	0	0	0	191. 00

					12/31/2019	6/29/2020 8: 3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(PATIENT DAYS)	
		(FTES)	(COSTED		(PATI ENT		
			REQUI S.)		CHARGES)		
		13. 00	14. 00	15. 00	16. 00	17. 00	
	PHYSICIANS' PRIVATE OFFICES	0	1, 395, 567	951	280, 193, 478		192. 00
	NONPALD WORKERS	0	0	0	0		193. 00
	RETAIL PHARMACY	0	1, 791	0	5, 390, 890	_	193. 01
	WHI TE HOSPI TAL	0	0	0	0		193. 02
193. 03 19303	l control of the cont	0	0	0	0		193. 03
	FRANKFORT HOSPITAL	0	0	0	0		193. 04
194. 00 07950	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	6, 808, 086	18, 162, 284	6, 357, 102	0	742, 203	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	160. 746252	0. 624534		0. 000000		
204. 00	Cost to be allocated (per Wkst. B,	562, 900	1, 656, 361	377, 434	0	5, 147	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	13. 290676	0. 056956	0. 009653	0. 000000	0. 105775	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
	Parts III and IV)						

COST A	LLOCATION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
				T	rom 01/01/2019 o 12/31/2019	Date/Time Pre	
		OTHER GENERAL	INTERNS &	RESI DENTS		6/29/2020 8: 3	3 am
		SERVI CE		T			
	Cost Center Description	PATI ENT TRANSPORT	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM -		
		SERVI CES	(ASSI GNED	(ASSI GNED	PHARMACY		
		(PATI ENT	TIME)	TIME)	(ASSI GNED		
		CHARGES) 18.00	21. 00	22.00	TI ME) 23. 00		
	GENERAL SERVICE COST CENTERS	10.00	21.00	22.00	23.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	OO101 CAP REL COSTS-BLDG & FIXT - NONHOSP OO102 CAP REL COSTS INTEREST EXPENSE						1. 01 1. 02
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 06	OO570 ADMITTING OO590 OTHER ADMINISTRATIVE & GENERAL						5. 01 5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00
9. 00 10. 00	01000 DI ETARY						9.00
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 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE						17. 00
	01850 PATIENT TRANSPORT SERVICES	1, 646, 006, 807					18. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	5, 054				21.00
23. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM - PHARMACY	0		5, 054	100		22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_					1
30.00	03000 ADULTS & PEDIATRICS	146, 281, 068	4, 045				30. 00
31. 00 33. 00	03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	16, 918, 961 0	0	0	_		31.00
33. 00	03301 BURN INTENSIVE CARE UNIT	0	0				33. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	17, 099, 339	0	0			35. 00
43. 00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	3, 928, 140	0	0	0		43. 00
50. 00	05000 OPERATING ROOM	143, 096, 297	2	2	0		50.00
51.00	05100 RECOVERY ROOM	13, 716, 404		1			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	25, 625, 852	863	1			52.00
53. 00 53. 01	05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY	26, 061, 318 4, 481, 564	0	0			53. 00 53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	91, 373, 464	0	ő	0		54. 00
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0		55. 00
	05600 RADI OI SOTOPE	14, 564, 007	0	0	0		56.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	59, 202, 039 74, 332, 624	0				59. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	4, 942, 007	Ö	Ö	0		63. 00
65. 00	06500 RESPI RATORY THERAPY	13, 224, 849	0	0	0		65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	4, 141, 290 1, 805, 896	0	0	0		66.00
68. 00	06800 SPEECH PATHOLOGY	1, 589, 095	0	0	0		68.00
	06900 ELECTROCARDI OLOGY	29, 931, 791	0	Ö	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 568, 327	0	0	0		70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	43, 162, 723 88, 160, 050	0	0	0		71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	192, 366, 075	0	0	100		73.00
74.00	07400 RENAL DIALYSIS	3, 161, 116	0	0	0		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0		75. 00
75. 01 76. 00	O7501 ASC (NON-DISTINCT PART) O3950 CARDIAC CATHERIZATION	126, 804, 135	0	0	0		75. 01 76. 00
76. 97	07697 CARDIAC CATHERIZATION	113, 225	0	0			76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	7 215 500	0	0			90.00
90. 01 90. 03	04950 SLEEP CLINIC 09002 ARNETT CANCER CARE CENTER	7, 215, 508 23, 216, 254) 0	0	0		90. 01
90. 04	09003 OUTPATIENT INFUSION CENTER	803, 064	Ö	Ö	Ö		90. 04
91. 00	09100 EMERGENCY	181, 535, 957	144	144	0		91.00
92. 00 92. 01	O9200 OBSERVATION BEDS (NON-DISTINCT PART) O9201 OBSERVATION BEDS (DISTINCT PART)	0	_	0			92. 00 92. 01
92.01	04951 OTHER OUTPATIENT SERVICES	0	0	0	0		93. 00
	SPECIAL PURPOSE COST CENTERS					•	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 360, 422, 439	5, 054	5, 054	100		118. 00

Health Financial Systems	IU HEALTH ARN	ETT HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet B-1 Date/Time Prepared: 6/29/2020 8:33 am
Cost Center Description	OTHER GENERAL SERVI CE PATI ENT	I NTERNS & SERVI CES-SALAR	RESI DENTS	R PARAMED ED	
cost center bescription	TRANSPORT SERVI CES (PATI ENT CHARGES)	Y & FRINGES (ASSIGNED TIME)	PRGM. COSTS (ASSIGNED TIME)	PRGM - PHARMACY (ASSIGNED TIME)	
	18. 00	21. 00	22. 00	23. 00	
NONREI MBURSABLE COST CENTERS	1		ı		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	190.00
191. 00 19100 RESEARCH	200 102 170			0	191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	280, 193, 478	3		0	192. 00
193. 00 19300 NONPALD WORKERS	5 000 000			0	193. 00
193. 01 19301 RETAIL PHARMACY	5, 390, 890			0	193. 01
193. 02 19302 WHI TE HOSPI TAL				0	193. 02
193. 03 19303 HOSPI CE				0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL				0	193. 04
194. 00 07950 MARKETI NG/PUBLI C RELATI ONS		١		U	194. 00
200.00 Cross Foot Adjustments					200. 00 201. 00
201.00 Negative Cost Centers	1 220 420	/00 700	1 57/ 14	4 272 142	
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 238, 429	688, 789	1, 576, 14	4 273, 142	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000752	136, 285912	311. 86070	4 2, 731. 420000	203. 00
204.00 Cost to be allocated (per Wkst. B,	116, 825				204. 00
Part II)	110, 623	4, 433	32,01	11, 602	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000071	0. 877127	6. 45350	118. 620000	205. 00
206 00 NAHE adjustment amount to be allocated				0	206 00

0.000000

206. 00

207. 00

206.00

207.00

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

				ļτ	o 12/31/2019	Date/Time Pre 6/29/2020 8:3	pared:
			Title	XVIII	Hospi tal	PPS	<u>3 alli</u>
			11110	XVIII	Costs	113	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost denter beschiptron	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313	
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	60, 509, 514		60, 509, 514	0	60, 509, 514	30.00
31. 00	03100 I NTENSI VE CARE UNI T	7, 699, 820		7, 699, 820	289, 860	7, 989, 680	31. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0		0	0	0	33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 129, 809		6, 129, 809	0	6, 129, 809	35. 00
43.00	04300 NURSERY	1, 819, 432		1, 819, 432	0	1, 819, 432	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	15, 122, 186		15, 122, 186	0	15, 122, 186	
51. 00	05100 RECOVERY ROOM	1, 865, 177		1, 865, 177	0	1, 865, 177	
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 488, 081		6, 488, 081	0	6, 488, 081	
53.00	05300 ANESTHESI OLOGY	6, 890, 158		6, 890, 158	0	6, 890, 158	1
53. 01	05301 ASC ANESTHESI OLOGY	92, 154		92, 154	0	92, 154	
54.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	9, 463, 556		9, 463, 556	0	9, 463, 556 0	1
55. 00 56. 00	05600 RADI OLOGY - THERAPEUTT C	792, 793		792, 793	0	792, 793	55. 00 56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 523, 487		4, 523, 487		4, 523, 487	59.00
60. 00	06000 LABORATORY	14, 583, 463		14, 583, 463		14, 583, 463	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	958, 366		958, 366		958, 366	
65. 00	06500 RESPIRATORY THERAPY	3, 269, 916				3, 269, 916	
66. 00	06600 PHYSI CAL THERAPY	1, 073, 884	0	1, 073, 884		1, 073, 884	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	668, 048	0	668, 048	0	668, 048	
68. 00	06800 SPEECH PATHOLOGY	411, 571	0	411, 571	o	411, 571	1
69. 00	06900 ELECTROCARDI OLOGY	2, 588, 765	_	2, 588, 765	o	2, 588, 765	
70. 00	07000 ELECTROENCEPHALOGRAPHY	137, 438		137, 438	o	137, 438	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 179, 398		14, 179, 398	o	14, 179, 398	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17, 516, 553		17, 516, 553	0	17, 516, 553	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	54, 412, 001		54, 412, 001	0	54, 412, 001	73.00
74.00	07400 RENAL DIALYSIS	1, 266, 940		1, 266, 940	0	1, 266, 940	74. 00
	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	9, 369, 936		9, 369, 936	0	9, 369, 936	
76. 00	03950 CARDI AC CATHERI ZATI ON	0		0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	852, 457		852, 457	0	852, 457	76. 97
	OUTPATIENT SERVICE COST CENTERS	1	I				
90.00	09000 CLI NI C	0		0	0	0	90.00
90. 01	04950 SLEEP CLINIC	1, 067, 492		1, 067, 492	0	1, 067, 492	
90. 03	09002 ARNETT CANCER CARE CENTER	2, 626, 005		2, 626, 005	0	2, 626, 005	
90. 04 91. 00	09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY	132, 754		132, 754	0	132, 754	
		13, 155, 111		13, 155, 111	266, 279	13, 421, 390	
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	6, 703, 542		6, 703, 542	0	6, 703, 542 0	92. 00 92. 01
	04951 OTHER OUTPATIENT SERVICES					0	93.00
200.00		266, 369, 807	0	266, 369, 807	556, 139	266, 925, 946	
201.00		6, 703, 542		6, 703, 542	330, 137	6, 703, 542	
202.00		259, 666, 265	0		556, 139	260, 222, 404	
_52.00	1 (000 1.101. 4011 0110)	1 207,000,200	1	1 207, 000, 200	1 330, 137	200, 222, 104	,_02.00

From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:33 am Title XVIII Hospi tal **PPS** Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 111, 073, 587 111, 073, 587 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 918, 961 16, 918, 961 31.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 33.01 03301 BURN INTENSIVE CARE UNIT 0 33.01 14, 384, 611 02060 NEONATAL INTENSIVE CARE UNIT 35.00 14, 384, 611 35.00 43.00 04300 NURSERY 3, 928, 140 3, 928, 140 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 63, 235, 998 79, 860, 299 143, 096, 297 0.105678 0.000000 50.00 05100 RECOVERY ROOM 51.00 4, 779, 122 8, 937, 282 13, 716, 404 0.135981 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 24, 059, 898 1, 565, 954 25, 625, 852 0. 253185 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 4, 095, 055 4, 519, 672 8, 614, 727 0. 799812 0.000000 53.00 5, 609 4, 475, 955 05301 ASC ANESTHESI OLOGY 0.020563 0.000000 53.01 4, 481, 564 53.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 36, 585, 233 54, 788, 231 91, 373, 464 0.103570 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 56.00 05600 RADI OI SOTOPE 2, 219, 682 12, 344, 325 14, 564, 007 0.054435 0.000000 56.00 05900 CARDIAC CATHETERIZATION 28, 913, 076 30, 288, 963 59, 202, 039 59 00 0.076408 0.000000 59 00 60.00 06000 LABORATORY 27, 860, 108 45, 703, 120 73, 563, 228 0. 198244 0.000000 60.00 1, 280, 281 4, 942, 007 0. 193922 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 3, 661, 726 0.000000 63.00 06500 RESPIRATORY THERAPY 12, 326, 764 898, 085 13, 224, 849 0. 247255 0.000000 65.00 65.00 4, 141, 290 66.00 06600 PHYSI CAL THERAPY 3, 753, 457 387, 833 0.259311 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 1, 639, 179 166, 717 1, 805, 896 0.369926 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 398, 352 190, 743 1, 589, 095 0.258997 0.000000 68.00 13, 585, 774 29, 931, 791 69 00 06900 ELECTROCARDI OLOGY 16, 346, 017 0.086489 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 256, 890 311, 437 1, 568, 327 0.087634 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 19, 834, 887 23, 327, 836 43, 162, 723 0. 328510 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 47, 118, 900 41, 041, 150 88, 160, 050 0.198690 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 49.874.439 142, 491, 636 0.282857 73.00 192, 366, 075 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 560, 040 601,076 3, 161, 116 0.400789 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0.000000 75.00 75 01 07501 ASC (NON-DISTINCT PART) 172, 788 126, 631, 347 126, 804, 135 0.073893 0.000000 75 01 03950 CARDI AC CATHERI ZATI ON 76.00 0.000000 0.000000 76.00 07697 CARDIAC REHABILITATION 28, 541 113, 225 7.528876 0.000000 76. 97 84,684 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0.000000 0.000000 90 00 7, 215, 508 90.01 04950 SLEEP CLINIC 5, 981 7, 209, 527 0.147944 0.000000 90.01 286, 402 09002 ARNETT CANCER CARE CENTER 22, 929, 852 23, 216, 254 0.113111 0.000000 90.03 90.03 90.04 09003 OUTPATIENT INFUSION CENTER 2,594 800, 470 803, 064 0.165309 0.000000 90.04 91 00 09100 EMERGENCY 181, 535, 957 42, 874, 619 138, 661, 338 0.072466 0.000000 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 548, 956 24, 483, 639 25, 032, 595 0. 267793 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0.000000 0.000000 92.01 93. 00 04951 OTHER OUTPATIENT SERVICES 93.00 0.000000 0.000000 200.00 Subtotal (see instructions) 541, 805, 755 787, 511, 083 1, 329, 316, 838 200.00

541, 805, 755

787, 511, 083 1, 329, 316, 838

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0173	From 01/01/2019 Part I
		To 12/31/2019 Date/Time Prepared:

				10 12/31/2019	6/29/2020 8:3	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient		<u> </u>		
	•	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30. 00
31.00	03100 INTENSIVE CARE UNIT					31.00
33.00	03300 BURN INTENSIVE CARE UNIT					33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT					33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT					35. 00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 105678				50. 00
51. 00	05100 RECOVERY ROOM	0. 135981				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 253185				52. 00
53.00	05300 ANESTHESI OLOGY	0. 799812				53.00
53. 01	05301 ASC ANESTHESI OLOGY	0. 020563				53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 103570				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00	05600 RADI 0I SOTOPE	0. 054435				56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 076408				59. 00
60.00	06000 LABORATORY	0. 198244				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 193922				63. 00
65. 00	06500 RESPI RATORY THERAPY	0. 247255				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 259311				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 369926				67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 258997				68. 00
	06900 ELECTROCARDI OLOGY	0. 086489				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 087634				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 328510				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 198690				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 282857				73. 00
	07400 RENAL DIALYSIS	0. 400789				74. 00
	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
	07501 ASC (NON-DISTINCT PART)	0. 073893				75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON	0. 000000				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	7. 528876				76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	0.000000				
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	04950 SLEEP CLINIC	0. 147944				90. 01
90. 03	09002 ARNETT CANCER CARE CENTER	0. 113111				90. 03
90. 04	09003 OUTPATIENT INFUSION CENTER	0. 165309				90.04
91. 00	09100 EMERGENCY	0. 073932				91.00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 267793				92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000				92. 01
	04951 OTHER OUTPATIENT SERVICES	0. 000000				93. 00 200. 00
200. 00 201. 00	1 1					200.00
201.00	l I					201.00
202.00	linga (see thistinctions)	1				1202.00

From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:33 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 60, 509, 514 60, 509, 514 60, 509, 514 03100 INTENSIVE CARE UNIT 7, 699, 820 7, 699, 820 289, 860 7, 989, 680 31.00 31.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 33.00 03301 BURN INTENSIVE CARE UNIT 33.01 33.01 0 0 0 0 02060 NEONATAL INTENSIVE CARE UNIT 35.00 6, 129, 809 6, 129, 809 0 6, 129, 809 35.00 43.00 04300 NURSERY 1, 819, 432 1, 819, 432 1, 819, 432 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 15, 122, 186 15, 122, 186 15, 122, 186 51.00 05100 RECOVERY ROOM 1,865,177 1, 865, 177 0 1, 865, 177 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 488, 081 6, 488, 081 0 0 0 6, 488, 081 52.00 05300 ANESTHESI OLOGY 6, 890, 158 6, 890, 158 6, 890, 158 53.00 53.00 05301 ASC ANESTHESI OLOGY 53.01 92, 154 92, 154 92, 154 53.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 463, 556 9, 463, 556 9, 463, 556 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55.00 792, 793 05600 RADI OI SOTOPE 792, 793 792, 793 56 00 56 00 59.00 05900 CARDIAC CATHETERIZATION 4, 523, 487 4, 523, 487 4, 523, 487 59.00 06000 LABORATORY 14, 583, 463 14, 583, 463 14, 583, 463 60.00 60.00 0 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 958, 366 958, 366 958, 366 63.00 06500 RESPIRATORY THERAPY 3, 269, 916 3, 269, 916 3, 269, 916 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 1,073,884 1,073,884 1,073,884 66.00 06700 OCCUPATI ONAL THERAPY 67.00 668, 048 668, 048 0 0 0 668, 048 67.00 68 00 06800 SPEECH PATHOLOGY 411 571 411, 571 68 00 411 571 69.00 06900 ELECTROCARDI OLOGY 2, 588, 765 2, 588, 765 2, 588, 765 69.00 07000 ELECTROENCEPHALOGRAPHY 137, 438 137, 438 137, 438 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 14, 179, 398 14, 179, 398 0 14, 179, 398 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 17 516 553 17, 516, 553 17, 516, 553 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 54, 412, 001 54, 412, 001 54, 412, 001 73.00 07400 RENAL DIALYSIS 1, 266, 940 0 74.00 1, 266, 940 1, 266, 940 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 75.01 07501 ASC (NON-DISTINCT PART) 9, 369, 936 9, 369, 936 9, 369, 936 75 01 76.00 03950 CARDI AC CATHERI ZATI ON Ω 76.00 07697 CARDIAC REHABILITATION 76.97 852, 457 852, 457 852, 457 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0 0 04950 SLEEP CLINIC 1,067,492 1, 067, 492 0 1, 067, 492 90.01 90.01 90.03 09002 ARNETT CANCER CARE CENTER 2, 626, 005 2, 626, 005 0 2, 626, 005 90.03 09003 OUTPATIENT INFUSION CENTER 132, 754 132.754 132, 754 90.04 90.04 09100 EMERGENCY 91.00 13, 155, 111 13, 155, 111 266, 279 13, 421, 390 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 703, 542 6, 703, 542 6, 703, 542 92.00 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01

266, 369, 807

259, 666, 265

6, 703, 542

0

556, 139

556, 139

266, 369, 807

259, 666, 265

6, 703, 542

Ω

0 93.00

266, 925, 946 200. 00

260, 222, 404 202. 00

6, 703, 542 201. 00

93. 00 04951 OTHER OUTPATIENT SERVICES

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

Worksheet C Part I Date/Time Prepared: 6/29/2020 8:33 am Peri od: From 01/01/2019 To 12/31/2019 Title XIX Hospi tal PPS

		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	+ col. 7)	Ratio	Inpati ent	
			,		Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	111, 073, 587		111, 073, 587			30. 00
31.00 03100 INTENSIVE CARE UNIT	16, 918, 961		16, 918, 961			31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		l			33. 00
33. 01 03301 BURN INTENSIVE CARE UNIT	0		l o			33. 01
35.00 02060 NEONATAL INTENSIVE CARE UNIT	14, 384, 611		14, 384, 611			35. 00
43. 00 04300 NURSERY	3, 928, 140		3, 928, 140			43. 00
ANCILLARY SERVICE COST CENTERS	271227110		27 1227 112	I		
50. 00 05000 OPERATING ROOM	63, 235, 998	79, 860, 299	143, 096, 297	0. 105678	0.000000	50.00
51. 00 05100 RECOVERY ROOM	4, 779, 122	8, 937, 282	13, 716, 404	0. 135981	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	24, 059, 898	1, 565, 954			0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	4, 095, 055	4, 519, 672	8, 614, 727	0. 799812	0. 000000	53. 00
53. 01 05301 ASC ANESTHESI OLOGY	5, 609	4, 475, 955		0. 020563	0. 000000	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	36, 585, 233	54, 788, 231		0. 103570	0. 000000	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0, 505, 255	04, 700, 231	1	0. 000000	0. 000000	55. 00
56. 00 05600 RADI 0I SOTOPE	2, 219, 682	12, 344, 325	-	0. 054435	0. 000000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	28, 913, 076	30, 288, 963		0. 076408	0. 000000	59.00
60. 00 06000 LABORATORY	27, 860, 108	45, 703, 120		0. 198244	0. 000000	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 661, 726	1, 280, 281	4, 942, 007	0. 198244	0. 000000	63.00
65. 00 06500 RESPIRATORY THERAPY	12, 326, 764			0. 193922	0. 000000	65.00
		898, 085		0. 247255	0. 000000	66.00
	3, 753, 457	387, 833				
67. 00 06700 OCCUPATI ONAL THERAPY	1, 639, 179	166, 717		0. 369926	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 398, 352	190, 743			0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	16, 346, 017	13, 585, 774		0. 086489	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 256, 890	311, 437		0. 087634	0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 834, 887	23, 327, 836		0. 328510	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	47, 118, 900	41, 041, 150		0. 198690	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	49, 874, 439	142, 491, 636		0. 282857	0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	2, 560, 040	601, 076	3, 161, 116	0. 400789	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	172, 788	126, 631, 347	126, 804, 135	0. 073893	0.000000	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	0	0	0	0.000000	0.000000	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	84, 684	28, 541	113, 225	7. 528876	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0.000000	0.000000	90.00
90. 01 04950 SLEEP CLINIC	5, 981	7, 209, 527	7, 215, 508	0. 147944	0.000000	90. 01
90.03 09002 ARNETT CANCER CARE CENTER	286, 402	22, 929, 852	23, 216, 254	0. 113111	0.000000	90. 03
90.04 09003 OUTPATIENT INFUSION CENTER	2, 594	800, 470	803, 064	0. 165309	0.000000	90. 04
91. 00 09100 EMERGENCY	42, 874, 619	138, 661, 338	181, 535, 957	0. 072466	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	548, 956	24, 483, 639	25, 032, 595	0. 267793	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	
200.00 Subtotal (see instructions)	541, 805, 755	787, 511, 083	1, 329, 316, 838			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	541, 805, 755	787, 511, 083	1, 329, 316, 838			202. 00
1	, ,	, 300	, , , , , , , , , , , , , , , , , , , ,	1		

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0173	Period: Worksheet C From 01/01/2019 Part I
		To 12/31/2019 Date/Time Prepared:

				12,01,201,	6/29/2020 8: 33 am
			Title XIX	Hospi tal	PPS
Cost Center D	escription	PPS Inpatient			
		Ratio			
		11.00			
INPATIENT ROUTINE S	SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI					30.00
31.00 03100 INTENSIVE CAR	RE UNIT				31.00
33.00 03300 BURN INTENSI V	'E CARE UNIT				33. 00
33. 01 03301 BURN INTENSI V	E CARE UNIT				33. 01
35. 00 02060 NEONATAL INTE	NSIVE CARE UNIT				35. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE (COST CENTERS				
50. 00 05000 OPERATING ROC	M	0. 105678			50.00
51.00 05100 RECOVERY ROOM	1	0. 135981			51.00
52. 00 05200 DELIVERY ROOM	1 & LABOR ROOM	0. 253185			52. 00
53. 00 05300 ANESTHESI OLOG	SY	0. 799812			53.00
53. 01 05301 ASC ANESTHESI	OLOGY	0. 020563			53. 01
54. 00 05400 RADI OLOGY-DI A	GNOSTI C	0. 103570			54.00
55. 00 05500 RADI OLOGY-THE	RAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI 0I SOTOPE		0. 054435			56. 00
59. 00 05900 CARDI AC CATHE	TERI ZATI ON	0. 076408			59. 00
60. 00 06000 LABORATORY		0. 198244			60.00
63. 00 06300 BLOOD STORING	, PROCESSING & TRANS.	0. 193922			63.00
65. 00 06500 RESPIRATORY T		0. 247255			65. 00
66. 00 06600 PHYSI CAL THER	RAPY	0. 259311			66.00
67. 00 06700 OCCUPATI ONAL		0. 369926			67. 00
68.00 06800 SPEECH PATHOL		0. 258997			68. 00
69. 00 06900 ELECTROCARDI 0		0. 086489			69. 00
70. 00 07000 ELECTROENCEPH		0. 087634			70.00
	IES CHARGED TO PATIENTS	0. 328510			71. 00
72.00 07200 I MPL. DEV. CH		0. 198690			72. 00
73. 00 07300 DRUGS CHARGED		0. 282857			73. 00
74.00 07400 RENAL DIALYSI		0. 400789			74. 00
75. 00 07500 ASC (NON-DI ST		0. 000000			75. 00
75. 01 07501 ASC (NON-DIST		0. 073893			75. 01
76. 00 03950 CARDI AC CATHE		0. 000000			76. 00
76. 97 07697 CARDI AC REHAB		7. 528876			76. 97
OUTPATIENT SERVICE					
90. 00 09000 CLI NI C		0. 000000			90.00
90. 01 04950 SLEEP CLINIC		0. 147944			90. 01
90. 03 09002 ARNETT CANCER	CARE CENTER	0. 113111			90. 03
90. 04 09003 OUTPATIENT IN		0. 165309			90. 04
91. 00 09100 EMERGENCY		0. 073932			91.00
	BEDS (NON-DISTINCT PART)	0. 267793			92.00
92. 01 09201 OBSERVATION B		0. 000000			92.01
93. 00 04951 OTHER OUTPATI	,	0. 000000			93. 00
1 1	e instructions)	3. 000000			200. 00
201.00 Less Observat	•				201. 00
202.00 Total (see in					202. 00
202.00 1000 (300 11		1			1232.00

				10	12/31/2019	6/29/2020 8: 3	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total Cost		Operating Cost	Capi tal	Operating Cost	
			(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
			ĺ	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	15, 122, 186	2, 491, 527	12, 630, 659	0	0	50.00
51.00	05100 RECOVERY ROOM	1, 865, 177	347, 779	1, 517, 398	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 488, 081	1, 192, 988	5, 295, 093	0	0	52.00
53.00	05300 ANESTHESI OLOGY	6, 890, 158	150, 463	6, 739, 695	0	0	53.00
53. 01	05301 ASC ANESTHESI OLOGY	92, 154	8, 332	83, 822	0	0	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 463, 556	1, 329, 938	8, 133, 618	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	792, 793	154, 251	638, 542	0	0	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 523, 487	677, 108	3, 846, 379	0	0	59. 00
60.00	06000 LABORATORY	14, 583, 463	815, 153	13, 768, 310	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	958, 366	56, 923	901, 443	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	3, 269, 916	117, 817	3, 152, 099	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 073, 884	66, 500	1, 007, 384	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	668, 048	30, 064	637, 984	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	411, 571	25, 439	386, 132	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 588, 765	202, 646	2, 386, 119	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	137, 438	1, 157	136, 281	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 179, 398	461, 829	13, 717, 569	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17, 516, 553	572, 848	16, 943, 705	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	54, 412, 001	516, 764	53, 895, 237	0	0	73. 00
74.00	07400 RENAL DIALYSIS	1, 266, 940	122, 811	1, 144, 129	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	9, 369, 936	639, 375	8, 730, 561	0	0	75. 01
76.00	03950 CARDI AC CATHERI ZATI ON	0	0	0	0	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	852, 457	45, 691	806, 766	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01	04950 SLEEP CLINIC	1, 067, 492	92, 829	974, 663	0	0	90. 01
90. 03	09002 ARNETT CANCER CARE CENTER	2, 626, 005	225, 836	2, 400, 169	0	0	90. 03
90.04	09003 OUTPATIENT INFUSION CENTER	132, 754	49, 935	82, 819	0	0	90. 04
91.00	09100 EMERGENCY	13, 155, 111	1, 640, 074	11, 515, 037	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 703, 542	1, 115, 020	5, 588, 522	0	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
93.00	04951 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93. 00
200.00	Subtotal (sum of lines 50 thru 199)	190, 211, 232	13, 151, 097	177, 060, 135	0	0	200. 00
201.00	Less Observation Beds	6, 703, 542	1, 115, 020	5, 588, 522	0		201. 00
202.00	Total (line 200 minus line 201)	183, 507, 690	12, 036, 077	171, 471, 613	0	0	202. 00

1125001	. 5.16 . 5.1			1	To 12/31/2019	Date/Time Pr 6/29/2020 8:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
			(Worksheet C,				
		Operating Cost					
		Reduction	8)	/ col . 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	15, 122, 186	143, 096, 297	0. 105678			50. 00
51. 00	05100 RECOVERY ROOM	1, 865, 177	13, 716, 404	0. 135981			51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 488, 081	25, 625, 852	0. 253185			52. 00
53. 00	05300 ANESTHESI OLOGY	6, 890, 158	8, 614, 727	0. 799812			53. 00
	05301 ASC ANESTHESI OLOGY	92, 154	4, 481, 564	0. 020563			53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 463, 556	91, 373, 464	0. 103570			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000			55. 00
56. 00	05600 RADI 0I SOTOPE	792, 793	14, 564, 007	0. 054435			56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 523, 487	59, 202, 039	0. 076408			59. 00
60. 00	06000 LABORATORY	14, 583, 463	73, 563, 228	0. 198244			60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	958, 366	4, 942, 007	0. 193922			63. 00
65. 00	06500 RESPI RATORY THERAPY	3, 269, 916	13, 224, 849	0. 247255			65. 00
66.00	06600 PHYSI CAL THERAPY	1, 073, 884	4, 141, 290	0. 259311			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	668, 048	1, 805, 896	0. 369926			67. 00
68. 00	06800 SPEECH PATHOLOGY	411, 571	1, 589, 095	0. 258997			68. 00
	06900 ELECTROCARDI OLOGY	2, 588, 765	29, 931, 791	0. 086489			69. 00
	07000 ELECTROENCEPHALOGRAPHY	137, 438	1, 568, 327	0. 087634			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 179, 398	43, 162, 723	0. 328510			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	17, 516, 553	88, 160, 050	0. 198690			72. 00
	07300 DRUGS CHARGED TO PATIENTS	54, 412, 001	192, 366, 075				73. 00
	07400 RENAL DIALYSIS	1, 266, 940	3, 161, 116	0. 400789			74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0. 000000			75. 00
	07501 ASC (NON-DISTINCT PART)	9, 369, 936	126, 804, 135	0. 073893			75. 01
	03950 CARDI AC CATHERI ZATI ON	0	0	0. 000000			76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	852, 457	113, 225	7. 52887 <i>6</i>	5		76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0. 000000			90. 00
	04950 SLEEP CLINIC	1, 067, 492	7, 215, 508	0. 147944			90. 01
	09002 ARNETT CANCER CARE CENTER	2, 626, 005	23, 216, 254	0. 113111			90. 03
90. 04	09003 OUTPATIENT INFUSION CENTER	132, 754	803, 064	0. 165309			90. 04
	09100 EMERGENCY	13, 155, 111	181, 535, 957	0. 072466			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 703, 542	25, 032, 595	0. 267793			92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0. 000000			92. 01
	04951 OTHER OUTPATIENT SERVICES	0	0	0. 000000			93. 00
200.00		1	1, 183, 011, 539				200. 00
201.00		6, 703, 542	0				201. 00
202.00	Total (line 200 minus line 201)	183, 507, 690	1, 183, 011, 539				202. 00

Health Financial Systems	IU HEALTH ARNE	ETT HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider Co	CN: 15-0173	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part I	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cos- (col. 1 - col		Per Diem (col. 3 / col. 4)	
	26)		2)			
INDATIONE DOUTING CERVILOE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	10.0/4.707		100117	10.050		
30. 00 ADULTS & PEDI ATRI CS	10, 064, 727	0				
31. 00 INTENSIVE CARE UNIT	992, 444		992, 44	· ·		
33. 00 BURN INTENSIVE CARE UNIT	0			0	0.00	
33. 01 BURN INTENSIVE CARE UNIT	752 071		752.0	71 2 040	0.00	
35. 00 NEONATAL INTENSIVE CARE UNIT	753, 071		753, 0			
43. 00 NURSERY	338, 566	l e	338, 56			
200.00 Total (lines 30 through 199) Cost Center Description	12, 148, 808 Inpati ent		12, 148, 80	08 52, 623		200. 00
Cost Center Description		Inpati ent				
	Program days	Program Capital Cost				
		(col. 5 x col.				
		6)				
	6, 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	l .			
30. 00 ADULTS & PEDIATRICS	17, 091	3, 913, 839				30.00
31. 00 INTENSIVE CARE UNIT	1, 059		1			31.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
33. 01 BURN INTENSIVE CARE UNIT	0	0				33. 01
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	18, 150	4, 287, 465				200. 00

Health Financial Systems	IU HEALTH ARN			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 6/29/2020 8:3	pared: 3 am
		Ti tl e	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I Inpati ent	Capital Costs	
· ·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	·				
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 491, 527	143, 096, 297	0. 01741	2 24, 559, 986	427, 638	50.00
51.00 05100 RECOVERY ROOM	347, 779	13, 716, 404	0. 02535	5 1, 896, 618	48, 089	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 192, 988	25, 625, 852	0. 04655	4 161, 725	7, 529	52. 00
53. 00 05300 ANESTHESI OLOGY	150, 463	8, 614, 727	0. 01746	6 1, 525, 534	26, 645	53.00
53. 01 05301 ASC ANESTHESI OLOGY	8, 332	4, 481, 564	0. 00185	9 2, 131	4	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 329, 938	91, 373, 464	0. 01455	5 16, 678, 218	242, 751	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	O	0. 00000	o o	0	55. 00
56. 00 05600 RADI 0I SOTOPE	154, 251	14, 564, 007	0. 01059	1, 096, 617	11, 614	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	677, 108	59, 202, 039	0. 01143	7 10, 352, 528	118, 402	59.00
60. 00 06000 LABORATORY	815, 153				117, 117	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	56, 923				17, 269	
65. 00 06500 RESPI RATORY THERAPY	117, 817		1		42, 638	65.00
66. 00 06600 PHYSI CAL THERAPY	66, 500				30, 255	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	30, 064		1		13, 227	67. 00
68. 00 06800 SPEECH PATHOLOGY	25, 439		1		12, 302	68.00
69. 00 06900 ELECTROCARDI OLOGY	202, 646				54, 013	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 157		1		370	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	461, 829		1		79, 375	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	572, 848				129, 166	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	516, 764				50, 362	73.00
74. 00 07400 RENAL DIALYSIS	122, 811	3, 161, 116			60, 377	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		0. 00000		0	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	639, 375	_			505	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	00,70,0		0. 00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	45, 691	_			11, 015	76. 97
OUTPATIENT SERVICE COST CENTERS	10,071	110, 220	0. 10001	21,271	11,010	70.77
90. 00 09000 CLINIC	1 0	0	0.00000	0 0	0	90.00
90. 01 04950 SLEEP CLI NI C	92, 829				77	90. 01
90. 03 09002 ARNETT CANCER CARE CENTER	225, 836				829	90. 03
90. 04 09003 OUTPATIENT INFUSION CENTER	49, 935		l .		0	90. 04
91. 00 09100 EMERGENCY	1, 640, 074				175, 175	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 115, 020		1		10, 810	92.00
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	1, 113, 020		1		10, 010	92.00
93. 00 04951 OTHER OUTPATIENT SERVICES			0. 00000		0	93.00
200.00 Total (lines 50 through 199)	13 151 007	1, 183, 011, 539		152, 506, 819	-	
200.00 10tal (111103 00 till ough 177)	13, 131, 077	1, 100, 011, 007	I	132, 300, 017	1,007,004	1200.00

Health Financial Systems	IU HEALTH ARNI	FTT HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER				Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III	pared:
		Ti tl e	: XVIII	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments	Ü	Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education Cost	
INDATIONE DOUBLING CODY, OF COCT CONTEDC	1A	1.00	2A	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 33. 01 03301 BURN INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 35. 00 04300 O4300 O4300 O4300 Total (Lines 30 through 199)	0 0 0 0 0	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	31. 00 33. 00 33. 01 35. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days 8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
30. 00	0	000000000000000000000000000000000000000	2, 81 3, 04 2, 81	0.00 0.00 0.00 0.00 9 0.00 1 0.00	1, 059 0 0 0 0	33. 00 33. 01 35. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 33.00 03300 BURN INTENSI VE CARE UNI T 35.00 02060 NEONATAL INTENSI VE CARE UNI T 43.00 04300 NURSERY Total (lines 30 through 199)	0 0 0 0 0 0					30. 00 31. 00 33. 00 33. 01 35. 00 43. 00 200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: THROUGH COSTS

Title XVII Hospital PPS Title XVII Hospital PPS Title XVII School Nursing School All Ide Heal th Post-Stepdown Adjustments Another Step Step Step Step Step Step Step Step					'	12,01,201,	6/29/2020 8: 3	3 am
Anesthétis Cost				Ti tl e	e XVIII	Hospi tal		
ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00		Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
ANCILLARY SERVICE COST CENTERS		'	Anestheti st	Post-Stepdown		Post-Stepdown		
ANCILLARY SERVICE COST CENTERS			Cost	Adjustments		Adjustments		
50.00 05000 05000 05000 05000 05000 05000 05000 05100 05100 05100 05100 05100 05200 05100 05200 05100 05200 05100 05200 05100 05200 05100 05200 05100 0520			1.00	2A	2.00	3A	3. 00	
51.00 05100 RECOVERY ROOM LABOR ROOM D D D D D D D D D		ANCILLARY SERVICE COST CENTERS						
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 53.00	50.00	05000 OPERATI NG ROOM	C	0) (0	0	50. 00
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00 53.01 05301 ASC ANESTHESI OLOGY 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 0 0 0 0 56.00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 0 0 0 0 56.00 05600 RADIO OLOGY - THERAPEUTI C 0 0 0 0 0 0 57.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 60.00 06600 RADIO OLOGY - THERAPEY 0 0 0 0 0 0 60.00 06600 DHYSIC LAT HERAPY 0 0 0 0 0 0 60.00 06600 PHYSIC LAT HERAPY 0 0 0 0 0 0 60.00 06600 PHYSIC LAT HERAPY 0 0 0 0 0 0 0 60.00 06600 SPEECH PATHOLOGY 0 0 0 0 0 0 60.00 06600 SPEECH PATHOLOGY 0 0 0 0 0 0 60.00 06600 SPEECH PATHOLOGY 0 0 0 0 0 0 60.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 60.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 60.00 0700 0700 0700 0700 0700 0700 60.00 0700 0700 0700 0700 0700 0700 60.00 0700 0700 0700 0700 0700 0700 60.00 0700 0700 0700 0700 0700 0700 0700 60.00 0700 0700 0700 0700 0700 0700 0700 60.00 0700 0700 0700 0700 0700 0700 0700 0700 60.00 070	51.00	05100 RECOVERY ROOM) c) (0	0	51.00
53.01 05301 ASC ANESTHESI OLOGY	52.00	05200 DELIVERY ROOM & LABOR ROOM	(c) c		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 0 0 0 0 55. 00 55. 00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 55. 00 55. 00 05600 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 55. 00 55. 00 05600 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 55. 00 55. 00 05600 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 55. 00 55. 00 05600 RADI AC CATHETERI ZATION 0 0 0 0 0 0 0 0 0 55. 00 55. 00 05600 RADI AC CATHETERI ZATION 0 0 0 0 0 0 0 0 0 0 55. 00 65. 00 05600 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53.00	05300 ANESTHESI OLOGY	(c) c		0	0	53.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	53. 01	05301 ASC ANESTHESI OLOGY		o c		o	0	53. 01
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 56. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C) c		o	0	54.00
59, 00 05900 CARDI AC CATHETERIZATION 0 0 0 0 0 0 59, 00	55.00	05500 RADI OLOGY-THERAPEUTI C				0	0	55. 00
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 63. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0	56.00	05600 RADI OI SOTOPE				0	0	56. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 63. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76. 07 07501 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76. 07 07697 CARDI AC CATHERI ZATI ON 0 0 0 0 0 76. 97 07000 CLINI C O 0 0 0 0 90. 01 04950 SLEEP CLINI C O 0 0 0 0 90. 01 04950 SLEEP CLINI C O 0 0 0 0 90. 02 09002 CLINI C COST CENTERS O 0 0 0 90. 03 09002 OSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 90. 04 09003 OUTPATI ENT I INFUSI ON CENTER 0 0 0 0 0 90. 04 09003 OUTPATI ENT I INFUSI ON CENTER 0 0 0 0 0 90. 04 09003 OUTPATI ENT I INFUSI ON CENTER 0 0 0 0 0 92. 00 09200 OSERVATI ON BEDS (IDSTINCT PART) 0 0 0 0 0 92. 01 09201 OSERVATI ON BEDS (IDSTINCT PART) 0 0 0 0 92. 01 09201 OSERVATI ON BEDS (IDSTINCT PART) 0 0 0 0 92. 01 09201 OSERVATI ON BEDS (IDSTINCT PART) 0 0 0 0 92. 01 09201 OSERVATI ON BEDS (IDSTINCT PART) 0 0 0 0 0 92. 01 09201 OSERVATI ON BEDS (IDSTINCT PART) 0 0 0 0 0 92. 01 09201 OSERVATI ON BEDS (IDSTINCT PART) 0 0 0 0 0 92. 01 09201 OSERVATI ON BEDS (I	59.00	05900 CARDI AC CATHETERI ZATI ON				0	0	59. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 00 67. 00 06700 0CUPATIONAL THERAPY 0 0 0 0 0 0 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 01 07501 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 97 07697 CARDI AC CATHERI ZATI ON 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 790. 01 094950 SLEEP CLINIC 0 0 0 0 790. 02 09000 CLINIC 0 0 0 0 790. 03 09000 CLINIC 0 0 0 0 790. 04 09003 OUTPATI ENT INFUSION CENTER 0 0 0 0 791. 00 09200 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0	60.00	06000 LABORATORY				0	0	60.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 00 67. 00 06700 0CUPATIONAL THERAPY 0 0 0 0 0 0 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 01 07501 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 97 07697 CARDI AC CATHERI ZATI ON 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 790. 01 094950 SLEEP CLINIC 0 0 0 0 790. 02 09000 CLINIC 0 0 0 0 790. 03 09000 CLINIC 0 0 0 0 790. 04 09003 OUTPATI ENT INFUSION CENTER 0 0 0 0 791. 00 09200 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 792. 01 09201 DSSERVATI ON BEDS (DISTINCT PART) 0 0 0 0						0	0	1
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0	0	65. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 68800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 68. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0	0	66.00
68. 00						0	0	1
69. 00						0	0	68. 00
70.00						0	0	1
71. 00						0	0	70.00
73. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	71. 00
73. 00						0	0	1
74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 00 75. 01 07501 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 01 76. 00 03950 CARDI AC CATHERI ZATI ON 0 0 0 0 0 0 0 75. 01 76. 97 000 03950 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 76. 00 76. 97 000 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 76. 97 000 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0	273, 142	1
75. 00						0		1
75. 01 07501 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 01 76. 00 03950 CARDI AC CATHERI ZATI ON 0 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABILI TATI ON 0 0 0 0 0 0 76. 97 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 0 90. 01 04950 SLEEP CLI NI C 0 0 0 0 0 0 0 90. 03 09002 ARNETT CANCER CARE CENTER 0 0 0 0 0 0 0 90. 04 09003 OUTPATI ENT INFUSI ON CENTER 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 94. 00 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 94. 00 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 95. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 95. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 96. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 97. 00 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 97. 00 00 00 00 0 97. 00 00 00 00 0 97. 00 00 00 00 00 97. 00 00 00 00 00 97. 00 00 00 00 00 97. 00 00 00 00 97. 00 00 00 00 97. 00 00 00 00 97. 00 00 00 00 97. 00 00 00						0	0	75. 00
76. 00						0	0	75. 01
76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 0 0 0						0	0	1
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS 90. 00						0	0	76. 97
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 01 90. 01 90. 01 90. 03 90. 02 ARNETT CANCER CARE CENTER 0 0 0 0 0 0 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 03 90. 04 90. 05 90. 04 90. 05 90. 06								
90. 03 09002 ARNETT CANCER CARE CENTER 0 0 0 0 0 90. 03 90. 04 90. 04 90. 04 91. 00 0 0 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 0 0 0	90.00) C		0	0	90.00
90. 03 09002 ARNETT CANCER CARE CENTER 0 0 0 0 0 90. 03 90. 04 90. 04 90. 04 91. 00 0 0 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 0 0 0						0	0	1
90. 04 09003 OUTPATIENT INFUSION CENTER 0 0 0 0 90. 04 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 0 0						0	0	90. 03
91. 00 09100 EMERGENCY						0	0	90. 04
92.01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 92.01						0	0	1
92.01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 92.01							0	
				ol c	ol d	0	o o	
93, 00 10495 HOTHER OUTPATTENT SERVICES 01 01 01 01 01 01 93, 00		04951 OTHER OUTPATIENT SERVICES		ol d	ol d	o o	ő	1
200.00 Total (lines 50 through 199)						o o		

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0173	Peri od:	Worksheet D

Period: From 01/01/2019 | Part IV To 12/31/2019 | Date/Time Prepared: THROUGH COSTS 6/29/2020 8:33 am Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 143, 096, 297 0.000000 50.00 0000000000000000000000000 51.00 05100 RECOVERY ROOM 0 0 13, 716, 404 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 625, 852 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 53 00 8, 614, 727 0.000000 53 00 0 53.01 05301 ASC ANESTHESI OLOGY 0 4, 481, 564 0.000000 53.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 91, 373, 464 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55 00 05600 RADI OI SOTOPE 0 14, 564, 007 56.00 0.000000 56.00 59.00 05900 CARDI AC CATHETERI ZATI ON 59, 202, 039 0.000000 59.00 06000 LABORATORY 60.00 73, 563, 228 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 4, 942, 007 0 000000 63.00 63 00 65.00 06500 RESPIRATORY THERAPY 13, 224, 849 0.000000 65.00 06600 PHYSI CAL THERAPY 4, 141, 290 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1, 805, 896 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 589, 095 0.000000 68 00 69.00 06900 ELECTROCARDI OLOGY 29, 931, 791 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 568, 327 0.000000 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 43, 162, 723 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0.000000 72.00 88, 160, 050 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 273, 142 273, 142 192, 366, 075 0.001420 73.00 07400 RENAL DIALYSIS 0.000000 74.00 0 3, 161, 116 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0.000000 75.00 0 07501 ASC (NON-DISTINCT PART) 0 126, 804, 135 0.000000 75.01 Ω 75 01 03950 CARDIAC CATHERIZATION 0 0 0.000000 76.00 76.00 07697 CARDIAC REHABILITATION 76. 97 113, 225 0.000000 76. 97 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0.000000 90.00 04950 SLEEP CLINIC 7, 215, 508 0.000000 90.01 0000000 90.01 09002 ARNETT CANCER CARE CENTER 90. 03 0 0 23, 216, 254 0.000000 90.03 09003 OUTPATIENT INFUSION CENTER 0 0 803.064 0.000000 90 04 90 04 91. 00 | 09100 | EMERGENCY 181, 535, 957 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 25, 032, 595 0.000000 92.00 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 92.01 93. 00 04951 OTHER OUTPATIENT SERVICES 0.000000 93.00 200.00 Total (lines 50 through 199) 273, 142 273, 142 1, 183, 011, 539 200.00

From 01/01/2019 THROUGH COSTS Part IV 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am Title XVIII Hospi tal PPS Outpati ent Outpati ent Cost Center Description Inpatient Inpati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. 8 x col . 12) 13.00 7) x col. 10) 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 24, 559, 986 20, 153, 559 50.00 0 05100 RECOVERY ROOM 0 51.00 0.000000 1, 896, 618 2, 388, 860 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 161, 725 0 52.00 52.00 22, 573 0 05300 ANESTHESI OLOGY 0.000000 1, 525, 534 0 1, 012, 509 53.00 53.00 0 05301 ASC ANESTHESI OLOGY 0.000000 53.01 2, 131 926, 582 53.01 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 16, 678, 218 0 16, 015, 723 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55.00 1, 096, 617 0 56.00 05600 RADI OI SOTOPE 0.000000 4, 166, 004 56.00 0 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 10, 352, 528 10, 846, 632 0 59.00 60.00 06000 LABORATORY 0.000000 10, 569, 147 5, 495, 630 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 499, 307 0 63.00 0.000000 357, 061 0 63.00 0 06500 RESPIRATORY THERAPY 4, 785, 962 187, 110 0.000000 65 00 0 65 00 66.00 06600 PHYSI CAL THERAPY 0.000000 1, 884, 138 46, 236 0 66.00 06700 OCCUPATIONAL THERAPY 794, 505 0 12, 797 67.00 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 0.000000 768, 517 22,863 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.000000 7, 978, 302 0 4, 172, 444 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 501, 685 0 64, 986 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 7, 418, 262 0 6, 771, 779 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 13, 024, 250 72 00 0.000000 19, 877, 805 O 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0.001420 18, 749, 850 26, 625 51, 086, 999 72, 544 73.00 07400 RENAL DIALYSIS 0.000000 1, 554, 062 0 74.00 74.00 202, 676 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 07501 ASC (NON-DISTINCT PART) 0 0.000000 100, 150 25, 605, 404 75.01 75.01 0 03950 CARDI AC CATHERI ZATI ON 76.00 0.000000 0 76.00 07697 CARDIAC REHABILITATION 0.000000 27, 297 0 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS

0.000000

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5, 981

85, 176

242, 682

19, 390, 634

152, 506, 819

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26, 625

1, 625, 082

8, 356, 641

23, 917, 605

203, 230, 212

6, 574, 410

173.797

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90.04 0

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72, 544 200. 00

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90.01

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91 00

92.00

92. 01

200.00

109000 CLI NI C

04950 SLEEP CLINIC

09100 EMERGENCY

90. 03 09002 ARNETT CANCER CARE CENTER

93. 00 |04951 OTHER OUTPATIENT SERVICES

09003 OUTPATIENT INFUSION CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

09201 OBSERVATION BEDS (DISTINCT PART)

Total (lines 50 through 199)

Heal th	Financial Systems	IU HEALTH ARN	ETT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0173	Period: From 01/01/2019	Worksheet D Part V	
					To 12/31/2019	Date/Time Pre 6/29/2020 8:3	pared: 3 am
			Ti tl e	xVIII	Hospi tal	PPS	<u> </u>
				Charges	•	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins			
		1.00	2.00	(see inst.)	(see inst.)	Г 00	
	ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	0. 105678	20, 153, 559		0 0	2, 129, 788	50.00
51.00	05100 RECOVERY ROOM	0. 105078			0 0	324, 840	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 253185			0 0	5, 715	
53. 00	05300 ANESTHESI OLOGY	0. 799812			0 0	809, 817	1
53. 01	05301 ASC ANESTHESI OLOGY	0. 020563				19, 053	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 103570		1		1, 658, 748	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000		1	0 0	1, 030, 740	55. 00
56. 00	05600 RADI OI SOTOPE	0. 054435				226, 776	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 076408				828, 769	59.00
60.00	06000 LABORATORY	0. 198244		1		1, 089, 476	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 193922		1	0 0	69, 242	1
65. 00	06500 RESPI RATORY THERAPY	0. 247255		1	0 0	46, 264	
66. 00	06600 PHYSI CAL THERAPY	0. 259311		1	0 0	11, 990	
67.00	06700 OCCUPATI ONAL THERAPY	0. 369926			0 0	4, 734	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 258997	22, 863		0 0	5, 921	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 086489	4, 172, 444		0 0	360, 871	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 087634	64, 986	,	0	5, 695	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 328510	6, 771, 779	1	0	2, 224, 597	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 198690			0	2, 587, 788	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 282857		1	0 45, 946	14, 450, 315	73. 00
74. 00	07400 RENAL DI ALYSI S	0. 400789		1	0	81, 230	
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	l e		0	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	0. 073893		1	0	1, 892, 060	
76. 00	03950 CARDI AC CATHERI ZATI ON	0. 000000		1	0 0	0	76. 00
76. 97	07697 CARDI AC REHABILITATION	7. 528876	0	1	0 0	0	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS	0.000000		ı			00.00
90. 00 90. 01	09000	0. 000000 0. 147944		1	0 0	0 240, 421	90. 00 90. 01
90.01	09002 ARNETT CANCER CARE CENTER	0. 147944		1	0 0	945, 228	1
90. 03	09003 OUTPATIENT INFUSION CENTER	0. 165309			0 0	28, 730	
91. 00	09100 EMERGENCY	0. 072466			0 0	1, 733, 213	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 072400		1	0 0	1, 760, 581	
92. 01	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000		1	0 0	1, 700, 301	1
93. 00	04951 OTHER OUTPATIENT SERVICES	0. 000000			0 0	0	93. 00
200.00		0.00000	203, 230, 212	21, 70	-		
201.00			200, 200, 212		0 75, 740	33, 341, 302	201.00
201.00	Only Charges				-		
202.00			203, 230, 212	21, 70	45, 946	33, 541, 862	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2019 Part V
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am

						6/29/2020 8: 3	3 am
			Title	XVIII	Hospi tal	PPS	
		Cos	ts				
	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						
50.00	05000 OPERATING ROOM	0	0				50. 00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0				52. 00
53.00	05300 ANESTHESI OLOGY	o	0				53.00
53. 01	05301 ASC ANESTHESI OLOGY	o	0				53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	l ol	0				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00	05600 RADI OI SOTOPE	l ol	0				56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	أم	0				59. 00
60.00	06000 LABORATORY	4, 302	0				60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 002	0				63. 00
65. 00	06500 RESPI RATORY THERAPY		0				65. 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
70. 00	07000 ELECTROENCEPHALOGRAPHY		0				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		12, 996	1			73. 00
74. 00	07400 RENAL DIALYSIS		12, 440	i			74.00
75.00	1		0				75. 00
75. 00 75. 01	O7500 ASC (NON-DISTINCT PART) O7501 ASC (NON-DISTINCT PART)	0	0				75. 00
		0					1
76.00	03950 CARDI AC CATHERI ZATI ON	0	0				76. 00
76. 97	07697 CARDI AC REHABILITATION	0	0				76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	0		I			00.00
90.00	09000 CLINIC	0	0				90.00
90. 01	04950 SLEEP CLINIC	0	0				90. 01
90. 03	09002 ARNETT CANCER CARE CENTER	0	0				90. 03
90. 04	09003 OUTPATIENT INFUSION CENTER	0	0				90. 04
91. 00	09100 EMERGENCY	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				92. 01
93. 00	04951 OTHER OUTPATIENT SERVICES	0	0				93. 00
200.00		4, 302	12, 996				200. 00
201.00	9	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	4, 302	12, 996				202. 00

Health Financial Systems	IU HEALTH ARNE	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider CO	CN: 15-0173	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part I Date/Time Pre 6/29/2020 8:3	pared: 3 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos	t l	,	
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30. 00 ADULTS & PEDI ATRI CS	10, 064, 727	0	10, 064, 72	27 43, 950	229. 00	30.00
31.00 INTENSIVE CARE UNIT	992, 444		992, 44	14 2, 813	352. 81	31.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
33. 01 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 01
35. 00 NEONATAL INTENSIVE CARE UNIT	753, 071		753, 0	71 3, 049	246, 99	35. 00
43. 00 NURSERY	338, 566		338, 50		120. 44	43.00
200.00 Total (lines 30 through 199)	12, 148, 808		12, 148, 80			200.00
Cost Center Description	I npati ent	Inpatient	,,			
	Program days	Program				
	1	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>			
30. 00 ADULTS & PEDI ATRI CS	739	169, 231				30.00
31. 00 INTENSIVE CARE UNIT	771	272, 017				31.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
33. 01 BURN INTENSIVE CARE UNIT	0	0				33. 01
35. 00 NEONATAL INTENSIVE CARE UNIT	299	73, 850				35. 00
43. 00 NURSERY	1, 342					43. 00
200.00 Total (lines 30 through 199)	3, 151					200.00
		1 2.2,720	1			

Health Financial Systems	IU HEALTH ARN	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 6/29/2020 8:3	pared: 3 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 491, 527				11, 485	50.00
51.00 05100 RECOVERY ROOM	347, 779				922	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 192, 988			4 515, 704	24, 008	52. 00
53. 00 05300 ANESTHESI OLOGY	150, 463				880	53. 00
53. 01 05301 ASC ANESTHESI OLOGY	8, 332				0	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 329, 938	91, 373, 464	0. 01455	5 640, 708	9, 326	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	154, 251	14, 564, 007	0. 01059	1 15, 142	160	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	677, 108	59, 202, 039	0. 01143	7 138, 561	1, 585	59. 00
60. 00 06000 LABORATORY	815, 153	73, 563, 228	0. 01108	1 634, 559	7, 032	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	56, 923				624	63. 00
65. 00 06500 RESPIRATORY THERAPY	117, 817		1	9 485, 948	4, 329	65.00
66. 00 06600 PHYSI CAL THERAPY	66, 500	4, 141, 290	0. 01605	8 51, 693	830	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	30, 064		1		376	67. 00
68. 00 06800 SPEECH PATHOLOGY	25, 439		1		474	68.00
69. 00 06900 ELECTROCARDI OLOGY	202, 646				1, 609	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 157				22	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	461, 829		1		2, 668	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	572, 848				1, 264	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	516, 764				3, 207	73.00
74. 00 07400 RENAL DIALYSIS	122, 811	3, 161, 116			1, 186	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0, 101, 110	0. 00000		0	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	639, 375	126, 804, 135			0	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	007,070		0. 00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	45, 691	_	l .		377	76. 97
OUTPATIENT SERVICE COST CENTERS	10,071	110, 220	0. 10001	2 700	377	70.77
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 01 04950 SLEEP CLINIC	92, 829				0	90. 01
90. 03 09002 ARNETT CANCER CARE CENTER	225, 836				0	90. 03
90. 04 09003 OUTPATIENT INFUSION CENTER	49, 935				0	90.04
91. 00 09100 EMERGENCY	1, 640, 074				6, 631	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 115, 020		1		386	92.00
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	1, 113, 020		1		0	92.00
93. 00 04951 OTHER OUTPATIENT SERVICES			0. 00000		0	93.00
200.00 Total (lines 50 through 199)	13 151 007	1, 183, 011, 539		6, 013, 939	-	
200.00 10tal (111103 00 till ough 177)	13, 131, 077	1, 100, 011, 007	I	0,015,757	77, 301	1200.00

Health Financial Systems	IU HEALTH ARN	FTT HOSPLTAL		In lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		TS Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Pre 6/29/2020 8:3	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments		Allied Healt Post-Stepdow Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•		•			
30. 00 03000 ADULTS & PEDI ATRI CS	C) C		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT		ol c		0 0	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT				0 0	0	33.00
33. 01 03301 BURN INTENSIVE CARE UNIT				0 0	0	1
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				0	0	
43. 00 04300 NURSERY				0	0	
200.00 Total (lines 30 through 199)				0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	200.00
555t 5511tG. 255511pt.511	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	,-			
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>	•	•			
30. 00 03000 ADULTS & PEDI ATRI CS	C) C	43, 95	0.00	739	30.00
31.00 03100 INTENSIVE CARE UNIT		C	2, 81	3 0.00	771	31.00
33.00 03300 BURN INTENSIVE CARE UNIT		C		0.00	0	33.00
33.01 03301 BURN INTENSIVE CARE UNIT				0.00	0	33. 01
35.00 02060 NEONATAL INTENSIVE CARE UNIT			3, 04	9 0.00	299	35. 00
43. 00 04300 NURSERY			2, 81	0.00	1, 342	43.00
200.00 Total (lines 30 through 199)						200.00
Cost Center Description	I npati ent		•			
'	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C					30.00
31.00 03100 INTENSIVE CARE UNIT	C)				31.00
33.00 03300 BURN INTENSIVE CARE UNIT						33. 00
33.01 03301 BURN INTENSIVE CARE UNIT						33. 01
35.00 02060 NEONATAL INTENSIVE CARE UNIT						35. 00
43. 00 04300 NURSERY						43.00

43.00 200. 00

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

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: THROUGH COSTS

					10 12/31/2017	6/29/2020 8: 3	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anestheti st	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
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
53. 01	05301 ASC ANESTHESI OLOGY	0	0		0	0	53. 01
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 OI SOTOPE	0	0		0	0	56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0		0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	o	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	o	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 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	273, 142	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 01
76.00	03950 CARDI AC CATHERI ZATI ON	0	0		0 0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	O		0 0	0	90. 00
90. 01	04950 SLEEP CLINIC	0	0		0	0	90. 01
90. 03	09002 ARNETT CANCER CARE CENTER	0	0		0	0	90. 03
90.04	09003 OUTPATIENT INFUSION CENTER	0	0		0	0	90. 04
91.00	09100 EMERGENCY	o	0		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o			0	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	o	0		0 0	0	92. 01
93.00	04951 OTHER OUTPATIENT SERVICES	o	0		0 0	0	93. 00
200.00	Total (lines 50 through 199)	0	0		0 0	273, 142	200. 00

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0173	Peri od:	Worksheet D

From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: THROUGH COSTS 6/29/2020 8:33 am Title XIX Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 143, 096, 297 0.000000 50.00 0000000000000000000000000 51.00 05100 RECOVERY ROOM 0 0 13, 716, 404 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 625, 852 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 53 00 8, 614, 727 0.000000 53 00 0 53.01 05301 ASC ANESTHESI OLOGY 0 4, 481, 564 0.000000 53.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 91, 373, 464 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55 00 05600 RADI OI SOTOPE 0 14, 564, 007 56.00 0 0.000000 56.00 59.00 05900 CARDI AC CATHETERI ZATI ON 59, 202, 039 0.000000 59.00 06000 LABORATORY 60.00 73, 563, 228 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 4, 942, 007 0 000000 63.00 63 00 65.00 06500 RESPIRATORY THERAPY 13, 224, 849 0.000000 65.00 06600 PHYSI CAL THERAPY 4, 141, 290 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1, 805, 896 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 589, 095 0.000000 68 00 69.00 06900 ELECTROCARDI OLOGY 29, 931, 791 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 568, 327 0.000000 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 43, 162, 723 0.000000 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0.000000 72.00 88, 160, 050 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 273, 142 273, 142 192, 366, 075 0.001420 73.00 07400 RENAL DIALYSIS 0.000000 74.00 0 3, 161, 116 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0.000000 75.00 07501 ASC (NON-DISTINCT PART) 0 126, 804, 135 0.000000 75.01 Ω 75 01 03950 CARDIAC CATHERIZATION 0 0 0.000000 76.00 76.00 07697 CARDIAC REHABILITATION 76. 97 113, 225 0.000000 76. 97 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0.000000 90.00 04950 SLEEP CLINIC 7, 215, 508 0.000000 90.01 0000000 90.01 09002 ARNETT CANCER CARE CENTER 90. 03 0 0 23, 216, 254 0.000000 90.03 09003 OUTPATIENT INFUSION CENTER 0 0 803.064 0.000000 90 04 90 04 91. 00 | 09100 | EMERGENCY 181, 535, 957 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 25, 032, 595 0.000000 92.00 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0 0.000000 C 93. 00 04951 OTHER OUTPATIENT SERVICES 0.000000 93.00 200.00 Total (lines 50 through 199) 273, 142 273, 142 1, 183, 011, 539 200.00

 Heal th Financial
 Systems
 IU HEALTH ARNETT

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provi der CCN: 15-0173 THROUGH COSTS

					0 12/31/2019	0/29/2020 8:3	pared: 3 am
			Ti tl	e XIX	Hospi tal	PPS	o am
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0. 000000	659, 631		-	0	
51. 00	05100 RECOVERY ROOM	0. 000000	36, 364		0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	515, 704		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	50, 392	(0	0	53. 00
53. 01	05301 ASC ANESTHESI OLOGY	0. 000000	0	(0	0	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	640, 708	(0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	C	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	15, 142	(0	0	56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	138, 561		0	0	59. 00
60.00	06000 LABORATORY	0. 000000	634, 559		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	54, 188	(0	0	63. 00
65.00	06500 RESPIRATORY THERAPY	0. 000000	485, 948	1 0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	51, 693	1 0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	22, 591	1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	29, 597		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	237, 736		0	o o	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	29, 311		0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	249, 329		0	o o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	194, 447	•	1	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 001420	1, 193, 928	_	_	o o	
74. 00	07400 RENAL DIALYSIS	0. 000000	30, 527		o o	o o	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	00, 027		o o	Ö	
75. 01	07501 ASC (NON-DISTINCT PART)	0. 000000	0		o o	o o	75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON	0. 000000	0		o o	o o	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	933		-	1	
70. 77	OUTPATIENT SERVICE COST CENTERS	0.000000	733		,		70.77
90.00	09000 CLINIC	0.000000	0		0	0	90. 00
90. 01	04950 SLEEP CLINIC	0. 000000	0			Ö	
90. 03	09002 ARNETT CANCER CARE CENTER	0. 000000	0		o o	Ö	90. 03
90. 03	09003 OUTPATIENT INFUSION CENTER	0. 000000	0			0	90.03
91. 00	09100 EMERGENCY	0. 000000	733, 988			0	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	8, 662			0	92.00
92. 01	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0, 002			0	1
93. 00	04951 OTHER OUTPATIENT SERVICES	0. 000000	0		0	0	1
200.00		0.000000	6, 013, 939	1	1		200. 00
200.00	Total (Tilles 50 till ough 177)	1	0, 013, 737	1,090	, ₁ 0 ₁	,	1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0173 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 6/29/2020 8:33 am Title XIX Hospi tal 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. 105678 0 50.00 51.00 05100 RECOVERY ROOM 0.135981 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 253185 0 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0.799812 0 0 53.00 53.01 05301 ASC ANESTHESI OLOGY 0.020563 0 53.01 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.103570 0 54.00 0 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 0.054435 0 56.00 05900 CARDIAC CATHETERIZATION 0 59.00 0.076408 0 0 59.00 06000 LABORATORY 0 198244 0 0 60 00 60 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.193922 0 0 63.00 06500 RESPIRATORY THERAPY 0. 247255 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0. 259311 0 0 66,00 0 06700 OCCUPATIONAL THERAPY 67.00 0.369926 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.258997 0 0 0 68.00 69. 00 06900 ELECTROCARDI OLOGY 0.086489 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.087634 0 0 70.00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0.328510 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 198690 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 282857 0 0 73.00 73.00 0 07400 RENAL DIALYSIS 0 74.00 0.400789 0 0 74.00 07500 ASC (NON-DISTINCT PART) 07501 ASC (NON-DISTINCT PART) 0 0 75.00 0.000000 Ω 75.00 75. 01 0.073893 0 0 0 75.01 03950 CARDI AC CATHERI ZATI ON 0 76.00 0.000000 0 0 76.00 07697 CARDIAC REHABILITATION 0 76. 97 7. 528876 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 0 0 90. 01 04950 SLEEP CLINIC 0.147944 0 0 0 0 0 0 0 0 0 90.01 09002 ARNETT CANCER CARE CENTER 0 0.113111 0 90.03 90 03 0 90.04 09003 OUTPATIENT INFUSION CENTER 0. 165309 0 0 90.04 09100 EMERGENCY 0 91.00 91.00 0.072466 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 0.267793 0 0 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.000000 0 0 92.01 93.00 04951 OTHER OUTPATIENT SERVICES 0.000000 0 0 93.00 200.00 Subtotal (see instructions) 0 200.00 0

0

201. 00

0 202. 00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

From 01/01/2019 Part V 12/31/2019 Date/Time Prepared: 6/29/2020 8:33 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 53.01 05301 ASC ANESTHESI OLOGY 0 53.01 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56. 00 05600 RADI 0I SOTOPE 0 56.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 0 60 00 60 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 07501 ASC (NON-DISTINCT PART) 75.00 0 75.00 75. 01 0 75.01 03950 CARDI AC CATHERI ZATI ON 76.00 0 76.00 07697 CARDIAC REHABILITATION 0 oj 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 90. 01 04950 SLEEP CLINIC 000000000 90.01 09002 ARNETT CANCER CARE CENTER 90.03 0 90.03 0 90.04 09003 OUTPATIENT INFUSION CENTER 90.04 09100 EMERGENCY 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 92.01 93.00 04951 OTHER OUTPATIENT SERVICES 0 93.00

0

0

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0173	Peri od: From 01/01/2019	Worksheet D-1	
			Date/Time Pre 6/29/2020 8:3	
	Title XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	6/29/2020 8: 3 PPS	3 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			43, 950	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.		ivate room days,	43, 950 0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		39, 081	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)			0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swi ng-bed and	17, 091	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yellow Medically necessary private room days applicable to the Program			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	3)		60, 509, 514	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		60, 509, 514	27. 00
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 :	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	25)		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	ına prıvate room cost di	rrerential (line	60, 509, 514	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	CTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 376. 78	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		23, 530, 547	
40. 00	Medically necessary private room cost applicable to the Progra	-		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		23, 530, 547	41. 00

Heal th	Financial Systems	IU HEALTH ARNI	TT HOSPITAL		In lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	TO TIETLETTI 7		CN: 15-0173	Peri od:	Worksheet D-1	
					From 01/01/2019 To 12/31/2019		pared:
						6/29/2020 8: 3	
	Coot Conton Decement on	Total	Ti tl e	XVIII	Hospi tal	PPS Program Cost	
	Cost Center Description	Total Inpatient Cost		Average Per	Program Days	(col. 3 x col.	
		patront oost	patront baye	col . 2)		4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	(0.0	0 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	7, 989, 680	2, 813	2, 840. 2	1, 059	3, 007, 846	43 00
44. 00	CORONARY CARE UNIT	7, 707, 000	2,013	2,040.2	1,039	3,007,040	44. 00
45. 00	BURN INTENSIVE CARE UNIT	0	(0.0	0	0	
45. 01	BURN INTENSIVE CARE UNIT	0	(0.0	0	0	
46. 00	SURGICAL INTENSIVE CARE UNIT	/ 100 000	0.046	0.010			46. 00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	6, 129, 809	3, 049	2, 010. 4	3 0	0	47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			26, 012, 342	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instruction	ons)		52, 550, 735	49. 00
F0 00	PASS THROUGH COST ADJUSTMENTS			W . D	6.5	4 007 4/5	F0 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (Tro	n WKST. D, SUM	or Parts I and	4, 287, 465	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	1, 714, 179	51.00
	and IV)		,				
52. 00	Total Program excludable cost (sum of lines					6, 001, 644	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-phy	ysician anesth	etist, and	46, 549, 091	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54.00	Program di scharges					0	54.00
55. 00	Target amount per discharge					0.00	55. 00
56.00	Target amount (line 54 x line 55)				50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (i	ine 56 minus	11 ne 53)	0	
59. 00						59.00	
	market basket	parama parama		.,			
60.00	Lesser of lines 53/54 or 55 from prior year						60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		.s (TITIES 34 X	00), 01 1% 01	the target		
62.00	.00 Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63. 00
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Door	mbon 21 of the	anat manamti	ng norted (Coo		64. 00
64. 00	instructions)(title XVIII only)	ts through bece	sliber 31 of the	e cost reporti	ng perrou (see		04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the o	cost reporting	period (See	0	65.00
	instructions)(title XVIII only)					_	
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost re	porting period	0	67. 00
	(line 12 x line 19)				J 1		
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
60.00	(line 13 x line 20)	routino costs (lino 67 : lino	. 60)		0	69. 00
07.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						J 07. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71. 00
72.00	, ,		· (lino 14 v !:	no 2E)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			art II, column		75. 00
	26, line 45)		,	•			
76. 00	Per diem capital related costs (line 75 ÷ li	. *					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der record	ds)			79.00
	Total Program routine service costs for comp			*	us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi						81. 00
82.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ons)				85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
07.05	PART IV - COMPUTATION OF OBSERVATION BED PASS						07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			4, 869 1, 376. 78	1
	Observation bed cost (line 87 x line 88) (se	•	,			6, 703, 542	1

Health Financial Systems	IU HEALTH ARNE	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Prep 6/29/2020 8:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	10, 064, 727	60, 509, 514	0. 16633	6, 703, 542	1, 115, 020	90.00
91.00 Nursing School cost	0	60, 509, 514	0.00000	6, 703, 542	0	91.00
92.00 Allied health cost	0	60, 509, 514	0.00000	6, 703, 542	0	92.00
93.00 All other Medical Education	0	60, 509, 514	0.00000	6, 703, 542	0	93.00

Health Financial Systems	IU HEALTH ARNETT HO	OSPI TAL	In Lie	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Pi		Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prep 6/29/2020 8:33	
		Title XIX	Hospi tal	PPS	
Cost Center Description					

Ref - ALL PROVIDER COMPONERS 1.00					6/29/2020 8: 3	3 am
			Title XIX	Hospi tal	PPS	
NAME ALL PROVIDER COMPONENTS		Cost Center Description				
Name					1.00	
1.00 Inpatient days (Including private room days and swing-bed days, excluding newborn)		PART I - ALL PROVIDER COMPONENTS				
1.00 Private room days, (secluding simply bed and observation bed days) 1.7 you have only private room days, (so on complete this is inc. 3.00 Private room days, (sociuding saving-bed and observation bed days) 1.7 you have only private room days, 3.00 1.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00	1.00					
do not complete this line. 4. 00 Sele-private room days (excluding swing-bed and observation bed days) 5.00 Intal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 8. 00 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost 9. 01 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost 10. 02 Saing-bed SNF type inpatient days (and using private room days) after December 31 of the cost 10. 03 Saing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 10. 00 Saing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 10. 00 Saing-bed SNF type inpatient days applicable to the Program (excluding private room days) 10. 00 Saing-bed SNF type inpatient days applicable to the Program (excluding private room days) 10. 00 Saing-bed SNF type inpatient days applicable to the Program (excluding private room days) 10. 00 Saing-bed SNF type inpatient days applicable to the Program (excluding private room days) 10. 00 Saing-bed SNF type inpatient days applicable to the SNF type inpatient days applicable to SNF	2.00				43, 950	2. 00
	3.00		ys). If you have only pr	vate room days,	0	3. 00
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reporting period (if Calendar year, enter 0 on this line) 10.00 Swing-bed SNF type injustient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becomber 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after becomber 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost price of the cost reporting period (line New Account of the Cost applicable to SNF type services through December 31 of the cost reporting period (line New Account of the Cost applicable to SNF type services through December 31 of the cost reporting period (line New Account of the Cost applicable to SNF type services through December 31 of the cost reporting period (line New Account of the Cost applicable to SNF type services after December 31 of the cost reporting period (line New Account of the New Account of the New Account of the New Account of the New Acco	0.00			1 6 11		0.00
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newborn days) (see Instructions) 0 10.00	0.00			and an least and	720	0.00
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		, , , , , , , , , , , , , , , , , , , ,	•			
Ti. 00 Total Trogram general impatient routine service cost (Time 37 + Time 40)		, , , , , , , , , , , , , , , , , , , ,	*			1
	41.00	Tiotai Trogram general Tripatrent Toutine Service Cost (Tine 39	+ ITHE 40)		1,017,440	41.00

COMPUTA		TO TIETETTI THATE	T_HOSPITAL			u of Form CMS-2	
	ATION OF INPATIENT OPERATING COST		Provider CCN		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 6/29/2020 8:3	pared:
	Cost Center Description	Total Inpatient Costlr	npatient Days D	Average Per iem (col. 1 col. 2)	÷	PPS Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 1, 819, 432	2. 00	3. 00 647. 2	4. 00 25 1, 342	5. 00 868, 610	42.00
	Intensive Care Type Inpatient Hospital Units					·	
	INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 989, 680	2, 813	2, 840. 2	27 771	2, 189, 848	43. 00 44. 00
	BURN INTENSIVE CARE UNIT	o	0	0.0	00	0	
	BURN INTENSIVE CARE UNIT	0	0	0.0	00	0	45. 01
	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	6, 129, 809	3, 049	2, 010. 4	13 299	601, 119	46. 00 47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1. 00 1, 166, 410	48. 00
	Total Program inpatient costs (sum of lines			s)		5, 843, 427	
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine se	ervices (from \	Wkst. D, sum	of Parts I and	676, 728] 50. 00
	III)		·			01.07/	F4 00
	Pass through costs applicable to Program inpand IV)	atient anciliary	Services (Tro	⊞ WKST. D, S	sum or Parts II	81, 076	51.00
52. 00	Total Program excludable cost (sum of lines					757, 804	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	ated, non-phys	ıcıan anesth	netist, and	5, 085, 623	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program discharges Target amount per discharge					0 0. 00	
	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and targ	get amount (li	ne 56 minus	line 53)	0	57.00
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period er	nding 1996, up	dated and co	ompounded by the	0 0. 00	58. 00 59. 00
	market basket				,		
	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60 er n expected costs	nter the Lesse	r of 50% of		0. 00 0	60. 00 61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	cost reporti	na period (See	0	 64. 00
	instructions) (title XVIII only)	J		·	3 1		
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 of the co	st reporting	period (See	0	65. 00
	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65	(title XVII	I only). For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through [December 31 of	the cost re	eporting period	0	67. 00
40.00	(line 12 x line 19)	o costo often Dec	21 of t	ha aaat mana	unting ported	0	40.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter bed	celliber 31 01 ti	ne cost repo	n triig perrou	0	68.00
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI					0	69. 00
	Skilled nursing facility/other nursing facil						70. 00
1	Adjusted general inpatient routine service of		ne 70 ÷ line 2)			71.00
	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x line	e 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ice costs (line 7	72 + line 73)				74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service d	costs (from Wo	rksheet B, P	Part II, column		75. 00
1	Per diem capital-related costs (line 75 ÷ li						76. 00
1	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
1	Aggregate charges to beneficiaries for exces		ovi der records)			79.00
1	Total Program routine service costs for comp.		st limitation	(line 78 min	nus line 79)		80.00
1	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions))				83. 00
84. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		5)				84. 00 85. 00
1	Total Program inpatient operating costs (sum						86. 00
85. 00 86. 00		. TUDOL:					
85. 00 86. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					4 869	 87 ∩∩
85. 00 86. 00 87. 00 88. 00) diem (line 27 ÷ l	ine 2)			4, 869 1, 376. 78 6, 703, 542	88. 00

Health Financial Systems	IU HEALTH ARN	ETT HOSPITAL		In Lie	u 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		pared: 3 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	10, 064, 727	60, 509, 514	0. 16633	6, 703, 542	1, 115, 020	90.00
91.00 Nursing School cost	0	60, 509, 514	0.00000	6, 703, 542	0	91.00
92.00 Allied health cost	0	60, 509, 514	0.00000	6, 703, 542	0	92.00
93.00 All other Medical Education	0	60, 509, 514	0.00000	6, 703, 542	0	93.00

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 15-0173	Peri od:	Worksheet D-3	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre	pared:
					6/29/2020 8: 3	3 am
		Ti ti	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
· ·			To Charges	Program	Program Costs	
					(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
20 00 02000 ADULTO A DEDLATRICE				40 547 270		1 20 00

	Cost Center Description	Ratio of Cost	I npati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS		48, 546, 260		30. 00
31.00	03100 I NTENSI VE CARE UNI T		6, 319, 677		31. 00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT		0		33. 01
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35. 00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	O5000 OPERATI NG ROOM	0. 105678	24, 559, 986	2, 595, 450	50.00
51.00	05100 RECOVERY ROOM	0. 135981	1, 896, 618	257, 904	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 253185	161, 725	40, 946	52.00
53.00	05300 ANESTHESI OLOGY	0. 799812	1, 525, 534	1, 220, 140	53.00
53. 01	05301 ASC ANESTHESI OLOGY	0. 020563	2, 131	44	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 103570	16, 678, 218	1, 727, 363	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0.000000	0		55. 00
56.00	05600 RADI 0I SOTOPE	0. 054435	1, 096, 617	59, 694	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 076408	10, 352, 528		59.00
60.00	06000 LABORATORY	0. 198244	10, 569, 147		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 193922	1, 499, 307		63. 00
65. 00	06500 RESPI RATORY THERAPY	0. 247255	4, 785, 962		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 259311	1, 884, 138		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 369926	794, 505		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 258997	768, 517		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 086489	7, 978, 302		69.00
70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0. 080484	501, 685		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 328510	7, 418, 262		70.00
71.00					
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 198690	19, 877, 805		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 282857	18, 749, 850		•
74. 00	07400 RENAL DI ALYSI S	0. 400789	1, 554, 062		•
	07500 ASC (NON-DISTINCT PART)	0.000000	100.450	1	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	0. 073893	100, 150		
76.00	03950 CARDI AC CATHERI ZATI ON	0.000000	07.007	0	76. 00
76.97	07697 CARDI AC REHABI LI TATI ON	7. 528876	27, 297	205, 516	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	0.000000			00.00
90.00	09000 CLINIC	0.000000	0	-	90.00
90. 01	04950 SLEEP CLINIC	0. 147944	5, 981	885	90. 01
90. 03	09002 ARNETT CANCER CARE CENTER	0. 113111	85, 176		90. 03
90. 04	09003 OUTPATIENT INFUSION CENTER	0. 165309	0		90. 04
91. 00	09100 EMERGENCY	0. 073932	19, 390, 634		91.00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 267793	242, 682	64, 989	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	
	04951 OTHER OUTPATIENT SERVICES	0. 000000	0	0	93. 00
200.00			152, 506, 819	26, 012, 342	
201.00			0		201. 00
202.00	Net charges (line 200 minus line 201)		152, 506, 819		202. 00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0173	Peri od: Worksheet D-3

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0173		Peri od:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019	Date/Time Prepared:	
			10 12/31/2019	6/29/2020 8:33 am	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	•	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		4.00	0.00	2)	
INDATIONT DOUTING CODY OF COCT CONTEDC		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			2, 191, 745		30. 00
31. 00 03100 NTENSI VE CARE UNIT			555, 337		31. 00
33. 00 03300 BURN INTENSIVE CARE UNIT			0 0		33. 00
33. 01 03301 BURN INTENSIVE CARE UNIT			0		33. 01
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			1, 026, 680		35. 00
43. 00 04300 NURSERY			235, 049		43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 10567	8 659, 631	69, 708	50. 00
51.00 05100 RECOVERY ROOM		0. 13598	1 36, 364	4, 945	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 25318	5 515, 704	130, 569	52.00
53. 00 05300 ANESTHESI OLOGY		0. 79981	2 50, 392	40, 304	53.00
53. 01 05301 ASC ANESTHESI OLOGY		0. 02056		0	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 10357		66, 358	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 05443		824	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 07640		10, 587	59. 00
60. 00 06000 LABORATORY		0. 19824		125, 798	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 19392			63. 00
65. 00 06500 RESPI RATORY THERAPY		0. 24725			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 25931		13, 405	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 36992		8, 357	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 25899		7, 666	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY		0.08648		20, 562 2, 569	69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 08763 0. 32851		81, 907	70. 00 71. 00
72. 00 07100 MPL. DEV. CHARGED TO PATIENTS		0. 19869		38, 635	71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 19809			73. 00
74. 00 07400 RENAL DI ALYSI S		0. 40078		12, 235	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000		0	75.00
75. 01 07501 ASC (NON-DI STI NCT PART)		0. 07389		Ö	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON		0.00000		Ö	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		7. 52887		7, 024	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000	0 0	0	90.00
90. 01 04950 SLEEP CLINIC		0. 14794	4 0	0	90. 01
90. 03 09002 ARNETT CANCER CARE CENTER		0. 11311	1 0	0	90. 03
90. 04 09003 OUTPATIENT INFUSION CENTER		0. 16530	9 0	0	90. 04
91. 00 09100 EMERGENCY		0. 07393		54, 265	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 26779		2, 320	92.00
92. 01 O9201 OBSERVATION BEDS (DISTINCT PART)		0.00000		0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES		0.00000		0	93. 00
Total (sum of lines 50 through 94 and 96 through 98)	(1)		6, 013, 939	1, 166, 410	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IINE 61)		0 010 000		201. 00
202.00 Net charges (line 200 minus line 201)		I	6, 013, 939		202. 00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0173	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/29/2020 8:33 am

				6/29/2020 8: 3	3 am
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurrin	a prior to October 1 (s	see	25, 512, 172	1. 01
	instructions)	g p. 10. 10 001020. 1 (,00	20,012,172	
1.02	DRG amounts other than outlier payments for discharges occurrin	g on or after October	(see	8, 967, 148	1. 02
	instructions)		,		
1.03	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October	0	1. 03
	1 (see instructions)				
1.04	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring o	on or after	0	1. 04
	October 1 (see instructions)				
2.00	Outlier payments for discharges. (see instructions)			_	2.00
2.01	Outlier reconciliation amount	`		0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructio			0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (s			882, 121	2. 03
2.04	Outlier payments for discharges occurring on or after October 1	(see instructions)		115, 997	2. 04
3.00	Managed Care Simulated Payments			11, 184, 406	3. 00
4.00	Bed days available divided by number of days in the cost report	ing period (see instru	ctions)	178. 20	4. 00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting p	period ending on	0. 00	5. 00
	or before 12/31/1996. (see instructions)				
6.00	FTE count for allopathic and osteopathic programs that meet the	criteria for an add-o	n to the cap for	0. 00	6. 00
	new programs in accordance with 42 CFR 413.79(e)				
7. 00	MMA Section 422 reduction amount to the IME cap as specified un			0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 4	2 CFR §412.105(f)(1)(i	/)(B)(2) If the	0. 00	7. 01
	cost report straddles July 1, 2011 then see instructions.		_		
8. 00	Adjustment (increase or decrease) to the FTE count for allopath			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79	(c)(2)(iv), 64 FR 26340) (May 12,		
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slot	s under § 5503 of the A	ACA. If the cost	0. 00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slot	s from a closed teachii	ng hospital	0. 00	8. 02
0.00	under § 5506 of ACA. (see instructions)	(0 0 04 1 0 00) (0.00	0.00
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01 and 8,02) (s	see	0. 00	9. 00
10.00	instructions)	.		0.00	10.00
10.00	FTE count for allopathic and osteopathic programs in the curren	t year from your record	ıs	0.00	
11.00	FTE count for residents in dental and podiatric programs.				11.00
12.00	Current year allowable FTE (see instructions)				12.00
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year	ended on or after Sep	ember 30, 1997,	0. 00	14. 00
45.00	otherwise enter zero.			0.00	45.00
15.00	Sum of lines 12 through 14 divided by 3.				15.00
16.00	Adjustment for residents in initial years of the program			6. 64	
17. 00	Adjustment for residents displaced by program or hospital closu	re			17. 00
18. 00	Adjusted rolling average FTE count			6. 64	
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 037262	
20. 00	Prior year resident to bed ratio (see instructions)			0. 013977	20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 013977	
22. 00	IME payment adjustment (see instructions)			262, 388	
22. 01				85, 113	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422				
23. 00	Number of additional allopathic and osteopathic IME FTE residen	t cap slots under 42 Cl	R 412. 105	0. 00	23. 00
	(f)(1)(iv)(C).				
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	
25. 00	If the amount on line 24 is greater than -O-, then enter the lo	wer of line 23 or line	24 (see	0. 00	25. 00
	instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			262, 388	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			85, 113	29. 01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruc	i ons)	3. 00	30. 00
31.00	Percentage of Medicaid patient days (see instructions)	- -	•	21. 41	1
32.00	Sum of lines 30 and 31			24. 41	1
33.00	Allowable disproportionate share percentage (see instructions)			9. 35	
34.00	Di sproporti onate share adjustment (see instructions)			805, 954	
			'		•

CALCUL	Financial Systems IU HEALTH ARNE ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0173	Period: From 01/01/2019	u of Form CMS-2 Worksheet E Part A	
			To 12/31/2019	Date/Time Prep 6/29/2020 8:33	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2. 00	
	Uncompensated Care Adjustment				
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		8, 272, 872, 447 0. 000357615	8, 350, 599, 096 0, 000233338	
35. 02	1	ter zero on this line) (se		1, 948, 514	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment at Total uncompensated care (sum of columns 1 and 2 on line 35	489, 790	35. 00 36. 00		
40. 00	Additional payment for high percentage of ESRD beneficiary of Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding M: an 685. (see instructions)	S-DRGs 652, 682, 683, 684	0		41. 0°
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42. 00 43. 00
44. 00	<pre>instructions) Ratio of average length of stay to one week (line 43 divided days)</pre>	d by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instruction		0.00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line subtotal (see instructions)	41. 01)	0 39, 248, 366		46. 0 47. 0
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	39, 240, 300		48. 0
	John V. (See Thistructrons)			Amount	
49. 00	Total payment for inpatient operating costs (see instruction	ns)		1. 00 39, 333, 479	49. 0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			3, 164, 807	1
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	TITIE 49 See THSTRUCTIONS).		213, 159 0	1
54. 00	Special add-on payments for new technologies			1, 950	ı
54. 01	Islet isolation add-on payment	(0)		0	54.0
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in			0	55. 0 56. 0
57. 00	Routine service other pass through costs (from Wkst. D, Pt.	*	hrough 35).	Ö	57. 0
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	. IV, col. 11 line 200)		26, 625	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			42, 740, 020 17, 618	
61. 00	Total amount payable for program beneficiaries (line 59 min	us line 60)		42, 722, 402	1
62. 00	Deductibles billed to program beneficiaries			3, 757, 857	
63.00				159, 247	
65.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			266, 004 172, 903	
66. 00	Allowable bad debts for dual eligible beneficiaries (see in:	structions)		57, 719	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		38, 978, 201	67.0
68. 00	Credits received from manufacturers for replaced devices for			0	1
59. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)).(For SCH see instruction	s)	0	69. 0 70. 0
70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70. 5
70. 87	Demonstration payment adjustment amount before sequestration	•		Ö	70. 8
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see in:	structions)		0	70.8
70. 90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	1
70. 91	, , , , , , , , , , , , , , , , , , , ,			0	ı
70. 91 70. 92	Bundled Model 1 discount amount (see instructions)				
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			10, 416 -67, 249	70. 9

Health Financial Systems	U HEALTH ARNETT	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der (CCN: 15-0173	Peri od: From 01/01/2019 To 12/31/2019		pared: 3 am
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal year the corresponding federal year for the period		n column 0		0	0	70. 96
70.97 Low volume adjustment for federal fiscal year		n column 0		0	0	70. 97

		Ti +Lo	xVIII	Hospi tal	6/29/2020 8: 3 PPS	3 am
		HILLE		Hospi tal (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in co	Lumn O		0		70. 96
	the corresponding federal year for the period prior to 10/1)				_	
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in co	lumn O		0	0	70. 97
	the corresponding federal year for the period ending on or after	10/1)				
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 &	70)			38, 921, 368	71. 00
71. 01	Sequestration adjustment (see instructions)				778, 427	1
71. 02	Demonstration payment adjustment amount after sequestration				0	
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72. 00	Interim payments				38, 320, 777	1
72. 01	Interim payments-PARHM					72. 01
73. 00	Tentative settlement (for contractor use only)				0	ł
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 7	2, and			-177, 836	74. 00
74.04	73)					74.04
74. 01	Balance due provider/program-PARHM (see instructions)				70/ 400	74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance	with			736, 180	75. 00
	CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2	02	I		0	90.00
90.00	plus 2.04 (see instructions)	. 03			U	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instructi	one)			0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruction				0	93.00
94. 00	The rate used to calculate the time value of money (see instructi				0.00	
95. 00	Time value of money for operating expenses (see instructions)	0113)			0.00	95. 00
96. 00	Time value of money for capital related expenses (see instruction	s)			0	1
70.00	Trimo variao or monog ror oupritur roratou oxponesso (coo rhetruotron	<u> </u>		Prior to 10/1		70.00
				1.00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	1
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstrati					
200.00	Is this the first year of the current 5-year demonstration period	under t	ha 21ct			
			116 2131			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.		116 2131			200. 00
201 00	Cost Reimbursement		116 2131			
	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49		TIE 2131			201. 00
202.00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49 Medicare discharges (see instructions)		ne 213t			201. 00 202. 00
202.00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions))		E voor domont		201. 00
202.00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir)		5-year demonst		201. 00 202. 00
202. 00 203. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period))		5-year demonst	ration	201. 00 202. 00 203. 00
202. 00 203. 00 204. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount)		5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00
202. 00 203. 00 204. 00 205. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204))		5-year demonst	ration	201. 00 202. 00 203. 00 204. 00 205. 00
202. 00 203. 00 204. 00 205. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205))		: 5-year demonst	ration	201. 00 202. 00 203. 00 204. 00
202. 00 203. 00 204. 00 205. 00 206. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement) st year		: 5-year demonst	ration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
202. 00 203. 00 204. 00 205. 00 206. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct)	st year		: 5-year demonst	ration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Lin	st year		: 5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line Adjustment to Medicare IPPS payments (see instructions)	st year		5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, lin Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	st year		5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, lin Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	st year		5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, lin Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	st year		5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, lin Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	st year		5-year demonst	rati on	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00

| Period: | Worksheet E | From 01/01/2019 | Part A Exhibit 4 | Date/Time Prepared: 6/29/2020 8:33 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0173

						0 12/31/201/	6/29/2020 8: 33	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	1.00	1.00	2. 00	3.00	4. 00	5. 00	1. 00
1.00	payments	1.00	١	0	0	U	ď	1.00
1. 01	DRG amounts other than outlier	1. 01	25, 512, 172	0	25, 512, 172		25, 512, 172	1. 01
	payments for discharges		20,012,172	· ·	20/012/172		20,012,172	
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	8, 967, 148	0		8, 967, 148	8, 967, 148	1. 02
	payments for discharges							
	occurring on or after October							
	1							
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to October 1							
1. 04	DRG for Federal specific	1. 04	٥	0		0	o	1. 04
1.04	operating payment for Model 4	1.04	l	0		O	ď	1.04
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2.00
	discharges (see instructions)							
2.01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
	discharges for Model 4 BPCI			_				
2. 02	Outlier payments for	2. 03	882, 121	0	882, 121		882, 121	2. 02
	discharges occurring prior to October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	115, 997	0		115. 997	115, 997	2. 03
2.03	di scharges occurring on or	2. 04	110, 997	U		115, 997	110, 997	2. 03
	after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	ol	0	0	0	o	3. 00
	reconciliation							
4.00	Managed care simulated	3. 00	11, 184, 406	0	7, 762, 491	3, 421, 916	11, 184, 407	4.00
	payments							
	Indirect Medical Education Adj							
5. 00	Amount from Worksheet E, Part	21. 00	0. 013977	0. 013977	0. 013977	0. 013977		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22.00	262, 388	0	194, 148	68, 240	262, 388	6. 00
0.00	instructions)	22.00	202, 300	Ü	174, 140	00, 240	202, 300	0.00
6. 01	IME payment adjustment for	22. 01	85, 113	0	59, 072	26, 041	85, 113	6. 01
	managed care (see							
	instructions)							
	Indirect Medical Education Adj	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
	(see instructions)		_	_	_	_	_	
8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
0.01	instructions)	20.01		0		0		0.01
8. 01	IME payment adjustment add on for managed care (see	28. 01	٩	Ü	0	U	۷	8. 01
	instructions)							
9.00	Total IME payment (sum of	29. 00	262, 388	0	194, 148	68, 240	262, 388	9. 00
	lines 6 and 8)		232, 300	0	.,,,,	33, 210	232, 300	
9. 01	Total IME payment for managed	29. 01	85, 113	0	59, 072	26, 041	85, 113	9. 01
	care (sum of lines 6.01 and							
	8. 01)							
10.00	Disproportionate Share Adjustm		0.000=	0.0005	0.0005	0.000=		10.00
10. 00	Allowable disproportionate	33. 00	0. 0935	0. 0935	0. 0935	0. 0935		10. 00
	share percentage (see instructions)							
11. 00	Di sproporti onate share	34.00	805, 954	0	596, 347	209, 607	805, 954	11 00
11.00	adjustment (see instructions)	34.00	003, 734	O	370, 347	207, 007	000, 754	11.00
11. 01	Uncompensated care payments	36.00	2, 702, 586	0	843, 295	315, 057	1, 158, 352	11. 01
	Additional payment for high pe			di scharges				
12.00	Total ESRD additional payment	46.00	0	0	0	0	0	12.00
	(see instructions)							
13.00	Subtotal (see instructions)	47. 00	39, 248, 366	0	29, 572, 317	9, 676, 049	39, 248, 366	
14. 00	Hospital specific payments	48. 00	0	0	0	0	0	14. 00
	(completed by SCH and MDH,							
	small rural hospitals only.) (see instructions)							
15. 00	Total payment for inpatient	49. 00	39, 333, 479	0	29, 631, 389	9, 702, 090	39, 333, 479	15 00
13.00	operating costs (see	47.00	37, 333, 4/9	Ü	27, 031, 309	7, 102, 090	37, 333, 4/9	13.00
	instructions)							
16. 00	Payment for inpatient program	50.00	3, 164, 807	0	2, 373, 962	790, 845	3, 164, 807	16. 00
	capital (from Wkst. L, Pt. I,					, , , ,	,	
	if applicable)							

						o 12/31/2019	Date/Time Pre 6/29/2020 8:3	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
17.00		0	1.00	2. 00	3.00	4. 00	5. 00	47.00
17. 00	Special add-on payments for new technologies	54.00	1, 950	0	(1, 950	1, 950	17. 00
17. 01	Net organ aguisition cost							17. 01
17. 02	Credits received from	68. 00	ol	0		0	0	
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0	(0	0	18. 00
	adjustment amount (see							
40.00	instructions)					40 404 005	40 500 004	40.00
19. 00	SUBTOTAL	W/S L. line	(A	0	32, 005, 351	10, 494, 885	42, 500, 236	19.00
		W/S L, TITTLE	(Amounts from L)					
		0	1, 00	2. 00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier		2, 783, 796	0	2, 070, 156		2, 783, 796	20. 00
20. 01	Model 4 BPCI Capital DRG other		0	0	_, _, , , , ,	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	198, 394	0	168, 004	30, 390	198, 394	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	(0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0150	0. 0150	0. 0150	0. 0150		22. 00
00.00	percentage (see instructions)		44 757	•	04.05	40.705	44 757	00.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	41, 757	0	31, 052	10, 705	41, 757	23. 00
24. 00	Allowable disproportionate	10.00	0. 0506	0. 0506	0. 0506	0. 0506		24. 00
24.00	share percentage (see	10.00	0.0300	0.0300	0.0500	0.0300		24.00
	instructions)							
25. 00	Di sproporti onate share	11. 00	140, 860	0	104, 750	36, 110	140, 860	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	3, 164, 807	0	2, 373, 962	790, 845	3, 164, 807	26. 00
	payments (see instructions)	W/C F D I A	(A					
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1. 00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor	0	1.00	2.00	0. 000000		3.00	27. 00
28. 00	Low volume adjustment	70. 96			0.00000	0. 000000	0	28. 00
	(transfer amount to Wkst. E,						_	
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
400	Pt. A, line)							400.05
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.	I	l l		I			I

					From 01/01/2019 To 12/31/2019	Part A Exhibit Date/Time Prep 6/29/2020 8:33	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1.00					1. 00
1.01	DRG amounts other than outlier payments for	1. 01	25, 512, 172	25, 512, 17	2	25, 512, 172	1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	8, 967, 148		8, 967, 148	8, 967, 148	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	882, 121	882, 12	1	882, 121	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	115, 997		115, 997	115, 997	2. 03
3.00	Operating outlier reconciliation	2. 01	0		0 0	0	3. 00
4. 00	Managed care simulated payments	3. 00	11, 184, 406	7, 762, 49	1 3, 421, 916	11, 184, 407	4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 013977	0. 01397	7 0. 013977		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	262, 388	194, 14	8 68, 240	262, 388	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	85, 113	59, 07	26, 041	85, 113	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0.00000	0. 000000		7. 00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0		0 0	0	8. 00 8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	262, 388	194, 14	8 68, 240	262, 388	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	85, 113			85, 113	9. 01
	lines 6.01 and 8.01)						
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0935	0. 093	5 0.0935		10. 00
10.00	(see instructions)	33.00	0.0933	0.093	0.0733		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	805, 954	596, 34	7 209, 607	805, 954	11. 00
11. 01	Uncompensated care payments	36. 00	2, 702, 586	934, 89	8 743, 667	1, 678, 565	11. 01
40	Additional payment for high percentage of ESF		di scharges				40
12. 00	Total ESRD additional payment (see instructions)	46. 00	0		0	0	12. 00
13.00		47. 00	39, 248, 366	29, 143, 70	7 10, 104, 659	39, 248, 366	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	0		0	0	14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	39, 333, 479	29, 202, 77	9 10, 130, 700	39, 333, 479	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	3, 164, 807	2, 373, 96	2 790, 845	3, 164, 807	16. 00
17. 00	Special add-on payments for new technologies	54.00	1, 950		0 1, 950	1, 950	17. 00
17. 01	Net organ acquisition cost	40.00					17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0		0	0	18. 00
19. 00	SUBTOTAL			31, 576, 74	1 10, 923, 495	42, 500, 236	19. 00

Health Financial Systems	IU HEALTH ARNE	ETT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider CO		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:3	pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	2, 783, 796	2, 070, 15	6 713, 640	2, 783, 796	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	198, 394	168, 00	4 30, 390	198, 394	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0150	0. 015	0. 0150		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	41, 757	31, 05	2 10, 705	41, 757	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0506	0. 050	6 0. 0506		24. 00
25.00 Disproportionate share adjustment (see instructions)	11.00	140, 860	104, 75	0 36, 110	140, 860	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	3, 164, 807	2, 373, 96	790, 845	3, 164, 807	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1. 00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		o	0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	10, 416	7, 38	0 3, 036	10, 416	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-67, 249	-33, 16	6 -34, 083	-67, 249	31. 00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
12 4011 0.10)					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3. 00	4, 00	
32.00 HAC Reduction Program adjustment (see	70. 99	1.00		0 0		32. 00
instructions)	70. 77					32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	- CCN: 15-0173	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 8:33 am

Mail 1 - MEDICAL AND OPER HEALTH SENDICES			Title XVIII	Hospi tal	6/29/2020 8: 3 PPS	3 alli
Medical and other services resistorised under OPPS (see Instructions)					1 00	
		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00PS payments						
2011 Fire payment (see instructions)		•	ons)			1
Dutilier reconcilitation amount (see instructions)						1
Line 2 times time 5		, , ,				1
2.00 Sam of lines 3, 4, and 4.01, divided by line 6 0.00 7.00			i ons)			
Transitional corridor payment (see instructions)						1
Acad Larry service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 72,544 9,00 10,00 10,00 10,000 10,000 10,000 10,000 17,298 11,00 10,000 17,298 11,00 10,000 17,298 11,00 10,000 17,298 11,00 10,000 17,298 11,00 12,000 17,298 11,00 12,000 12,000 12,000 12,000 12,000 13,00						1
Total cost (sun of lines 1 and 10) (see Instructions) 17,298 11,00			/, col. 13, line 200			1
COMPUTATION OF LESSER OF LOST OR CHARGES Reasonable charges Reasonable charges Reasonable charges Computation Comput		Organ acqui si ti ons				
Reasonable charges 1.2.00 Ancil Tarry service charges 1.2.00 1.2.	11. 00				17, 298	11. 00
2.00 Ancillary service charges 67,646 12.00 12.00 13.00 Organ acquist tion charges (from Wist. D-4, Pt. III, col. 4, line 69) 0.13.00 13.00 15.00						
13.00 Organ acquisition charges (from Wist. D-4, Pt. III. col. 4, line 69) 0.13.00	12. 00				67, 646	12. 00
Customary charges			ne 69)			1
15.00 Aggregate amount actually collected from patients Hiable for payment for services on a charge basis 0 15.00	14. 00				67, 646	14. 00
16.00 Amounts that would have been realized from patients Itable for payment for services on a chargebasis 0 10.00	15 00		avment for services on a	charge hasis	0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00						1
18.00 Total customary charges (see instructions) 67, 646 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00 Excess of cost or charges (see instructions) 22.00 Excess of cost or charges (see instructions) 22.00 Excess of physicians services in a teaching hospital (see instructions) 22.00 Excess of physicians services in a teaching hospital (see instructions) 29.645, 434 24.00 Excess of physicians services in a teaching hospital (see instructions) 29.645, 434 24.00 Excess of physicians services in a teaching hospital (see instructions) 29.65, 230, 231, 232, 232, 233, 233, 233, 233, 233				Ü		
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 50,348 19.00 Instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.00 20.00 1.00						
Instructions			/if line 18 evceeds lir	ne 11) (see	'	1
Instructions 17, 298 21.00	17.00		TI TITIC TO CACCEGO TIT	10 11) (300	30, 340	17.00
21.00 Lesser of cost or charges (see instructions) 17.298 21.0 0 22.00	20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lir	ne 18) (see	0	20. 00
22.00 Interns and residents See instructions 0 22.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 2	21 00				17 200	21 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 29,045,343 24.00						
COMPUTATION OF REIMBURSEMENT SETILEMENT Set No. Set No. Set		,	uctions)			
25. 00 Deductibles and coinsurance amounts (for CAH, see instructions) 4. 448 25. 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 24, 298, 213 27. 00	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	, 		29, 645, 434	24. 00
26. 00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 5, 360, 071 26. 00 27. 00	25.00				4 440	1 25 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 24, 298, 213 27. 00 Instructions) 136, 148 28. 00 29. 00 ESRD direct medical education payments (from Wkst. E-4, line 36) 24, 434, 361 30. 00 30. 00 Subtotal (sum of lines 27 through 29) 24, 434, 361 30. 00 75, 72 31. 00 75, 72		1		uctions)		
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 136, 148 28.00 0.00 29.00 29.00 28.00 30.						
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 24.434, 361 30.00 30.00 Subtotal (sum of lines 27 through 29) 24.434, 361 30.00 31.00 24.428, 789 32.00 32			>			
Subtotal (sum of lines 27 through 29) 24,434,361 30,00 21,000 24,428,789 32.00 31.00 32.			ne 50)			
32.00 Subtotal (line 30 minus line 31) 24,428,789 32.00 32.0		1				1
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 All lowable bad debts (see instructions) 794, 214 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 516, 239 35.00 Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions) 552, 798 36.00 Subtotal (see instructions) 24, 945, 028 37.00 38.00 MSP-LCC reconciliation amount from PS&R 156 38.00 MSP-LCC reconciliation amount before sequestrations) 29.90 2						
33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 33.00 34.00 All lowable bad debts (see instructions) 794, 214 34.00 35.00 All lowable bad debts (see instructions) 516, 239 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 552, 798 36.00 37.00 38.00 MSP-LCC reconciliation amount from PS&R 24, 945, 028 37.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00	32. 00				24, 428, 789	32. 00
34.00	22 00		.S)		0	22 00
35.00 Adjusted reimbursable bad debts (see instructions) 516, 239 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 552, 798 36.00 37.00 Subtotal (see instructions) 24, 945, 228 37.00 38.00 MSP-LCC reconciliation amount from PS&R 156 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 99.77 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 18, 84 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 24, 944, 872 40.00 40.03 40.01 40.03 40.01 40.02 40.03 40.02 40.03 40						1
37.00 Subtotal (see instructions) 24,945,028 37.00 38.00 MSP-LCC reconciliation amount from PS&R 156 38.00 39.00 MSP-LCC reconciliation amount from PS&R 156 38.00 39.00 39.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.97 Demonstration payment adjustment amount before sequestration 29.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 18,849 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 24,944,872 40.00 40.01 Sequestration adjustment (see instructions) 498,897 40.01 40.02 Demonstration payment adjustment amount after sequestration 498,897 40.01 40.02 40.03 40.02 40.03 40.02 40.03 40.02 40.03 40	35. 00	Adjusted reimbursable bad debts (see instructions)				
38.00 MSP-LCC reconciliation amount from PS&R 156 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0.39.00 39.00 39.50 39.50 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) 18,849 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0.00 0.00 39.99 40.00 Subtotal (see instructions) 24,944,872 40.00 40.01 Sequestration adjustment (see instructions) 498,897 40.01 40.02 Demonstration payment adjustment amount after sequestration 498,897 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 24,407,470 41.00 41.01 Interim payments 24,407,470 41.00 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 42.01 Tentative settlement (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) 38,505 43.00 43.01 Bal ance due provider/program-PARHM (see instructions) 43.00 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6,076 44.00 8115.2 60.00		, ,	uctions)		'	1
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 50 Finneer 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) 18,849 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 24,944,872 40.00 40.01 Sequestration adjustment (see instructions) 498.897 40.01 40.01 Sequestration adjustment amount after sequestration 498.897 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 40						
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50						1
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 18,849 39.98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40. 00 Subtotal (see instructions) 24,944,872 40.00 40. 01 Demonstration adjustment (see instructions) 498,897 40.01 40. 02 Sequestration adjustment amount after sequestration 0 40.02 40. 03 Sequestration adjustment-PARHM pass-throughs 40.03 41. 01 Interim payments 24,407,470 41.00 42. 01 Tentative settlement (for contractors use only) 42.00 42. 01 Tentative settlement-PARHM (for contractor use only) 42.01 43. 00 Bal ance due provider/program (see instructions) 38,505 43.00 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6,076 44.00 41. 02 To BE COMPLETED BY CONTRACTOR 0 90.00 90. 00 To ginal outlier amount (see instructions) 0 90.00 91. 00 The rate used to calculate the Time Value of Money 0.00 92.00 93. 00 Time Value of Mon	39. 50					
39. 99 40. 00 5 Subtotal (see instructions) 40. 01 5 Sequestration adjustment (see instructions) 40. 02 5 Demonstration payment adjustment amount after sequestration 40. 03 5 Sequestration adjustment-PARHM pass-throughs 41. 00 41. 01 6 Interim payments 1 Interim payments-PARHM 42. 00 42. 00 42. 01 43. 00 43. 01 43. 00 43. 01 43. 00 43. 01 44. 00 45 Bal ance due provider/program (see instructions) 43. 01 44. 00 45 Bal ance due provider/program-PARHM (see instructions) 45 Bal ance due provider/program-PARHM (see instructions) 46 Bal ance due provider/program-PARHM (see instructions) 47 Bal ance due provider/program-PARHM (see instructions) 48 Bal ance due provider/program-PARHM (see instructions) 49 Bal ance due provider/program-PARHM (see instructions) 40 Corporation (see instructions) 41 Description (see instructions) 42 Description (see instructions) 43 Description (see instructions) 44 Description (see instructions) 45 Description (see instructions) 46 Description (see instructions) 47 Description (see instructions) 48 Description (see instructions) 49 Description (see instructions) 40 Description (see instructions) 41 Description (see instructions) 42 Demonstration adjustment amount (see instructions) 44 Description (see instructions) 45 Description (see instructions) 46 Demonstration adjustment amount (see instructions) 47 Description (see instructions) 48 Demonstration adjustment amount (see instructions) 49 Demonstration adjustment amount (see instructions) 40 Demonstration adjustment amount (see instructions) 41 Demonstration adjustment amount (see instructions) 42 Demonstration adjustment amount (see instructions) 44 Demonstration adjustment amount (see instructions) 45 Demonstration adjustment amount (see instructions) 46 Demonstration adjustment amount (see instructions) 47 Demonstration a						1
40.00 Subtotal (see instructions) 24, 944, 872 40.00 40.01 Sequestration adj ustment (see instructions) 498, 897 40.01 40.02 Demonstration payment adj ustment amount after sequestration 0 40.02 40.03 Sequestration adj ustment-PARHM pass-throughs 24, 407, 470 41.00 41.00 Interim payments 24, 407, 470 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 Bal ance due provider/program (see instructions) 38,505 43.00 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6,076 44.00 44.00 \$\frac{115.2}{115.2}\$ 6,076 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00		·	ed devices (see instruct	(ions)		•
40.01 Sequestration adjustment (see instructions) 498,897 40.01 40.02 Demonstration payment adjustment amount after sequestration 5 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6,076 44.00 \$\frac{1}{5}\$15.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 49.01						1
40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments Interim payments Interim payments-PARHM 1.01 Interim payments-PARHM 1.02 Interim payments-PARHM 1.03 Interim payments Interim payments-PARHM 1.04 Interim payments-PARHM 1.05 Interim payments-PARHM 1.06 Interim payments-PARHM 1.07 Interim payments-PARHM 1.08 Interim payments 1.09 Interim payments 1.00 Interim payments 1.0		Sequestration adjustment (see instructions)				•
41.00		1			0	•
41.01 Interim payments-PARHM					24 407 470	•
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6,076 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 42.00 42.01 42.01 42.01 43.00 42.01 43.00 42.01 43.00 43.01 44.00 91.00 90.00 91.00 91.00 92.00 93.00		1			24, 407, 470	•
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6,076 44.00 91.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.505 43.00 43.01 44.00 90.00 90.00 91.00 92.00 93.00	42.00	Tentative settlement (for contractors use only)			0	42. 00
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6,076 44.00 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 To See Instructions 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		,			20 505	1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6,076 44.00 \$\frac{\text{\$115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}}\$ 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00					38, 505	1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00			ce with CMS Pub. 15-2, o	chapter 1,	6, 076	1
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00		§115. 2	,	· ·		
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	00.00				^	00.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00						•
93.00 Time Value of Money (see instructions) 0 93.00		,				
94.00 Iotal (sum of lines 91 and 93) 0 94.00		Time Value of Money (see instructions)			0	93. 00
	94. 00	lotal (sum of lines 91 and 93)			0	94.00

| Period: | Worksheet E-1 | From 01/01/2019 | Part | Date/Time Prepared: | 6/29/2020 8:33 am Health Financial Systems IU FANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0173

					6/29/2020 8: 3	3 am
			XVIII	Hospi tal	PPS	
		I npati er	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		38, 162, 27	7	24, 407, 470	1. 00
2.00	Interim payments payable on individual bills, either		(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	08/13/2019	158, 500	1	1 0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER	00/13/2019	156, 500			3. 01
3.02		•				3. 02
		•				
3. 04 3. 05		•	(3. 04 3. 05
3.05	Provider to Program			<u>/ </u>	0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM			1	0	3. 50
3. 50	ADJUSTIMENTS TO FROGRAM					3. 51
3. 52						3. 52
3. 53						3. 53
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		158, 500			3. 99
J. 77	3. 50-3. 98)		130, 300	1		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		38, 320, 77	7	24, 407, 470	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			T		
5.01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02			(0	5. 02
5.03			(0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		(38, 505	6. 01
6.02	SETTLEMENT TO PROGRAM		177, 836	5	0	6. 02
7.00	Total Medicare program liability (see instructions)		38, 142, 94°		24, 445, 975	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems IU HEALTH ARNETT	Γ HOSPITAL	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0173 Period: From 01/01/2019 To 12/31/2019				pared:	
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	1-12			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 l	ine 20			6. 00	
7. 00						
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
22 00	00 Palance due provider (i.e. 9 (or line 10) minus line 20 and line 21) (coe instructions)					

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

30. 00 31. 00 32. 00

	Financial Systems IU HEALTH ARNETT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C	CN: 15-0173	In Lie Period:	u of Form CMS-2 Worksheet E-4	:35Z-1(
	AL EDUCATION COSTS	Trovider of		From 01/01/2019 To 12/31/2019	Date/Time Prep	
		Title	e XVIII	Hospi tal	6/29/2020 8: 33 PPS	3 am
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	0.00	1. 00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM.		(1) (see instr	ucti ons)	0. 00 0. 00	2.00
. 00 . 01	Direct GME cap reduction amount under ACA §5503 in accordance		R §413.79 (m).	(see	0.00	3. 00 3. 01
. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4. 00
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	0.00	4. 01
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	tructions for	cost reporting	0. 00	4. 02
. 00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus l	ines 4.01 and	0.00	5. 00
. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	vear from vour	0.00	6. 00
. 00	records (see instructions) Enter the lesser of line 5 or line 6				0.00	7. 00
. 00	Litter the resser of Time 5 of Time 6		Primary Care	Other	Total	7.00
	Two 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		1.00	2. 00	3.00	
. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.		0.0	0.00	0.00	8. 00
. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		0.0	0.00	0. 00	9. 00
0. 00	Weighted dental and podiatric resident FTE count for the curr			0. 00		10. 00
0. 01 1. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	rrent year	0.0	0. 00 0. 00		10. 0°
2. 00	Total weighted resident FTE count for the prior cost reporting	g year (see	0.0			12. 00
3. 00	instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	0.0	0.00		13. 00
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0.0			14.00
5.00	Adjustment for residents in initial years of new programs	rograme	6.6			15. 00 15. 01
5. 01 6. 00	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0.0			16. 00
6. 01	Unweighted adjustment for residents displaced by program or h		0.0			16. 0
7. 00	closure		4 4	6 0.00		17. 00
7. 00 8. 00	Adjusted rolling average FTE count Per resident amount		6.6			18.00
	Approved amount for resident costs		666, 00		666, 000	
					1. 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42	0. 00	20. 00
1. 00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			0. 00	21. 00
2. 00	Allowable additional direct GME FTE Resident Count (see instr	uctions)			0.00	22. 00
3. 00	Enter the locality adjustment national average per resident a	mount (see i	nstructions)		0.00	23. 00
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 666, 000	24. 00 25. 00
	Total direct one amount (sum of fines 17 and 24)		Inpatient Par	t Managed Care	Total	23.00
			A			
			1 00	2 00	3 ()()	
	COMPUTATION OF PROGRAM PATIENT LOAD		1. 00	2. 00	3. 00	
5. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions)		1. 00		3.00	26. 00
5. 00 6. 00 7. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		18, 15 45, 84	0 6, 341 9 45, 849	3.00	27. 0
24. 00 25. 00 26. 00 27. 00 28. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		18, 15 45, 84 0. 39586	0 6, 341 9 45, 849 5 0. 138302		26. 00 27. 00 28. 00
6. 00 7. 00 8. 00 9. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount		18, 15 45, 84	0 6, 341 9 45, 849 5 0. 138302 6 92, 109	355, 755	27. 00 28. 00 29. 00
6. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		18, 15 45, 84 0. 39586	0 6, 341 9 45, 849 5 0. 138302		27. 00 28. 00 29. 00 29. 0

Hoal th	Financial Systems IU HEALTH ARNETT	HOSDITAI	In Lie	u of Form CMS-2	0552_10
	DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0173 Period:				
	MEDICAL EDUCATION COSTS From 01/01/2019 To 12/31/2019				pared: 3 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	·		CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	3, 161, 116	33.00
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)		0.000000	34.00
	Medicare outpatient ESRD charges (see instructions)			0	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line	34 x line 35)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			52, 550, 735	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00
	Primary payer payments (see instructions)			17, 618	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)		52, 533, 117	41. 00
	Part B Reasonable Cost			00 550 4/0	
42. 00				33, 559, 160	
43.00	1 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			5, 572	43.00
	Total Part B reasonable cost (line 42 minus line 43)			33, 553, 588	
	Total reasonable cost (sum of lines 41 and 44)	- 41 1: 45)		86, 086, 705	
	Ratio of Part A reasonable cost to total reasonable cost (line	,		0. 610235	
47.00	Ratio of Part B reasonable cost to total reasonable cost (line ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	,		0. 389765	47. 00
10 00	Total program GME payment (line 31)	(I D		349, 307	48. 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(soo instructions)		213, 159	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			136, 148	
50.00	prair b wedicale GWE payment (Time 47 x 40) (title XVIII Only)	(See HISH UCH OHS)		130, 148	50.00

Health Financial Systems

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

Provider CCN: 15-0173

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/29/2020 8:33 am

oni y)					6/29/2020 8: 3	3 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	197, 094, 235	l .	0	0	1.00
2.00	Temporary investments Notes receivable	005 413		_	0	2.00
3. 00 4. 00	Accounts receivable	985, 413 51, 921, 558	l .	ή	0	
5. 00	Other receivable	31, 721, 330		0	0	
6. 00	Allowances for uncollectible notes and accounts receivable		i c	o o	Ö	
7.00	Inventory	5, 245, 655	c	0	0	7. 00
8.00	Prepaid expenses	2, 734, 835	C	0	0	
9.00	Other current assets	0	C	0	0	9. 00
10.00	Due from other funds	001 (0)	C	_	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	257, 981, 696	<u> </u> C	0	0	11. 00
12. 00	Land	3, 859, 567		0	0	12. 00
13. 00	Land improvements	408, 976			0	
14.00	Accumulated depreciation	-77, 624	c	0	0	14. 00
15.00	Bui I di ngs	215, 286, 879	1	0	0	15. 00
16. 00	Accumulated depreciation	-53, 547, 942	1	_	0	16. 00
17. 00	Leasehold improvements	52, 897	1	1	0	17. 00
18. 00 19. 00	Accumulated depreciation Fixed equipment	-52, 897	C	1	0	18. 00 19. 00
20. 00	Accumulated depreciation				0	20.00
21. 00	Automobiles and trucks	194, 358		o o	ő	21.00
22. 00	Accumulated depreciation	-138, 802	l .	0	0	22. 00
23. 00	Major movable equipment	85, 773, 816	c	0	0	23. 00
24. 00	Accumulated depreciation	-62, 384, 421	C	0	0	24. 00
25. 00	Minor equipment depreciable	0	C	0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets			0	0	26. 00 27. 00
28. 00	Accumulated depreciation				0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	ĺ		ή	Ö	
30.00	Total fixed assets (sum of lines 12-29)	189, 374, 807	ď	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	3, 459, 967		-	-	31. 00
32. 00	Deposits on Leases	0	C	_	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	13, 827, 913	C	1	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	17, 287, 880	1	1	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	464, 644, 383	1	1		36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	18, 059, 589	C	0	0	37. 00
38. 00	Salaries, wages, and fees payable	26, 947, 396	1	_	0	38. 00
39. 00	Payroll taxes payable	0	C	0	0	39. 00
40. 00	Notes and Loans payable (short term)	5, 067, 165		0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments	0) U	U	41. 00 42. 00
43. 00	Due to other funds	2, 653, 175		0	0	1
44. 00	Other current liabilities	257, 562		o o		
45.00	Total current liabilities (sum of lines 37 thru 44)	52, 984, 887		0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	C	1	0	
47. 00	Notes payable	188, 691, 260	1	-		1
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	1, 891, 884		-	0	48. 00 49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	190, 583, 144	l .	-		
51. 00	Total liabilities (sum of lines 45 and 50)	243, 568, 031	l .			
	CAPI TAL ACCOUNTS		,			
52.00	General fund balance	221, 076, 352				52. 00
53.00	Specific purpose fund		C)		53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted			0		55. 00 56. 00
57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant		•	0	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	repl acement, and expansi on				Ĭ	
59.00	Total fund balances (sum of lines 52 thru 58)	221, 076, 352	l .	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	464, 644, 383	C	0	0	60.00
	[59]	I	I	I	I	I

Provider CCN: 15-0173

					То	12/31/2019	Date/Time Prep 6/29/2020 8:33	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	J GIII
				·				
	T=	1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		190, 892, 000			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		30, 173, 747			_		2. 00
3.00	Total (sum of line 1 and line 2)	10.00	221, 065, 747			0		3. 00
4.00	I NTERCO TRANSACTI ONS	10, 604			0		0	4. 00
5.00	ROUNDING				0		0	5. 00
6. 00 7. 00					0		0	6. 00 7. 00
8.00					0		0	8. 00
9. 00					0		0	9. 00
10.00	Total additions (sum of line 4-9)		10, 605		U	0	U	10. 00
11. 00	Subtotal (line 3 plus line 10)		221, 076, 352			0		11. 00
12. 00	Deductions (debit adjustments) (specify)		221,070,332		0	U	0	
13. 00	beddetrons (debrt adjustments) (specify)				0		0	13. 00
14. 00					0		0	14. 00
15. 00		o o			0		0	15. 00
16. 00		0			0		0	16. 00
17. 00		o			0		o	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	i	221, 076, 352			0		19.00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				Ŭ			2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4. 00	INTERCO TRANSACTIONS	1	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			0					9.00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12.00
13. 00			0					13.00
14. 00			0					14. 00
15. 00			0					15. 00
16.00			0					16.00
17. 00	T + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 +		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	٥			0			19. 00
	sheet (line 11 minus line 18)	1	ļ	I	- 1		l	

Health Financial Systems I STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0173

			То	12/31/2019	Date/Time Prep 6/29/2020 8:3	pared:
	Cost Center Description	I npati ent	-	Outpati ent	Total	J dill
	oost contor bescription	1. 00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	115, 001,	727		115, 001, 727	1. 00
2. 00	SUBPROVI DER - I PF	110,001,			110,001,727	2. 00
3.00	SUBPROVI DER - I RF					3. 00
4. 00	SUBPROVI DER					4. 00
5.00	Swi ng bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		٥		O	7. 00
8. 00	NURSI NG FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	115, 001,	727		115, 001, 727	
10.00	Intensive Care Type Inpatient Hospital Services	113,001,	121		113,001,727	10.00
11. 00	INTENSIVE CARE UNIT	16, 918,	961		16, 918, 961	11. 00
12. 00	CORONARY CARE UNIT	10, 710,	, , ,		10, 710, 701	12. 00
13. 00	BURN INTENSIVE CARE UNIT		O		0	
13. 01	BURN INTENSIVE CARE UNIT		0		0	13. 01
14. 00	SURGICAL INTENSIVE CARE UNIT		Ŭ		o .	14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	14, 384,	611		14, 384, 611	
16. 00	Total intensive care type inpatient hospital services (sum of line				31, 303, 572	
10.00	11-15)	01,000,	, _		01, 000, 072	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	146, 305,	299		146, 305, 299	17. 00
18. 00	Ancillary services	351, 781,		593, 426, 257	945, 208, 161	18. 00
19. 00	Outpati ent services	43, 718,		194, 084, 826	237, 803, 378	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					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	OTHER - PHYSICIAN, RETAIL PHARMACY		0	316, 689, 970	316, 689, 970	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to V	/kst. 541, 805,	755	1, 104, 201, 053	1, 646, 006, 808	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			459, 862, 934		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	T		0	_		41.00
42. 00	Total deductions (sum of lines 37-41)	6		450.040.001		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr	anster		459, 862, 934		43. 00
	to Wkst. G-3, line 4)	1				

		IU HEALTH ARNETT		_	u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0173	Peri od:	Worksheet G-3	
	From 01/01/2019					nanad.
				To 12/31/2019	Date/Time Pre 6/29/2020 8:3	pareu: 3 am
					072772020 0.0	
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line	28)		1, 646, 006, 808	1. 00
2.00	Less contractual allowances and discounts on	patients' accoun	ts		1, 171, 108, 622	2.00
3.00	Net patient revenues (line 1 minus line 2)				474, 898, 186	3. 00
4.00	Less total operating expenses (from Wkst. G-2	, Part II, line	43)		459, 862, 934	4.00
5.00	Net income from service to patients (line 3 m	inus line 4)			15, 035, 252	5. 00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6. 00
7.00	ON Income from investments				0	7. 00
8.00	8.00 Revenues from telephone and other miscellaneous communication services				0	8. 00
9.00	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	ts			0	14. 00
15.00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical sup	plies to other th	nan patients		0	16. 00
17.00	Revenue from sale of drugs to other than pati	ents	·		0	17. 00
18.00	Revenue from sale of medical records and abst	racts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, e	tc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, an				0	20. 00
21.00	Rental of vending machines				0	21. 00
22. 00	Rental of hospital space				0	22. 00
23. 00	Governmental appropriations				0	23. 00
0.4.00						04.00

15, 138, 495 24. 00

30, 173, 747 29. 00

0 27.00

25. 00 26. 00

28. 00

15, 138, 495 30, 173, 747

24. 00 MI SCELLANEOUS I NCOME

27. 00 OTHER EXPENSES (SPECIFY)

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)

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Li	eu of Form CMS-2552-10
CALCULATION OF DELMBUDGABLE BAD DERTS	TITLE VVIII DADT D	Providor CCN: 15 0172	Pari ad:	Workshoot I 5

Heal th	Financial Systems IU HEALTH ARNET	T HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Peri od:	Worksheet I-5	
			rom 01/01/2019		
			o 12/31/2019	Date/Time Pre	
				6/29/2020 8: 3	3 am
			1. 00	2. 00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII	- PART B	1.00	2.00	
1.00	Total expenses related to care of program beneficiaries (see		0		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see inst		o	0	2. 00
2. 01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see i				2. 01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see in	nstructions)			2. 02
2.03	Total payment due (see instructions)	•	o	0	2. 03
2.04	Outlier payments		o		2. 04
3.00	Deductibles billed to Medicare (Part B) patients (see instruc	ctions)	o	0	3. 00
3. 01	Deductibles billed to Medicare (Part B) patients (see instruc	ctions)			3. 01
3.02	Deductibles billed to Medicare (Part B) patients (see instruc	ctions)			3. 02
3.03	Total deductibles billed to Medicare (Part B) patients (see i	nstructions)	o	0	3. 03
4.00	Coinsurance billed to Medicare (Part B) patients		o	0	4. 00
4.01	Coinsurance billed to Medicare (Part B) patients (see instruc	ctions)			4. 01
4.02	Coinsurance billed to Medicare (Part B) patients (see instruc	ctions)			4. 02
4.03	Total coinsurance billed to Medicare (Part B) patients (see i	nstructions)	o	0	4. 03
5.00	Bad debts for deductibles and coinsurance, net of bad debt re	ecoveri es	0	0	5. 00
5. 01	Transition period 1 (75-25%) bad debts for deductibles and co	oinsurance net of bad debt	0	0	5. 01
	recoveries for services rendered on or after 1/1/2011 but bef	fore 1/1/2012			
5.02	Transition period 2 (50-50%) bad debts for deductibles and co		0	0	5. 02
	recoveries for services rendered on or after 1/1/2012 but bef				
5.03	Transition period 3 (25-75%) bad debts for deductibles and co		0	0	5. 03
	recoveries for services rendered on or after 1/1/2013 but bef				
5.04	100% PPS bad debts for deductibles and coinsurance net of bad	d debt recoveries for	0	0	5. 04
	services rendered on or after 1/1/2014				
5.05	Allowable bad debts (sum of lines 5 through line 5.04)		0	0	
6.00	Adjusted reimbursable bad debts (see instructions)		0		6. 00
7.00	Allowable bad debts for dual eligible beneficiaries (see inst	•	0		7. 00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) p	oatrents (see	0	0	8. 00
9. 00	instructions)		0	0	0.00
	Program payment (see instructions) Unrecovered from Medicare (Part B) patients (see instructions	-)	٩	U	9. 00 10. 00
10.00		•	0		11.00
11. 00	Reimbursable bad debts (see instructions) (transfer to Worksh PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PER		ı V		11.00
12 00	Total allowable expenses (see instructions)	COLIVIAGE	O		12. 00
	Total composite costs (from Wkst. I-4, col. 2, line 11)				13. 00
	Facility specific composite cost percentage (line 13 divided	hy line 12)	0. 000000		14. 00
1 7. 00	indentity specific composite cost percentage (fine is divided	Dy 11110 12)	0.000000		1 00

Heal th	Financial Systems IU HEALTH ARNETT	HOSPITAL	In lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0173	Peri od: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			2, 783, 796	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			198, 394	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructi ons)	125. 61	
4.00	Number of interns & residents (see instructions)			6. 64	
5. 00	Indirect medical education percentage (see instructions)			1. 50	
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	sum of lines 1 and 1.01,	, columns 1 and	41, 757	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p. 30) (see instructions)	atient days (Worksheet E	, part A line	3. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instru	ctions)		21. 41	8. 00
9.00	Sum of lines 7 and 8			24. 41	9. 00
10.00	0.00 Allowable disproportionate share percentage (see instructions)				10.00
11. 00	Disproportionate share adjustment (see instructions)			140, 860	11. 00
12. 00	12.00 Total prospective capital payments (see instructions)				
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see in	structions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9. 00	Current year capital payments (from Part I, line 12, as appli			0	
10.00	Current year comparison of capital minimum payment level to c			0	
11. 00	Carryover of accumulated capital minimum payment level over c. Worksheet L, Part III, line 14)	apital payment (from prid	or year	0	11. 00
12.00	Net comparison of capital minimum payment level to capital pa	yments (line 10 plus line	e 11)	0	12. 00
13.00	Current year exception payment (if line 12 is positive, enter			0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over c (if line 12 is negative, enter the amount on this line)			0	14. 00

15.00 0 16.00 0 17.00

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

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